MD Care UK Ltd

Fairways Residential Care Home

Inspection report

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection. Our previous inspection of the home on 31 March 2013 found that people's needs were not always assessed and care was not always planned and delivered to meet their assessed needs. We told the provider that they must make improvements to protect people from the risks of unsafe care. We required that the provider send us a report by 29 May 2014 detailing the improvements they would make

Summary of findings

to keep people safe. We did not receive this report and the provider was unable to offer an explanation as to why this report had not been sent. During this inspection we found that improvements had not been made.

The home provides accommodation and personal care for up to 70 older people some of whom have dementia care needs. At the time of inspection 41 people were living at the home. As a condition of registration the service must have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The service had not had a registered manager since 30 December 2013. A manager had been appointed and the provider told us that they would apply to become the registered manager.

People were not protected against the risks of receiving unsafe care as the provider had not assessed, planned or delivered care to ensure people's welfare and safety. People's bed rails were not fitted correctly to reduce the risk of injury or them becoming trapped. Not all people had a risk assessment to ensure that this type of equipment was suitable and did not pose additional risks to the person. We brought this to the attention of the provider during the inspection. We were told that the issue had been resolved. However, we checked a person's bed rails and found that they were in the same unsafe condition as they were when we first identified the issue.

People's nutritional needs were not always effectively met. Assessments of people's risk of malnutrition were not completed properly and plans to monitor people's weight loss were not followed. One person was placed at risk of choking as there were conflicting directions as to the consistency of their food and drink.

Care was not always assessed, planned or delivered to be responsive to people's needs. For example, a person's epilepsy care plan did not contain sufficient information to guide staff in the action to take in the event the person experienced an epileptic seizure. A person assessed as requiring a pressure-relieving mattress to reduce the risk of them developing a pressure ulcer did not have this type of equipment on their bed which placed them at risk. One person had asked staff to assist them to use the toilet. Over 40 minutes later the person remained in the lounge and had not been assisted to the toilet. We informed the manager that this person had not been assisted to ensure their needs were met.

People's medicines were not always managed safely. Staff administered two people's medicines at the same time which increased the risk of error. Medicine trollies were not always secured to the wall when not in use and medicine was left unattended. Controlled Drugs (CD) were not managed appropriately as the medicines recorded in the CD register did not correspond with the medicines held in the CD cupboard. The manager told us that this was a recording error as the CDs had been returned to the pharmacy but the register had not been updated.

The provider had not made suitable arrangements to respond to actual or alleged abuse. The manager was not aware of the local safeguarding and a complaint alleging neglect was not reported to the local authority as is required. Staff were aware of what constitutes abuse, the signs and how to report abuse. Staff were aware of the concept of whistle-blowing and outside organisations they could contact if they had concerns, such as the local authority.

People were not protected from the risks of unlawful deprivation of liberty as the provider had not made appropriate arrangements. People's care records indicated that they were under continuous supervision and control and were not free to leave the home. The manager told us they were aware of a change in the law in relation to the Deprivation of Liberty Safeguards (DoLS). However, they had not taken action to assess whether or not the change in the law would require them to seek DoLS authorisations for people living at the home.

Not all staff had received the training necessary to carry out their roles in subjects such as the Mental Capacity Act 2005 and moving and handling. Staff had not received formal supervision as identified in the provider's policy and had not had appraisals. Staff told us they felt they had enough training and received feedback as to their performance.

People's privacy and dignity was not always respected. Staff assisted one person to change position using a hoist in an undignified manner. Staff carried walkie-talkies and

Summary of findings

it was audible discussion around peoples personal care. However, doors to people's bedrooms were kept closed during personal care and people's relatives told us that staff were polite and helpful.

During our observations people had brief or no contact with staff . The television and radio were both on and call bells were audible within the lounge area. The mixture of noises may have had an adverse effect on people's well-being.

People's care records did not always contain accurate or up-to-date information and there was a risk that staff would not be responsive to their needs. For example, one person's care records indicated two different pieces of equipment that the person should use to change position. It was not clear which piece of equipment the person should use. The manager told us records were not up-to-date.

The provider had not made statutory notifications to the commission. A statutory notification is information about important events which the service is required to send us by law. The manager told us that they were not aware that notifications were required for this type of event.

The provider did not have an effective system to monitor the quality of the service or identify, assess and manage risks. The manager told us that audits of practice had not been undertaken properly or consistently. Audit reports stated that practice was safe in the management of medicines which was contrary to our findings.

The provider had a complaints procedure which staff were aware of. People told us they felt able to raise concerns and were confident that the provider would respond to them. However, the complaints procedure was not displayed to ensure people had access to this.

People and staff had mixed views as to whether or not there were enough staff. One person told us that there was sometimes a long wait for staff to answer their call bell. Staff reported they could be rushed and did not have enough time to spend with people. People waited an excessive amount of time to be supported to transfer from their wheelchairs to lounge chairs following their lunch.

People accessed healthcare professionals when they required. People's care records showed that they had received treatment from a variety of healthcare professionals. People told us they saw the doctor when they needed to. Two visiting community nurses told us that the staff at the home made appropriate referrals and followed their advice.

People felt involved in making decisions about their care. One person told us they could get up and go to bed at times convenient to them. Relatives told us they felt staff were informative and helpful and involved them in developing their relative's care plan.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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?

The service was not safe. People's medicines were not managed safely. People's bed rails were not correctly fitted to protect them from the risks of injury.

There were not appropriate arrangements to identify and respond to actual or alleged abuse and people were not protected from the risks of unlawful deprivation of liberty.

There were not sufficient staff to meet people's needs in a timely manner.

Inadequate

Is the service effective?

The service was not effective. People's nutritional risks were not effectively assessed.

Not all staff had received training in topics that were relevant to the needs of people using the service. Staff were not effectively supported, supervised or appraised.

People accessed healthcare professionals when they required.

Inadequate

Is the service caring?

The service was not always caring. People's privacy and dignity were not always respected and people were not always treated with consideration.

People felt involved in making decisions about their care and treatment.

Inadequate

Is the service responsive?

The service was not responsive to people's needs. Care was not always assessed or planned to be responsive to people's needs.

People's care records did not always contain accurate information to enable staff to respond to their individual needs.

People felt able to raise concerns.

Inadequate

Is the service well-led?

The service was not well-led. The provider had not supplied the Commission with information when required.

The provider did not have an effective system to monitor the quality of the service or identify, assess and manage risks.

The provider did not submit statutory notifications as required.

Inadequate

Fairways Residential Care Home

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors and an expert by experience who had experience of services for older people. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we asked the provider to complete 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. However, the PIR was not returned within the required timescale. The provider returned the PIR to us by e-mail when prompted.

Before our inspection, we reviewed the information included in the PIR along with information we held about the home. This included statutory notifications, safeguarding information and the findings of previous inspections.

We visited the home on 11 and 12 August 2014. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with seven people and the relatives of three people. We spoke with the provider, the manager, the head of care, one member of the catering staff and five care staff.

We looked at five people's care records which included assessments and care plans and records relating to medicines. We looked at records relating to the management of the home, including staffing rota's, training records, policies and procedures, quality monitoring reports and complaints records. We also spoke with two community nurses who were visiting the home. We observed care being provided in communal areas.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Inadequate

Is the service safe?

Our findings

Our inspection on 31 March 2014 found that the bed rails fitted to one person's bed were incorrectly fitted as there was a gap between the bed rail and the bed which placed the person at risk of becoming trapped. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.We told the provider that they must make improvements to protect people from the risks of unsafe care. At this inspection we found that sufficient improvements had not been made.

We looked at six people's bed rails and found they were not fitted correctly to reduce the risk of injury to the person using the bed. Not all people who used bed rails had a risk assessment to ensure the equipment was suitable and did not pose additional risks to the person. Not all people had covers over the bed rails to reduce the risk of injury. One person's bed rails were not high enough to sufficiently reduce the risk of them falling from bed as they had a specialist mattress which increased the height of the bed. There were gaps between the bed rails and people's beds which placed them at risk of becoming trapped.

People were not protected against the risks of receiving unsafe care as the provider had not assessed, planned or delivered care to ensure people's welfare and safety. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's medicines were not always managed safely. Medicine trollies were not always secured to the wall when not in use and medicine was left unattended. We observed that one staff member of administered two people's medicine at the same time which increased the risk of error. A urine sample was stored alongside medicines in the refrigerator which the manager agreed was not safe practice.

A number of people living at the home took warfarin, a medicine that stops blood from clotting. The manager told us that the hospital advised of changes in the dosage of this medicine by verbal instruction via the telephone. The manager told us that two staff would confirm the message and the dosage was changed and administered in line with this verbal instruction. We found that changes to one person's medicine administration chart in respect of this medicine were not signed by the staff making the change. This meant arrangements were not appropriate for the safe administration of medicines as dosages were changed and administered without written confirmation.

Controlled drugs (CD) were not appropriately managed. Items listed in the CD register were not present in the CD cupboard. The manager told us that medicines had been returned to the pharmacy and the register had not been updated. Other items which were not CD, such as water for injections, were documented in the CD register.

The provider had not made suitable arrangements to protect people against the risks associated with unsafe use and management of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had not made suitable arrangements to identify and respond to actual or alleged abuse. The manager was not aware of the local safeguarding arrangements in relation to responding to allegations of abuse. The manager told us that they would investigate allegations of abuse and if true would report these to the local authority safeguarding team. This is contrary to the local multi-agency safeguarding adult's policy. The provider's safeguarding policy did not provide explicit guidance as to when or how allegations of abuse should be reported. A complaint record detailing an allegation of neglect that had been made by a person's family had not been reported to the local authority safeguarding team by the provider as is required.

Staff were aware of what constitutes abuse and the signs that may indicate that a person had been abused. All staff knew to report any allegation or suspicion of abuse to the manager. Safeguarding leaflets were available at the entrance to the home.

People were not protected from the risks of being unlawfully deprived of liberty as the provider had not made appropriate arrangements. The manager told us that one person was subject to an authorisation to deprive them of their liberty. However, we looked at this person's care records and found that their Deprivation of Liberty Safeguards (DoLS) authorisation had expired. This meant that there was a risk that the person had been unlawfully deprived of their liberty as the arrangements for their care had not changed.

Inadequate

Is the service safe?

The manager was aware of a change in the law in relation to DoLS. However, they told us that they had not taken action to assess whether or not the change in the law would require them to seek DoLS authorisations for people living at the home. Four of the five care staff we spoke with did not have an understanding of DoLS and told us that they had not received training about the subject.

There was a risk that people were unlawfully deprived of their liberty as assessments had not been carried out. People's care records indicated that they were under continuous supervision and control and were not free to leave the home. For example, one person's care record stated that staff should prevent the person from leaving the home unaccompanied by staff due to the risk of harm. Another person's care records stated that it was at the discretion of the person in change whether or not the person would be "allowed" to leave the home.

The provider had not made appropriate arrangements to respond appropriately to allegations of abuse or protect people from the risks of unlawful or excessive restraint. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The manager told us that they were able to increase staff as required. Staff absences were covered using agency staff or the senior staff team would provide support and assistance. The numbers of staff detailed on staffing rotas corresponded with the provider's assessment of the numbers of staff required.

People had mixed views as to whether or not there were enough staff to meet their needs. People told us that the response to their call bell was variable depending on how busy the staff were. One person told us that there sometimes was a long wait at night when they pressed their call bell for help to access the toilet. A person's relative commented that the staff often appeared rushed.

Staff had mixed views as to whether or not there were enough staff to enable them to perform their roles effectively. Staff reported they could be rushed and did not have enough time to spend talking with people. We saw that people waited an excessive amount of time waiting to be supported to transfer from their wheelchairs to lounge chairs following their lunch. For example, one person who had been sat in their wheelchair repeatedly said, "What's going on. I can't stay here all day." However, this person was not supported by staff for over an hour.

Inadequate

Is the service effective?

Our findings

People's risk of malnutrition was not always accurately assessed or effectively responded to. One person had been assessed as being at a high risk of malnutrition in January 2014. This assessment had not been repeated for six months and their weight had not been recorded weekly as was planned. Another person had lost 10kg of weight in the previous three months and their malnutrition risk assessment had not identified that they were at a high risk of malnutrition.

One person did not have a 'safe swallow plan' to detail the consistency of the food and drink that they could consume safely. A notice board in the office contained conflicting information as it stated that the person should have both a soft and a pureed diet. The manager told us that the consistency of the person's diet would depend on the type of food. The person's care plan stated that they did not need a soft diet. Staff told us that this person received a pureed diet but provided different accounts as to how thick the person's fluid should be. This placed the person at risk of choking as assessment and planning of this person's care was inconsistent.

People were not protected against the risks of receiving unsafe care as the provider had not assessed, planned or delivered care to ensure people's welfare and safety. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had a plan which detailed the training staff had undertaken. The plan stated that staff should receive training in a variety of relevant topics such as fire, infection control and safeguarding people from abuse. Staff told us they considered they had received sufficient training to carry out their roles. However, not all care staff had received the training necessary to carry out their roles. For example, 11 out of 23 care staff detailed on the training plan had not received training in topics such as the Mental Capacity Act, the Deprivation of Liberty Safeguards or moving and handling. This meant that there was a risk that people were supported by staff who did not have the knowledge and skills to effectively provide care and support.

The provider did not have an effective process to supervise, appraise and support staff. Staff told us that they did not have formal supervision and appraisal but had received feedback. The manager told us that staff did not have supervision on a one to one basis but the provider was planning to implement this. The manager told us that staff supervision was completed during the daily handovers, although no record was kept of this. The provider's training policy stated that staff should receive supervision and observation at least six times per year.

The provider had not made suitable arrangements to ensure that staff received appropriate training and supervision to enable them to provide effective care to people using the service. This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Meal times were not as pleasurable as they could have been. People were supported to the dining room well in advance of their meals being served. Some people expressed dissatisfaction at this for example one person said, "Come along we're waiting." Another person said repeatedly, "Ready now." Two further people were banging on the dining tables. During the lunchtime, a member of the domestic staff vacuumed in close proximity to where people were eating their meals.

People were supported to eat and drink and told us they enjoyed the meals. One person told us, "I think we are very lucky to have such good food." Staff offered people help to cut up their food and people were provided with aids such as plate guards and double handled beakers so that they could eat and drink independently. Staff sat with people they were assisting to eat and checked that they had finished their mouthful before offering more food. People were encouraged to eat when they had not consumed much of their meal. Staff checked that people had finished their meals before removing their plates.

Catering staff told us that there were two choices of main meal offered. People had to make their meal choice the day before the meal was served. Meals were placed in front of people and they were not offered a choice at the table. One person was provided with a drink of orange juice and asked for an alternative. Staff told this person that there was not an alternative drink for them. People were offered a choice of desert and a description was given by staff before returning with the desert. Catering staff told us that they were able to offer alternatives should a person not want any of the choices on offer.

Inadequate

Is the service effective?

People accessed healthcare professionals when they required. People's care records showed that they had received treatment from a variety of health professionals including GP's, dentists and district nurses. One person's relative told us that the doctor had been called following their relative having a fall. Another person's relative said, "She sees the doctor when she needs to. They have called an ambulance as well when she had a fall." Two community nurses told us that staff at the home made appropriate referrals and followed their advice.

Inadequate

Is the service caring?

Our findings

People's privacy and dignity were not always respected. We saw staff assisting one person, who was wearing a skirt, to change position using a hoist. The person was hoisted in an undignified manner in a communal area. Doors to people's bedroom and bathrooms were kept closed when people were being supported with their personal care needs. Staff carried walkie talkies around with them. Communication between staff with regards to which people were being supported to use the toilet were audible.

Staff did not always treat people with consideration. Staff supported two people to transfer from lounge chairs into their wheelchairs. On one occasion staff informed the person that they were going to take them to the dining room. However, on another occasion the person was wheeled away without explanation of their destination. One person's relative told us, "Everyone is very polite and helpful." Another person's relative said, "They take a real interest." Staff acknowledged people when they entered the room on a number of occasions.

We observed seven people in the main lounge, the majority of who were living with dementia. We saw that over our two 45 minute observation periods there was one member of staff supporting between 18 and 21 people. This resulted in the seven people we were observing having very brief or no contact with staff during that time. All of these minimal contacts people had with this staff member were positive and people reacted by smiling at the staff member. The other contacts people had with other staff were in relation to tasks such as going to the toilet. Most staff were friendly and smiling when they spoke and interacted with people. However, we also saw examples of staff ignoring people who were trying to make contact with them and staff being focused on the task they were supporting people with rather than having a conversation or reassuring the person.

In the main lounge there was both a television and a radio on. Call bells were also audible within this area. The mixture of noises may have had an adverse effect on people's well-being as not all people were able to independently move away from noises that they may have found disturbing. Daily check sheets prompted staff to turn both the television and the radio on in the morning.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People felt involved in making decisions about their care. One person told us that they could get up and go to bed at times convenient to themselves. A person's relative told us that they were involved in developing their relatives care plan. Another person's relative said, "The staff are very helpful. They are lovely and very informative. I do ask a lot of questions and they answer them." A further relative told us that staff at the home kept them informed.

Inadequate

Is the service responsive?

Our findings

Care was not always assessed or planned to be responsive to people's needs. For example, we looked at one person's care plan in relation to their epilepsy. This document did not contain a sufficient assessment or plan to guide staff in the action to take if this person had an epileptic seizure. The plan guided staff to notify the head of care if the person experienced a "fit". There was no information as to the types of seizure this person experienced or what a typical seizure was like for this person. There was no detail as to if or when the person would require hospitalisation. This placed them at risk of not receiving the treatment they needed.

When people were supported by staff to transfer between their wheelchairs and lounge chairs staff made sure that pressure relieving cushions were also transferred. However, one person's care records indicated that they required a pressure-relieving mattress on their bed to reduce the risk of the developing a pressure ulcer. The pressure-relieving mattress was not present on the person's bed. The manager confirmed that this equipment was needed but had not been provided.

One person had asked staff to assist them to use the toilet. Over 40 minutes later the person remained in the lounge and had not been assisted to access the toilet. Three different staff members spoke with the person and told them someone would take them. Staff took other people to the toilet but did not take this person. This meant the person's needs were not met as care was not delivered when required. We informed the manager and deputy manager that this person had not been assisted to ensure this person's needs were met. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People's care records did not always contain accurate or up-to-date information. For example, one person's care record had several handwritten amendments which were not dated or signed. This record identified two different pieces of equipment that the person should use to change position, a hoist and a stand-aid, but it was not clear which should be used. This put them at risk of inappropriate care. Another person's care records indicated that their blood sugars should be checked by staff. However, there was no indication as to the frequency or the action to be taken if the reading was of concern. The manager told us that this person's blood sugar levels no longer needed to be checked and that the record was outdated. Records relating to people's personal care had not been completed accurately. The manager told us that people's care records were not well maintained and that they would arrange training for staff in this area.

People were not protected from the risks of inappropriate care as records did not always contain accurate or sufficient information. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Activities were not provided to meet people's needs. Two dedicated activity workers were employed and worked over a seven day period. An outdated activity plan was displayed in the lounge which was over five months old and detailed activities such as making valentines cards. Care staff told us that they did not get involved in providing activities as this was not part of their role. There were between 18 and 21 people in the lounge for one activity worker to support. One person told us, "There's not much going on today or any other day. We just sit and watch TV." Another person told us they spent time in their room and did not see staff unless they called for something.

During our observations we saw one person living with dementia was attempting to walk around the home. A staff member repeatedly asked this person to sit down in a kind way and reassured them. However, the individual wanted to walk about and they became unsettled and anxious when they were asked to sit down. Another person was occupied with sorting cards and two other people took part in a game of hoopla. Other people were watching television or playing dominoes. However, the four other people were not occupied or involved in any activity or stimulation and spent their time either watching what was going on or closing their eyes.

People were not supported to orientate themselves. In one part of the building there were hand rails in bright contrasting colours to that of the walls to assist people to independently move around. Some toilets had pictorial signs to help people identify the room's purpose. However, there was little signage to help people find their way around the home or identify their bedrooms. an audit undertaken by the provider had identified that pictures to help people identify their bedrooms were needed. However, no action had been taken in response to this audit and the same issue was identified in a subsequent

Inadequate

Is the service responsive?

audit completed a month later. Two members of staff wore a uniform displaying the name of another care home which may have caused people confusion. There was a notice in the communal lounge which displayed the day, date, weather and season. This notice displayed incorrect information in respect of the day and date first thing in the morning which people may have found confusing.

The provider had a complaints procedure which detailed the action to take if someone complained. This procedure detailed other organisations that the complainant could contact if they were dissatisfied with the provider's response to their complaint. However, this procedure was not displayed. Staff told us they would try and resolve people's complaints as they arose, although would refer to the manager if the concerns were more serious or they were unable to resolve the issue. None of the people we spoke with had made a compliant. However, they felt able to raise concerns and make complaints and were confident that the provider would listen.

The record of a recent residents meeting documented that topics such as food and future plans for the service had been discussed. Future meetings were planned to provide people an opportunity to provide feedback in respect of the service provided.

Inadequate

Is the service well-led?

Our findings

At our inspection on 31 March 2013 we found that people's care and treatment was not always planned and delivered in a way that was intended to ensure their safety and welfare. We required that the provider send us a report by 29 May 2014 detailing the improvements they would make to keep people safe. We did not receive this report as required and the provider was unable to offer an explanation as to why this report had not been sent.

Prior to this inspection the provider was contacted and asked to return a Provider Information Return (PIR). The PIR contains information from the provider which helps us in planning our inspections to ensure we address potential areas of concern. The PIR was not returned within the required timescale by the provider who told us that they had received the request but had overlooked it. We received the PIR following a further e-mail and telephone call to the provider.

The provider told us that they had undertaken 700 visits to the service in the past 12 months to assess the quality of the care provision. No reports of actions were kept as a result of these visits. The provider told us that they monitored aspects such as the food and the environment when they visited and passed on any concerns to the manager verbally. However, these visits were ineffective as they had not identified the issues we had found, such as inappropriate management of medicines, inaccurate records and unsafe care and treatment.

The manager told us that audits of practice had not been undertaken properly or consistently. We looked at a number of audit reports relating to the management of medicines and general checks of the environment. These audits had not identified the issues we had found. For example, the audits for the previous two months indicated that there were no problems with the management of controlled drugs or security of medicines trollies which is the opposite of what we had found. Checks on aspects of the service such as cleanliness and the environment had identified issues, such as the absence of pictures on people's bedroom doors. However, there was no action plan or any action taken as a result of these checks.

The provider did not have an effective system to monitor the quality of the service or identify, assess and manage risks. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider had not made statutory notifications to the commission. A statutory notification is information about important events which the service is required to send us by law. The manager told us that five allegations of abuse had been made. However, statutory notifications to the Care Quality Commission (CQC) had not been made as is required. The manager told us that they were not aware that this type of notification was required. This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

The provider had a whistle-blowing policy which guided staff to contact the manager if they had concerns. Staff were aware of this procedure and told us they could contact other organisations such as the local authority or the Care Quality Commission if they had concerns which they felt unable to bring to the attention of the provider. Staff told us they felt able to raise concerns and make suggestions.

We spoke with the manager, head of care and provider about the concerns we had found during our inspection and they told us that they were committed to taking action as a result. However, we were told that the issues we had identified with people's bed rails had been resolved. We went to check one person's bed rails and found that they were in the same unsafe condition as they were when we first identified the issue. The provider told us there had been issues with staff "not following the rules" which had contributed to the problems and they hoped these would be addressed with the appointment of the head of care to the deputy position and the manager becoming the registered manager.

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 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The provider did not have an effective system to identify, assess and manage risks. There was not an effective system to regularly assess and monitor the quality of the service provided. Regulation 10 (1)(a)(b)**

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 **The provider had not made suitable arrangements to identify and respond to actual or suspected abuse. The provider had not made suitable arrangements to protect people from the risks of unlawful or otherwise excessive control or restraint. Regulation 11 (1)(a)(b)(2)(a)(b)**

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 not protected against the risks associated with the unsafe use and management of medicines. Regulation 13.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People's privacy and dignity were not always respected and they were not always treated with consideration. Regulation 17 (1)(a)(2)(a)**

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 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records People were not protected against the risks of unsafe or inappropriate care as records did not always contain accurate or sufficient information. Regulation 20 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider had not made suitable arrangements to ensure that staff received appropriate training, supervision and appraisal. Regulation 23 (1)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had not made notifications to the commission as required. Regulation 18 (1)(2)(e).

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure that people were protected against the risks of inappropriate or unsafe care as care had not been assessed, planned or delivered to meet people's needs or ensure their welfare. Regulation 9 (1)(a)(b)(i)(ii)(iii).

The enforcement action we took:
We have issued a warning notice requiring the provider to make improvements by 29 September 2014.