Care Quality Commission

Young@heart (The Willows) Care Home Limited

The Willows Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

We carried out this inspection on the 1 and the 3 December 2014. At our last inspection in May 2014, we had wide spread concerns in all areas of our inspection. The areas of concern included people not receiving safe appropriate care with accurate assessments. Staff not receiving adequate supervision and support along with poor record keeping and a failure to robustly identify through quality audits areas of concern throughout the service. The manager/ provider sent us an action plan to confirm how the service was going to address these areas of concern. We issued warning notices for two areas where no improvements had been made.

The Willows Care Home provides accommodation for up to 27 people who require personal and/or nursing care. At the time of our visit there were 25 people living at the

Summary of findings

home. The Willows Care Home is made up of two floors. It has communal areas including two dining areas, a lounge, conservatory and outdoor space. There are single and one double room, a kitchen and laundry facilities.

There was no registered manager in post at the time of our inspection. We have asked the provider to ensure they register a manager and that we see evidence of this. It is a requirement that the service must have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The Home had appointed an acting manager who was responsible for improving the quality of the service. There was also a deputy manager who was responsible for the day to day running of the home.

At this inspection risks to people's safety were not always reported and acted on. We found incidents and accidents which had failed to be addressed. Assessments relating to moving and handling did not include all specific details relating to care and treatment. Where there were risks within the communal areas the service had failed to reduce these risks by having a completed risk assessment in place.

Staff did not manage people's medication in a safe manner. This was because staff left medication unattended. This practice placed people at risk of harm.

Care plans did not always reflect people's individual and changing needs. Some information relating to people's individual needs, preferences and choices had not been updated in the main care plan.

The home failed to have robust systems and audits in place. This included not identifying areas of concern within people's care plans, assessments, the homes incident and accident logs and records. There were no action plans in place to address concerns.

Staff told us they felt there was a lack of clear leadership and the acting manager was not always accessible. Staff had received supervision and team meetings and there were daily handovers to keep staff informed of people's change in need. We found that staff were not receiving annual appraisals which meant opportunities to set goals and identify training needs had not happened.

Whilst people told us that they had no reason to complain we found that the service was not analysing complaints and ensuring that they were learning from them.

The home had a variety of snacks and meals which maintained a healthy diet. Staff offered choice and options at meal times and people were happy and relaxed within the meal time experience.

We saw that staff provided care that was caring and where people became upset they supported them in a professional calming manner. Staff we spoke with confirmed how they provide dignity and privacy to people they support.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not always safe.

Not all risks had been identified and assessed. This meant that people were at risk of care and treatment that was inappropriate or unsafe.

Medication was being left unattended. This practice placed people at risk of harm. People who we spoke with and relatives mostly said they felt safe and happy although one relative and a member of staff confirmed incidents involving physical altercations had occurred.

Staff knew what constituted abuse and who they would report any concerns to.

Is the service effective?

Requires Improvement

This service was not always effective. Not all care staff had a good understanding of people's care and support needs. Care plans did not always reflect people's current individual needs, preferences and choices.

Staff received supervision and team meetings, but they had not received a yearly appraisal which reviews their performance and identifies goals and training needs for the following year.

People had access to snacks and meals that maintained a healthy diet. However, not all dietary requirements were identified and recorded within the individual's care plan.

The Mental Capacity Act 2005 was not accurately being followed and not all assessments held accurate information relating to that person.

Is the service caring?

Good

Most people and relatives spoke positively about the care and support they received. People described staff as "very good" and they "are lovely to X". Staff we spoke with described how they maintained people's privacy and dignity. They explained how they ensured people have privacy and dignity whilst having their care needs met.

Staff knew people well who had been in the service for a period of time. We found for one new person they did not receive care and support from staff who knew their history, likes and dislikes.

Is the service responsive?

Requires Improvement

This service was not always responsive.

Whilst people told us that they had no reason to complain, the service was not analysing complaints and evidencing how they were learning from them.

Summary of findings

Meetings were held for relatives so they could share their views about the service. An issue which relatives had raised at the beginning of the year were still yet to be actioned. However the service confirmed that they would have a new activities co-ordinator starting in the new year.

Is the service well-led?

Inadequate

The service was not always well-led. Care staff said there was a lack of clear leadership and there was not always a manager available.

The regulations state that the registered person or provider must send notifications about incidents that affect people who use services to the Care Quality Commission (CQC). CQC had not been receiving notifications as required by law

The service did not have a manager who was registered with us. There were a number of staffing vacancies. The acting manager told us that they were in the process of recruiting new staff. They told us most of the vacancies should be filled by the new year.

The service was failing to undertake robust audits and identify areas of concern in relation to people's care plans, mental capacity assessments and other related paperwork.

The Willows Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was unannounced and consisted of two inspectors. This inspection took place over two days on the 1 and the 3 December 2014.

We spoke with one person of the 25 people living at The Willows Care Home and seven relatives about their views on the quality of the care and support being provided. Most people living at the home had dementia. We undertook a Short Observational Framework for Inspectors (SOFI) so that we could observe how people were receiving their care.

We spoke with the acting manager and deputy manager, one senior carer and five care staff. We looked at six people's care records and documentation in relation to the management of the home. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures. We looked around the premises, observed care practices and the administration of medicines.

Before the inspection, the provider had completed a provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at previous inspection records, the provider's action plan and enforcement action taken along with notifications we had received. Services tell us about important events relating to the care they provide using a notification.

Inadequate

Is the service safe?

Our findings

There was a safeguarding and whistleblowing policy in place and the service displayed the Local authority's safeguarding policy in the main entrance hall. The acting manager confirmed what safeguarding referrals had been made since our last inspection. The acting manager and the deputy confirmed they were responsible for raising all safeguarding's to the local authority and to us (CQC). The regulations state that the registered person or provider must send notifications about incidents and accidents that effect people who use the services to CQC. On our inspection we found there was one incident which we had not been notified about. This incident required action to be taken under safeguarding procedures.

The acting manager had failed to identify and take action relating to this incident. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We had received information before our inspection to suggest that medication was not being safely administered. We observed that on one occasion the medication was left unattended. People were therefore at risk of harm from medication that was not intended for them. This meant there had been a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The staff member told us this should not have happened. We discussed our findings with the acting manager they confirmed they would take appropriate action.

All medication was stored securely in a locked trolley. One member of staff carried the key on their person so that no else could access the trolley. We saw records confirm that medication was accurately recorded after being administered. The staff training matrix confirmed 8 members of staff had received training in the last 8 months. There were no staff responsible for administering medication that had not been trained.

One person confirmed they felt safe. Five of the six relatives felt their relatives were safe and they had no concerns in relation to safety of the people living at The Willows. They said "yes I feel X is safe" and "yes I know that X is safe and happy". One relative however told us whilst visiting, they had witnessed people hitting each other and staff and on one occasion they had been hit themselves.

We saw one incident form that confirmed one member of staff had been injured whilst supporting someone in the service. One member of staff confirmed there were incidents between people but they were unable to give any examples of this. We reported this to the acting manager who was unaware of this, we have asked them to take action in relation to these concern.

Not all risks to people using the service were appropriately assessed and reviewed. We looked at the care records for six people. We saw that one of these care records failed to identify the specific support and the moving and handling equipment that the person required. This meant there was a risk that the person could receive care or treatment which was inappropriate or unsafe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed two areas of risk within the home environment. We asked the acting manager for the risk assessments relating to the uneven floor in the main communal lounge and the stairs, which had a laundry trolley and gate across. The assessments could not be provided. Risk assessments are required so that the risk can be identified and reduced to ensure the environment was safe. This meant there has been a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Care records did not contain up to date information. We saw recorded on a body map unexplained bruising for one person. We looked for an incident and accident log but we could not find one. The acting manager was unaware of this information and had taken no action to address this concern. Two people's care plans lacked recorded information relating to their care and welfare. One person had information lacking in relation to their likes and dislikes in personal grooming and their choice of clothes. We spoke with the individual's relative who confirmed their relative had a personal style relating to their facial hair. We found on the day of our inspection the individual had received care that was not supported by their personal choice. We spoke with another person regarding their food preferences. They told us "I don't like fish so on a Friday, I eat eggs". We reviewed their care plan and nutritional preferences. There were no records that confirmed this preference. We also found that fluid and repositioning charts were incomplete and inaccurate. This meant people

Inadequate

Is the service safe?

were at risk of receiving unsafe care and support due to inaccurate records. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The service was currently recruiting staff. Several staff had left or were working their notice period. On the day of the inspection there were enough staff on duty to meet people's needs. Call bells were answered in a reasonable time, and staff were visible throughout the day. The service was using agency staff regularly. They tried to use the same agency staff to ensure continuity. One agency member of staff told us "I've been coming here for four or five months. I know that the continuity makes it easier for the people who live here". One member of staff told us "We've been really short staffed and it's been really hard; we have had to rely on agency staff, we try our best with what we've got". Another member of staff told us "We have been short staffed but we have a lot of new staff starting now, which is great".

There was a clear recruitment system in place. We looked at seven staff files and saw all but one had a completed disclosure and barring service (DBS) check in place prior to the staff member commencing their employment. We received information post this inspection to suggest a new member of staff was working without a DBS. On further investigation we found this was true, the service took action to reduce this risk whilst awaiting the individuals DBS. A DBS check confirms if the individual has any criminal convictions that might mean they are unsuitable for the role they are being employed for. All providers are expected to have effective and safe recruitment and section procedures in place.

There were personal emergency evacuation plans in place for people. Each person had a completed risk assessment which included the day and night risks. These had been reviewed in September 2014. When we spoke with staff regarding these risk assessments we found that those who were agency were unsure where the fire evacuation meeting point was. This meant that people could be at risk of not being safely evacuated due to some staff being unfamiliar with the correct procedures.

Requires Improvement

Is the service effective?

Our findings

There was not always clear documentation to confirm new staff had completed their induction process. We saw from the last inspection the service had implemented a new induction programme. 2 of the 7 staff files we reviewed did not contain evidence that staff had completed their induction. One member of staff who had completed the induction programme and told us "The induction training was good and covered a lot. I've also told them I want to go on and do my Level 2 NVQ".

The training information we saw confirmed that staff had attended training and updates in manual handling, fire safety and food hygiene. We saw that some refresher training was due. This included training in safeguarding adults as only 56% of staff had been trained. Other training due was Equality and diversity, and manual handling. We spoke with the acting manager who showed us the refresher training that was planned for the next two months. We also saw that 3 staff were currently undertaking dementia training as part of a distance learning programme. This showed the service had made arrangements to get all existing and new staff trained.

Staff told us that they felt supported by the acting manager. Previous inspections had identified the lack of formal supervision for staff, during this inspection we saw there was a current supervision schedule in place. We saw evidence in staff files that supervision sessions had taken place. Other sessions had been booked into the staff rota so that staff were aware when their sessions would be. Staff confirmed that they had received supervision. However, no staff had been formally appraised during the year. This meant that staff had not been given a formal opportunity to discuss their roles, training needs or career development in any meaningful way. This meant staff were not being given the opportunity to identify areas in which they might wish to improve on. We fed this back to the manager for them to take action.

People who used the service did not have access to appropriate meaningful activities as there was no activities co-ordinator in post. Staff told us "There isn't an activities co-ordinator and the people living here would really benefit from some better interaction. There is only limited social stimulation for people here" and "I think an activities person is starting soon, which will be so good for people; at the moment, they have nothing to do". The acting manager confirmed after the inspection that the activities co-ordinator had started but was temporarily supporting part time with some office administration tasks but this arrangement was temporary.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are an amendment to the Mental Capacity Act 2005, which allow the use of restraint or restriction but only if they are in the person's best interest. Staff were aware of encouraging people to be involved in day to day choices and decisions. This included people choosing what they wanted to wear and what they wanted to eat and drink. There was evidence that the legislation had been taken in to account for some people who did not have capacity to make certain decisions. This included decisions such as if the person could communicate their wish and if they were able to make daily decisions about what and when to eat and drink. Not all assessments included details to each individual need. For example one assessment confirmed the person was unable to communicate their decisions. We observed however that they were able to verbally confirm their decision when a member of staff spoke with them. We found in another person's file a completed mental capacity assessment. After further investigation we found that a mental capacity assessment should not have been completed as they were fully able to make all their own decisions. The Mental Capacity Act 2005 should only ever be used when an individual does not have capacity. This meant although there were assessments in place they were not always accurately being undertaken or that they included accurate information relating to that person. This meant there had been a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were knowledgeable about the needs of the people they were caring for. One of the agency staff told us "I've worked nights and days here so I am very familiar with people's routines, for example who likes to get up early or who likes to stay in bed". One member of staff discussed how they cared for people with continence issues. They also told us "I think there is a continence advisor who comes in if we need them to". This meant people were supported by staff who knew their routines well.

We saw people being offered drinks throughout our inspection. Fresh fruit and snacks were available between

Requires Improvement

Is the service effective?

meals. Staff told us they monitored people's food and fluid intake and that this was recorded within people's care records. One member of staff told us "We try and maximise people's independence during mealtimes. For example, rather than feeding a person, we sit with them and have something to eat too, as it's more sociable for them, and encourages them to eat. It's the same for drinks. If you offer to have a cup of tea with someone, they are more likely to drink it". We observed people having their lunch. We saw people being asked what they would like. Staff spoke clearly and with respect. The tables were set with table cloths, napkins, salt and pepper. We saw people were interacting and talking to each other enjoying the social aspect of the meal time experience. People were asked if they wanted seconds, we saw occasions when people said yes. This showed us that staff supported people to eat and drink sufficient amounts, and that staff had the necessary skills to encourage people to eat and drink.

The building was laid out over two floors. Each person had their own room, with brightly coloured doors, some had their names on and some did not. We saw one person accidently walk into another resident's room. We fed this observation back to the manager who said they would look into alternative ways for people to recognize their room. There was a good size outdoor space available for people to use during better weather. The handyman told us that they were planning to tidy up the space and plant some raised beds so that people could enjoy different plants and flowers throughout the year.

Good

Is the service caring?

Our findings

We spoke with one person who spoke positively about the care and support they received. They said “staff are very good”. Six relatives felt happy with the care and support received at the home. Comments included “quite happy with the care”, “staff know what makes X tick”, “Care the staff give is very good”, “we are very happy there have been improvements over the last few months” and “the staff are lovely to X”.

We observed staff were caring and treated people with kindness and compassion. We observed staff bending down or sitting next to the person they were speaking with, and staff spoke calmly and kindly with them. When people became agitated, staff were able to diffuse the situation calmly and were able to distract the person’s attention.

Staff spoke knowledgeably about how to maintain people’s privacy and dignity. Staff told us “It’s not just closing the room door when providing personal care, but it’s things like closing the curtains too”. One agency member of staff told us “ the staff here are some of the best carers I’ve worked with” One member of staff told us “The staff and the quality of care here is good; staff know people’s needs, I know all of the residents, I talk to them and learn about them”.

Another member of staff told us “We have a really good team here. I love my job, making people comfortable and raising a smile”. Staff spoke to people by their preferred name. There was a relaxed atmosphere throughout the day. We saw people having their hair done and we observed staff talking with people in the lounge.

The atmosphere of the home was calm and relaxed. We clearly saw people accessing areas of the home freely. Staff were friendly and talked to people in a positive and engaging manner. People were allowed time to reply to staff questions in a relaxed manner. Where staff did need to repeat a question they adjusted the content of the question, which allowed people the opportunity to understand and respond accordingly.

Staff confirmed how they support people. One agency member of staff spoke about how one person requires more emotional support throughout the day. They told us “I give reassurance, they can get upset so sometimes I might walk with them”, they confirmed what activities they liked to undertake. One other member of staff confirmed how they support with one person’s moving and handling techniques and how they use the equipment and talk to the person. They confirmed that sometimes they have to observe to see if the person is happy and if not they might come back later, talking to them all the time.

We found that for those people who had been in the service for a while staff were knowledgeable about their care needs. This was evidenced through our conversations with them about the care they had delivered that day. We found however this was not the case for one new admission to the service. We found that staff were not familiar with their care needs this meant for those new into the service care and support was not always provided in a person centered way.

The acting manager confirmed how important it was for the service to recruit the correct staff with the right attitude. They told us they had been ensuring that all new staff come with the right skills to do the job.

Three of the four care plans that we reviewed had a life story book in situ or a summary containing information about the person. The life story book covered detailed information including what time the person likes to get up, their spouse and family information, their occupation and activities they enjoy. Only two of the care plans had a signed relative’s consent form in situ. This confirmed in what situation the relative would like to be contacted if there was a problem. It covered areas such as if the person had fallen or was taken to hospital. This meant relatives might not be contacted when they wished due to lack of clarification when they would like to be contacted and if this was day or night or both.

Requires Improvement

Is the service responsive?

Our findings

We saw that a relative's survey had been carried out during January 2014. There were also minutes of "Relatives meetings" from August 2014. We saw an update confirm refurbishment plans for the service and the new activities co-ordinator post. Not all relatives that we spoke with were able to confirm they had received a copy of this meeting. This meant the service was not ensuring all relatives were aware of the changes and informed regarding up and coming proposals.

Four relatives told us they had not had a reason to complain in the last 6 months but they all felt able to discuss concerns with staff or the acting manager. We looked at the complaints file. The file contained a summary of complaints but we were unable to see any detail of the complaint, how it was investigated, dealt with, responded to, or if it was now resolved. This meant that the provider was not analysing complaints or feedback in order to improve services for people. We were unable to see how or if the provider used complaints as an opportunity for learning or for quality improvement. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

Care plans had an evaluation section which showed monthly reviews had been undertaken. However, the information generally stated "reviewed no change". Within one care plan, there was an incident which described the person as being verbally aggressive. Despite this, their evaluation behaviour plan stated "no changes". There was no evaluation which identified the change in behaviour or how this person might need to be supported with their behavioural needs. One member of staff said they ensure the person has additional support if they show signs of distress and upset. The high use of agency staff increased the risk of staff being unaware of this change and therefore not being responsive to people's needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

One person told us staff were responsive to their needs. They said "staff would help me if I need it, but I manage most care myself". We spoke with relatives who also said staff were good at responding to people's needs. Two relatives told us "staff know X well", and "they know what makes X tick, and how to work with X", "they seem to know X well, and understand X". We asked one visitor if they had been involved in the plan of care for their relative. They told us they had not and that their other family members had not been either. This meant that although people felt staff were responsive to their needs, information was not always sought from those close to them.

Inadequate

Is the service well-led?

Our findings

There was a procedure for reporting incidents and accidents. Not all incidents and accidents were being logged and recorded so that they could be analysed. We found that some injuries were just documented on the person's body map within the care plan but were not reported through the home's incident and accident procedure. One incident was not picked up through a robust audit of the individuals care plan as their behavior chart remained unchanged after an incident.

We reviewed the Health and Safety audit undertaken in October 2014. It failed to identify the lack of robust accident and incident recording. This meant the provider was failing to undertake robust audits that identified areas of concern in relation to incidents and accidents and address these concerns through a robust action plan. This was a Breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

We found that not all incidents and accidents were being notified to The Care Quality Commission (CQC) without delay. We saw one incident where a person had four areas of bruising on their body. This had failed to be reported to the CQC and investigated by the service. We also saw that where one person had been verbally aggressive towards someone else this had failed to be reported to the CQC. CQC is required to be notified without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity. This is important so that we can monitor services and when required take further action. This was a Breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2010.

The home was in the process of appointing a permanent manager. We were told after the inspection that this person would be appointed on the 29 December and that they would apply immediately to become the registered manager. The home is required by law to have a registered manager in post. The last registered manager left on the 15 July 2014. We informed the provider that we need to see evidence of an application form to register the new manager in the new year. We expect the provider to take appropriate action to address this.

The acting manager confirmed that they had a clear vision of the type of staff they wanted to recruit. They confirmed all new recruited staff were being selected to enhance the service. They also confirmed that they were ensuring staff had the right values and skills to do the job and that they brought the correct attitude. They confirmed this had taken a while due to the amount of vacancies, but they would be fully staffed from the new year. Staff and relatives all confirmed the home was going through an unsettled time. Relatives made some positive comments. They told us "the new manager is very approachable and has talked to me at great length", "we are very happy with the improvements over the last few months, it is more informative, the environment is cleaner and fresher, and it seems more organised". Staff told us "Relatives know that staff are leaving, they are concerned. Even the residents know staff are going; they keep seeing new faces". One member of staff told us "This place needs leadership". Staff felt able to discuss concerns with the managers at the home. But they all felt that at times managers were not always accessible and on site due to their part time working hours. We reviewed the recruitment plan after our inspection. It confirmed the home was still recruiting one domestic/ laundry assistant and 2 full time care staff. We expect the manager to keep us updated with the current recruitment situation.

We saw throughout our inspection that the new acting manager had started to make improvements to the previous widespread areas of concerns from our previous inspection. They confirmed they were only part time and had been since August. This meant progress had not been made as quickly as someone who might have been managing the service full time. We saw that staff supervision and team meetings were now in place and that people had personal evacuation plans. Care plans now had an evaluation section which was filled in monthly. However, whilst improvements had been made, some areas had yet to reach the required standard. After our inspection, we met with the acting manager and the provider to raise our concerns and confirm what action we would take, if improvements were not made and sustained.

We saw the acting manager actively walking around the building. They talked to people, visitors and staff. We saw them talking to one individual in a reassuring and sympathetic way when they were unsettled. Staff told us that they had regular handovers which allowed for sharing of information. There were two a day, so staff could discuss issues from that shift and any change or update relating to people's wellbeing. Staff told us that there had been staff meetings. We saw minutes of staff meetings that had been

Inadequate

Is the service well-led?

held every 4 to 8 weeks since July, and less frequently prior to that. The minutes showed us that staff were kept informed of challenges and changes within the Willows. Staff told us the meetings had taken place and they felt able to speak up. Staff were confident they would be listened to.

We reviewed the systems in place to monitor the quality of the service. We found that the home had a system in place to evaluate care plans monthly. This included an evaluation sheet, which was signed each month for each section of the person's individual care plan. The evaluation sheet failed to accurately audit deficits within behaviour charts and mental capacity assessments and identify shortfalls in details to one person's moving and handling assessment.

We found that these evaluation sheets and lack of good robust overall quality audits of the care plans had also meant that shortfalls relating to individual Mental Capacity Assessments had failed to be identified and addressed. For example we saw that one Mental Capacity Assessment had been completed for one person who had capacity. We also saw that another Mental Capacity Assessment identified that the person was unable to make decisions in certain aspects of their life. We found their assessment lacked any details in relation to their ability to make daily decisions.

This meant you were not identifying through robust quality audits information that was either incorrect or required more information. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Two medication audits had been completed over the last two months. They had identified areas of concern and highlighted what actions were required. The acting manager confirmed they were responsible for addressing these actions. We could see that some of the actions had been addressed. For example a new fridge for storing medication had been ordered and was being put in situ on the day of our inspection. The other outstanding actions had a clear timescale and plan as to how they were going to be addressed.

We also saw that the home had undertaken an infection control audit. This had a clear action plan, which identified areas to be addressed along with time scales. The infection control audit confirmed that mops and buckets were being stored appropriately. However on the day of our inspection we saw them standing outside the kitchen, up against the wall. This meant you had failed to identify through robust audits poor practice in relation to the storage of cleaning equipment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Planning and the delivery of care was not always done in such a way to meet people's individual needs and ensure their safety and welfare. Care plans had not been updated as people's needs had changed. This meant that up to date information about people's care and support was not always available.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse We found that the service was not taking suitable steps to ensure people were not at risk of abuse. Steps were not being taken to ensure that where allegations of abuse had been identified they were responded to appropriately. This meant people were not being safeguarded against the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were at risk due to poor practice of administration of medication. This was because medication was left unattended after it had been dispensed. This put people and that person at risk of receiving medication that was inappropriate or incorrect.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The Mental Capacity Act 2005 and its principles were not being adhered to. Assessments did not clearly document individual wishes and assessments had been completed when they were not required.
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider was not ensuring all incidents and accidents were reported without delay to The Care Quality Commission (CQC). There were two incidents where notifications should have been sent and were not. This meant that the provider was not taking action to ensure all injuries to people and allegations of abuse were reported as required so that where needed action could be taken.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The service was not protecting service users and others against the risk of inappropriate or unsafe care or treatment. This was because they failed to have robust audits and systems in place that identified shortfalls within the service. People were therefore at risk of receiving care and treatment that was not safe or appropriate to their needs.

The enforcement action we took:
We have issued a Warning Notice to the provider. They must become compliant by the 17 March 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not being protected against inappropriate care and treatment due to the lack of accurate information recorded. Care plans, assessments and charts contained lack of clear accurate information which meant that people were at risk of care and treatment that was inappropriate or unsafe.

The enforcement action we took:
We have issued a Warning Notice to the provider. They must become compliant by the 17 March 2015.