Care Quality Commission

Prime Healthcare UK Limited

Ranelagh Grange Care Home

Inspection report

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Date of inspection visit: 21 & 27 January 2016
Date of publication: 13/04/2016

Ratings

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

Overall summary

We visited this service on the 21 and 27 January 2016. The first day of the visit was unannounced.

Ranelagh Grange Care Home is registered to provide accommodation for persons who require personal care. The service accommodates up to 39 people and bedrooms are located on the ground and first floor of the building. There were 24 people using the service at the time of this inspection.

A registered manager has been in post since August 2014. 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.

An inspection was carried out at the service in May 2015 and we found the service was not meeting all of the regulations we assessed. We judged the service to be inadequate and the service was placed into special measures. A further inspection of the service took place in

Summary of findings

October 2015 and we found that there was not enough improvement to take the registered provider out of special measures. Since that inspection we have received concerns around the care and treatment of people using the service.

On 11 December 2015 we imposed a condition on the registration of the provider to restrict admissions to the service until the Care Quality Commission is satisfied that people are receiving safe, effective care.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'. During this inspection we found a number of continued breaches and a new breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not receive their medicines at the right time and some people did not receive their prescribed medication. Medication administration records (MARs) had not been completed at the right time and others had not been completed with accurate information to show the reason why people had not received their medicines.

Where there had been an increase to the level of risk people faced their care plans had not been updated to reflect the changes. Risk assessments were not completed accurately, therefore putting people at risk of receiving unsafe care.

Fluid monitoring charts did not provide staff with important information about the amount of fluid people were to be offered on a daily basis and this lead to people not being offered the appropriate amount of fluid which they needed to keep them hydrated.

Staff lacked an understanding of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS) and they did not know which people were subject to a DoLS. This meant that the rights of people who were not always able to make or communicate their own decisions or needed their liberty restricting for their safety were not protected.

People's confidentiality and dignity was undermined. Personal records belonging to people were not stored securely and they were left unattended in a communal lounge. A used commode and a commode without a lid was were left in people's bedrooms.

Care plans had not been reviewed at the required intervals and people did not always receive the care and support in line with their care plan. Guidance about how to support a person with their behaviour had not been followed and the appropriate recording charts were not in place to help monitor the person's behaviour.

The registered provider failed to make improvements to the service which had been brought to their attention by a number of different agencies. Insufficient systems were in place for the registered provider to monitor the quality of the service that people received at Ranelagh Grange.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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.

The registered provider and the registered manager had not made the improvements required at the last inspection to make people safe.

People's medicines were not managed safely.

Risks people faced were not accurately reflected in their care plans.

Inadequate

Is the service effective?
The service was not effective.

The registered provider and the registered manager had not made the improvements required at the last inspection to provide an effective service for people.

Staff lacked knowledge of the Mental Capacity Act 2005 and they were unsure which people had a Deprivation of liberty safeguard in place.

People's fluid intake was not appropriately recorded and monitored.

Inadequate

Is the service caring?
The service was not always caring.

Staff practices undermined people's confidentiality and dignity.

People and their relatives told us that staff were caring and friendly.

Requires improvement

Is the service responsive?
The service was not responsive.

The registered provider and the registered manager had not made the improvements required at the last inspection to make this a responsive service for people.

People's needs were not met in line with their care plan.

Inadequate

Is the service well-led?
The service was not well-led.

There was a registered manager in post.

The registered provider and the registered manager had not acted upon or made the improvements required at the last inspection to ensure that this is a well led service.

The registered provider did not have effective systems in place to monitor the quality of the care and service people received.

Inadequate

Ranelagh Grange Care Home

Detailed findings

Background to this inspection

We undertook an unannounced comprehensive inspection of Ranelagh Grange Care Home on 21 and 27 January 2016. This inspection took place to look into concerns we had received about people's care and welfare. The team inspected the service against the five questions we ask about services: is the service safe, effective, caring, responsive and well led.

The inspection was undertaken by four adult social care inspectors. During our inspection we spoke with six people who used the service, three family members, the operations director and five staff.

We looked at the care records belonging to eight people and other records related to the management of the service including some policies and procedures.

Before our inspection we reviewed all the information we held about the service. This included any notifications received from the registered manager, safeguarding referrals, concerns about the service and any other information from members of the public. We also considered information from the local commissioners of the service.

On 11 December 2016 we imposed a condition on the service's registration to ensure that the registered provider would not accept any new people into the service until the Care Quality Commission were satisfied that people would receive safe, effective care. This condition remains in place.

Inadequate

Is the service safe?

Our findings

At our inspection in October 2015 breaches of legal requirements were found. They included; Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people who used the service were not protected against the risk associated with unsafe or unsuitable premises or equipment. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected against the risk of receiving care that is unsafe and people who used the service were not protected from the proper and safe management of medicines.

At our inspection in October 2015 we found concerns with the management of people's medicines. Also before this inspection we received some concerns about the management of people's medicines. We looked at those concerns as part of the safe domain.

The registered provider had actioned some of the concerns which we identified at our last inspection in October 2015. They had purchased and put into place two new fridges for the storage of medication as required. However, we found ongoing concerns and other concerns with the management of people's medicines.

People did not receive their medicines in a timely way. On the first day of our inspection the morning medication round which was carried out by one member of staff continued up to 11:55 am and because of this the lunchtime medicine round had to be delayed. This meant that people did not receive their prescribed medicines at the correct times. This was also a concern at the last inspection in October 2015.

Some people did not receive their medicines as prescribed and some records had not been completed to show the reasons why the person had not received their medicines. No action was taken when people continuously refused to take their prescribed medication. For example, one person's Medication Administration Record (MAR) was coded to indicate that they had refused their medicines on three consecutive days this information had not been recorded on the reverse of MAR as required, and there was no evidence to show that the person's GP was contacted for advice regarding any possible effects of the omission of prescribed medication. This was also identified as a concern by St Helens medicines management team during a medicines audit which they carried out at the service on 13 and 14 January 2016. The timescale for action to address the concern given by the medicines management team was ASAP (as soon as possible).

It became apparent at 2:15 pm on the first day of our inspection that a person had not received their eye drops in the morning and at lunchtime as prescribed for an eye infection. We raised this with a member of staff who told us this was because the person had been asleep each time staff went into their bedroom that morning. However, we had met with the person in their room at 10:15 am and they were awake and sat in an easy chair. Also monitoring records completed by staff showed that the person had been awake since rising that morning. The persons MAR was left blank despite a requirement to use codes when a person did not receive their medicines, including a code to identify when a person was asleep. The person's MAR had still not been completed at 2:45 pm and it was confirmed by a member of staff that the person had not yet had their eye drops administered. This was despite us raising it as a concern half an hour before. The person received their eyes drops at approximately 3 pm. Failure to administer people's treatment/medicines when they were prescribed may result in their condition not being effectively treated.

MARs for a number of other people had not been signed or coded to show that they had received their medicines, or if they had not the reasons why. For example, one person's MAR had not been signed or coded on three separate occasions on the same day for medicines which they were prescribed. Another person's MAR had not been signed and dated on two separate occasions on the same day for prescribed ointment. This meant people were put at risk because they did not receive their prescribed medicines.

We observed that one medicine was signed for before it was administered to the person it was for. This was not in line with national guidance which states that a record of medicines given should only be made when the person had taken their medicines. Items of medication and instructions for their use on printed MARs were difficult to read due to the poor quality of them. Also the label on a medicine bottle for one person was of such poor quality that it could not be read.

Inadequate

Is the service safe?

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people who used the service were not protected from the proper and safe management of medicines.

Risks assessments had not been reviewed at the required intervals and updated to reflect changes in some people's needs. For example, a falls risk assessment for one person which was completed in September 2015 showed that the person was at high risk of falls. A review of the risk assessment was required each month; however no review had taken place in November or December 2015. The person had three falls in November 2015 and one in December 2015. The person had a further fall on 01 January 2016; despite this the risk assessment was not reviewed until 06 January 2016. The care plan which was last reviewed in October 2015 did not make any reference to the person being at high risk of falls and having a risk assessment in place for this. A falls risk assessment for another person showed that they were at high risk of falls; however, the identified need section of the person's care plan stated that the person was at medium risk of falls due to their mobility. Following a fall in December 2015 it had been recorded that a person was to be observed for 72 hours however the person's care plan and falls risk assessment had not been updated to reflect this information. Furthermore, when a review had taken place the falls history section of both people's risk assessment had not been updated to include falls which they had had. This meant people were at risk of receiving unsafe care.

We requested the registered provider's audits and analysis of accidents and incidents since the last inspection. The operations director who was acting as the representative for the registered provider told us they did not have access to the audits completed by the registered manager and provided details of an audit carried out in December 2015. Furthermore they were unable to provide the audits they had completed as they told us they were stored in the Birmingham office in paper format and staff at that office did not have a key to where they were stored. The audit carried out in December 2015 did not clearly identify the action taken as a result of accidents and incidents, for example risk assessments were not updated.

A personal emergency evacuation plan for two people identified that they were able to leave the building unaided in the event of an emergency, however their mobility care plan stated that they required the assistance of two staff at all times for mobilising. This meant that the people were at risk of not receiving the support they needed if there was an emergency at the service which required an evacuation of the building.

At our inspection in October 2015 we found concerns with the safety of the environment. Also before our inspection we received concerns about the safety of the environment. We looked at those concerns during this inspection.

Some improvements had been made to the safety of the environment since our last inspection in October 2015. The practice of holding fire doors open using wedges and items of furniture was no longer in use, fire exits were clear of obstructions and repairs had been carried out on fire doors so that they closed fully. However, an unlocked vacant bedroom on the first floor close to other occupied bedrooms was being used to store unused equipment including wheelchairs, walking/zimmer frames, walking sticks and boxes. This posed as a trip hazard to people who may wander into the room. Also flammable cleaning products and staff personal belongings including coats and bags were stored in a ground floor bathroom which was unlocked despite it being out of use. This posed as a trip hazard to people who may enter the bathroom and it was a fire risk as bathrooms do not have smoke detectors. In addition cleaning products which were not stored appropriately also posed to risk to people's health and safety.

This is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people using the service were not protected against the unsafe premises and equipment.

Inadequate

Is the service effective?

Our findings

At our inspection in October 2015 breaches of legal requirements were found. They included; Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems were not in place to ensure that people using the service were protected by The Mental Capacity Act 2005. Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014, as accurate records were not maintained in relation to people's planned care.

Before our inspection we received concerns about people's nutrition and hydration. We looked at those concerns as part of the effective domain.

Fluid balance charts were in place for people who needed their fluid intake monitoring. Since our last inspection a guide to help staff calculate fluid amounts had been added to the charts. Fluid charts should have specified the recommended amount of fluid which the person was to consume over a 24 hour period; however that information was not recorded onto fluid charts.

One person's care plan for hydration clearly stated that they were not able to identify when they required fluids and must be offered in excess of 1600 mls of fluids each day and each drink monitored and recorded. However, fluid balance charts completed for the previous three weeks showed that on at least five days the person was offered significantly less fluid than was required. For example, on two days during this period, less than 500 mls was offered and on another day 670 mls was offered. The significant reduction in the amount of fluid the person had been offered during a period of three weeks had not been identified, therefore no action was taken. This was despite the care plan stating; dehydration could have an impact on the person's health. At 11:30 am on the first day of our inspection we noted that the person's fluid balance chart had not been completed since 6 am that morning. Although observation records completed during the morning showed the person was offered a number of drinks, the amount offered and consumed was not specified on those records. This meant the person was at risk of dehydration.

Another person's care plan stated that they should be offered at least 1190 mls of fluids per day, that they should be offered fluids regularly and that their fluid intake should be recorded on a monitoring chart. However, when we visited the person in bed at 10:30 am on the first day of our inspection, they told us they had not been offered a drink that morning. There was a cup in the persons room with a small amount of water in it, however the person was unable to access it as they were lay flat in bed. A fluid balance chart, as required for the person was not in place for that day. This meant the person was at risk of dehydration.

A nutritional risk assessment carried out for one person in July 2015 identified that they were at very high risk. It was recorded onto their risk assessment that food and fluid intake should be recorded onto food intake and fluid balance charts and all foods provided were to be fortified. A review of the risk assessment was carried out in October 2015 and November 2015 and a further review was carried out in January 2016. Each of the reviews continued to identify that the person was at very high risk and that their food and fluid intake should be recorded and foods fortified. However, the care plan which was last updated in January 2016 stated that the person had a poor appetite but it did not highlight that they were at very high risk and required their food and fluid intake monitoring and foods fortifying. The risk assessment score guide showed that if a person was assessed as being very high risk contact with a dietician or GP was required to seek advice, despite this there was no evidence to show any action had been taken. This meant the person was at risk of not having their nutritional and hydration needs met.

Some people were offered breakfast at 11:30 am in the dining room, however the lunch was due to be serviced at 12:30 pm. This meant that some people may miss out on lunch because they received their breakfast late.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the nutritional needs and wishes of people were not always planned and monitored.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguarding (DoLS) and to report on what we find. The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. The Act makes it clear who can take decisions, in which situations and how they should go about this. Legal and professional guidance around the Mental Capacity Act 2005 is specific that if there is any probability that a person may

Inadequate

Is the service effective?

not have the capacity to consent to the preparation of a care plan then an assessment of the person's capacity to consent should take place. In addition all actions agreed on behalf of a person not having the capacity to make specific decisions are agreed to be in the person's best interests. All processes relating to establishing if a person has capacity should be fully recorded.

We looked at eight people's care records and could not locate any mental capacity assessments in line with the Mental Capacity Act 2005. This was despite more than half the people who used the service were living with dementia or experienced memory issues. Eight people who used the service had a DoLS in place; however staff did not know what was meant by a DoLS and what the implications of the DoLS were for those people who had one in place. Consent forms were used for things such as indicating people's preferred gender of carer to provide personal care and consenting to going out on trips. The forms had been completed by a relative on behalf of one person who we were told lacked capacity to consent. However there was not a mental capacity assessment in place for people and no evidence of any best interest meetings having taken place. This meant that the legal rights of people who used the service were not protected due to the lack of implementation of Mental Capacity Act 2005.

This is a breach of Regulation 11 and Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems were not in place to ensure that people using the service were protected by The Mental Capacity Act 2005 and people using the service were not protected from inappropriate deprivation of their liberty.

Requires improvement

Is the service caring?

Our findings

Before our inspection we received concerns about caring. We looked at those concerns as part of the caring domain.

People told us that they felt well cared for. Comments people made included; "The girls are lovely, they are very helpful too" "I'm very happy with the way the girls look after me. I'm very comfortable" and "They are caring and do their best". Family members told us that they thought the staff were caring and kind. One family member commented, "The staff are very good, nice and smiling".

People's privacy was not always respected. On the first day of our inspection we saw that a filing cabinet in the lounge, which stored people's personal care records, was unlocked and left unsupervised. We raised this with a senior member of staff who told us that the lock had broken and it had been reported to the registered manager. The operations director assured us that the records would be transferred to a lockable facility until a new cabinet was purchased. However, several days later on the second day of our inspection the same broken filing cabinet was still being used to store people's personal records. Also on the first day of our inspection one person's care file was left unsupervised on a table in the lounge. This meant that people's confidentiality was put at risk.

Care records belonging to a person who had died in October 2015 were left in the bedroom which they had occupied and care records belonging to another person who had moved rooms three days prior to our inspection, were left in the room which they previously occupied. Both rooms were unlocked. This meant that people's confidentiality was put at risk.

This is a breach of Regulation 17 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2014, as records in respect of people were not stored securely.

People's dignity was not always respected. On the first day of our inspection we visited three people who were being cared for in their bedrooms on the ground floor. One person was in bed and a commode which had not been emptied and a used incontinent pad was left in the person's room. A commode without a lid was left in another person's bedroom close to where they were sat in an easy chair. A similar issue had previously been raised as a concern and brought to the attention of the registered provider following a visit to the service by the local authority in December 2015.

Bedroom windows on the ground floor, which looked out onto public spaces had curtains fitted however the curtains were open in rooms where people were in bed. The windows had no other coverings, such as nets or blinds. This further compromised people's privacy and dignity.

A person's dentures were left on a table in their room whilst they were in bed. We raised this with a member of staff who told us that the dentures should have been placed in an appropriate container.

We observed one member of staff who stood over a person whilst assisting them with their lunch; the person's meal was interrupted on a number of occasions whilst the member of staff turned away from the person and engaged in conversations with other people sat at a different table and with staff who entered the dining room. These practices undermined people's dignity.

Some people were offered cold drinks from small disposable plastic cups which people found difficult to manoever and the use of disposable cups did not promote the dignity of the people using the service.

On the first day of our inspection three people were left sitting at a table in the dining room all morning. Staff undertook some interaction with those people, however it was minimal. One person person became agitated and tipped over a cup of water which had been placed in front of them and they played with the cup and spilt water on the table. At 12 pm two members of staff took the person out of the dining and sat them in the lounge area.

This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as people were not treated with dignity and respect.

Communal areas of the service and people's bedrooms were clean and tidy, people's belongings were neatly stored away and their beds were made with clean bedding, which was of a good standard. People had a good supply of soap and hand towels in their bedrooms and people were dressed in clean clothes.

Requires improvement

Is the service caring?

On the first day of our inspection we observed the lunch time meal being served. People were given a choice for their main meal and they were offered hot and cold drinks. Meals were served hot and they were nicely presented.

Family members told us that they were always welcomed at the service when visiting their relatives. They said they could meet with their relative in private if they wished and that they had always been offered refreshments on arrival.

Inadequate

Is the service responsive?

Our findings

At our inspection in October 2015 breaches of legal requirements were found. They included; Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the needs of people who used the service were not planned for.

Care plans were made up of a number of sections with headings which included, identified care need, purpose of the care and desired outcome and a section which described the planned care. However, people's identified care need had not been updated following a change in their needs. For example, one person's care plan under the heading of identified care need stated that they were at medium risk of falls although the most current risk assessment showed that the person was at high risk of falls. Another person's care plan had not been updated following a review which recorded a change in their needs which now required monitoring. This meant people were at risk of not having their needs met.

A review of a person's care plan which took place on 03 September 2015 recorded that the person was unable to weight bare following their discharge from hospital. The review also stated that the person had been referred onto an occupational therapist to be assessed for a sling to use with a lifting hoist. Further reviews which took place in October 2015, November 2015 and December 2015 showed that the person was still awaiting input from an occupational therapist and had therefore not been provided with the equipment which they required to mobilise safely. The person's moving and handling care plan had not been updated since their discharge from hospital, this was despite there being a significant change to their mobility, for example their inability to weight bare and how this was to be managed. This meant that the person was at risk of unnecessary harm.

One person had a care plan for challenging behaviour which stated that episodes of negative behaviour should be documented and an ABC (antecedent, behaviour, consequence) chart. These charts were to be utilised to assist staff in anticipating what triggers may create distress for the person. There was no ABC chart in place and staff told us that they were not aware of the chart. Daily reports completed over the past three weeks in respect of the person highlighted three occasions when the person had displayed negative behaviour. However, the reports did not make any reference to staff utilising an ABC chart and they did not demonstrate that staff had provided the person with the appropriate support, as detailed in their care plan. For example, one to one support to help the person relax and move on from the episode. This meant that the person was at risk of not having their needs met.

Some people's care plans had not been reviewed each month in line with the registered provider's requirements. For example one person's nutritional care plan was reviewed in October 2015 and then again in January 2016 and another person's personal hygiene care plan had not been reviewed since July 2015. This meant people were at risk of not having their needs met.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the needs of people who use the service were not always planned for or reviewed on a regular basis.

Inadequate

Is the service well-led?

Our findings

There was a registered manager in post who registered with the Care Quality Commission in August 2014.

At our inspection in October 2015 breaches of legal requirements were found. They included; Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because there were insufficient and ineffective systems were in place to assess, monitor and improve the service that people received and to protect them from the risk of harm.

People who used the service told us they knew who the registered manager was. A family member told us, "Management are always polite and listen. I could go to them if I needed to".

When we arrived at the service at 9:40 am on the first day of our inspection we met with the operations director who informed us that the registered manager had not turned up for duty although he was expected. The registered manager did not attend the service at any point during the first day of our inspection and the operations director confirmed that they had not been contacted by registered manager with an explanation as to why they failed to arrive at the service.

People's care planning documents, including risk assessments had not been reviewed at the required intervals and risks to people's health, safety and welfare had not been accurately reflected in their care plans. This put the health and safety of people at risk of not receiving the care and support they required. In addition, a lack of information for staff as to how they needed to support people's changing needs meant people were put at unnecessary risk of harm.

Monitoring records that were in place in relation to people's care and support did not include important information about people's needs and they were not always completed as required. This included a lack of information about people's fluid intake, non-completion of fluid intake charts for people who were at risk of dehydration and the lack of appropriate support for people with their behaviour. Staff failed to follow guidance about how to meet people's needs which was included in people's care plans.

We requested from the operations director copies of quality monitoring audits which had been carried out since the last inspection which took place in October 2015. Audits we requested included those carried out on care plans, medication, staff training and supervision and incidents and accidents. The operations director told us that the audits had taken place but could not be accessed at the time because they were held on computer and the registered manager was the only person who knew the password to the computer. They were unable to access their own monitoring records as these were held in Birmingham in paper form and the staff at the office did not have a key. We obtained copies of the records on the second day of our inspection.

Amongst the records we obtained were a one page document tilted care plan audit for four out of 24 people who used the service and they were dated as having taken place between January 05 and 21 January 2016. The document was made up of a list of records held in people's care files and included 'care plans'. People had a care plan for each of their identified needs, with some people having up to 10 care plans, however the audit documents did not provide any information about the content of which care plans were audited and how they were audited.

We were provided with the details of a medication audit which was dated 08 August 2015 and signed by the registered manager. The audit highlighted a number of concerns, for example errors with administration and recording of medicines. There was no evidence that any other medication audits had taken place at the service. This was despite the concerns highlighted by the registered manager as part of their audit in August 2015 and a breach of regulation which we identified at our last inspection because of concerns about the management of people's medicines. In addition to this St Helens medicines management team found a number of concerns during a visit to the service on 14 and 16 January 2016. The registered provider was made aware of the concerns which the medicines management team identified during their visit, however they remained outstanding at this inspection. The lack of effective systems to assess, monitor and improve the service that people received failed to protect them from the risk of harm.

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

Inadequate

Is the service well-led?

Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and to protect them from the risk of harm.