Care Quality Commission

Prime Healthcare UK Limited

Ranelagh Grange 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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This was an unannounced inspection carried out on the 8, 13 and 21 October 2015.

Ranelagh Grange Care Home is registered to provide accommodation for persons who require personal care. The home accommodates up to 39 people and bedrooms are located on the ground and first floor of the building. There were 31 people living at the home at the time of this inspection.

The service had a registered manager. 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 last inspection of the service took place in May 2015 and we found the service was not meeting all of the regulations we assessed. We judged the service to be

Summary of findings

inadequate and the service was placed into special measures. This inspection found that there was not enough improvement to take the registered provider out of special measures.

During this inspection we found a number of continued breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that the registered provider did not always provide a safe environment for people to live. Potential risks to people had not been considered or planned for in relation to the inside and outside living environment.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We looked at how the service implemented the MCA and found that people were not protected as the principles of the Act were not being adhered to in relation to assessing and recording people's capacity to make decisions.

People's medicines were not always stored or managed appropriately and therefore they were at risk from not receiving their medicines when they should.

Improvements were needed in relation to assessing, planning and reviewing people's care. The current systems in place failed to demonstrate how a person needed their care delivering. This put people at risk from not receiving the care and support they required.

Records were not in place or information was not recorded in relation to people's care needs and the safe recruitment of staff.

The systems that were in place to monitor the quality of the service delivered to people were not effective. This was because an effective system would have identified the areas of improvement required. For example, the registered provider and the registered manager had failed to identify and address areas that required improvement in relation to medicines management, staff recruitment, records and failure to acknowledge and respond to risks to people.

The overall rating for this service is 'Inadequate' and the service remains in 'Special measures'.

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?

Inadequate

The service was not safe.

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

Some areas of the service did not always promote the safety and wellbeing of people. Risk to people had not been considered or planned for.

Safe systems were not in place to monitor people's medicines which meant that on occasions people did not receive their prescribed medicines.

People told us that they felt safe living at the service.

Is the service effective?

Inadequate

The service was not effective.

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

People's capacity was not assessed and therefore they were not protected under the Mental Capacity Act 2005.

People's needs in relation to nutrition and hydration were not always planned for. This could put people at risk of unnecessary harm.

People enjoyed the food that was available at the service.

Is the service caring?

Requires improvement

The service was not always caring.

People's dignity and independence were not always addressed as staff had failed to recognise when a person's hygiene needed addressing and also failed to help ensure that clothing was placed appropriately to maintain people's dignity.

We saw that positive relationships had been formed between people and the staff team.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's needs and wishes were not always recorded or reviewed on a regular basis, therefore people were at risk of not receiving the care and support they needed.

People knew who to speak to if they had a concern. A complaint procedure and records of complaints were in place.

Summary of findings

Is the service well-led?

Inadequate

The service was not well-led.

The registered provider and the registered manager had not 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. This meant that people's changing needs in relation to their care and support and their living environment were not always identified or acted upon.

There was a registered manager in post.

Ranelagh Grange 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.

We visited the service on the 8, 13 & 21 October 2015. All of these visits were unannounced. The inspection team over the three days of visits consisted of three adult social care inspectors, a pharmacist inspector and a specialist professional advisor (SPA). The SPA was a health care professional with specialist knowledge in relation to the implementation of the Mental Capacity Act 2005 and care planning.

We observed the care and support people received, spoke with 16 people who used the service, the registered manager, eight staff members and one volunteer. We looked in detail at the care records of five people, the recruitment and training records of staff and records relating to the management of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Before our inspection we reviewed the information we held about the service including incidents that the registered provider had sent to us since our last inspection. We contacted the local authority who commission care at the service to obtain their views. They told us that they are continuing to monitor the service provided at Ranelagh Grange.

Inadequate

Is the service safe?

Our findings

People told us that they felt safe living at the service.

At our inspection in May 2015 we asked the provider to take action to make improvements to people's living environment, identifying and assessing risks to people, the management of medicines and staff recruitment procedures.

We found during this inspection that some improvements had been made to the cleanliness of the carpets and the management of unpleasant odours. However, the carpet in the conservatory remained stained, sticky when walked on and had an unpleasant odour.

Designated fire doors had been fitted with automatic release equipment, however people were not always protected from the risk of fire as a number of designated fire doors around the building were wedged open with furniture and door wedges. In addition, one door leading to the stairs and a designated fire exit was blocked by hoists and wheelchairs being stored in the area. We discussed this with the registered manager who arranged for the equipment to be moved. The registered manager told us that seven people's bedroom doors had failed to close appropriately the previous night as repair work had been undertaken on the doors. The registered manager confirmed that no risk assessment had been completed to consider and minimise any risks apparent due to the doors not closing. The registered manager recognised that the potential lack of effectiveness of the doors in the event of a fire should have been assessed and appropriate plans put in place. The registered provider was currently working to an improvement plan in relation to ensuring that fire regulations are met. These improvements were to be assessed by the local fire and rescue service in November 2015.

Few bedroom doors had working privacy locks. In addition, the registered manager told us that five people's bedrooms had locks that automatically engaged when the doors were closed and staff were required to open these doors with a key. This meant that people were not always ensured privacy or were able to access their bedrooms independently. Since our previous inspection the registered provider had purchased new locks, however these had not been fitted to people's bedroom doors at the time of this inspection.

Prior to this inspection we received information that a fence panel had been missing from the garden for a period of more than four weeks. The missing fence panel gave direct access to the property. This posed a serious risk to people as they would have unrestricted access. During our inspection we saw that the fence panel had been replaced. We asked the registered manager what actions had been taken to ensure people's safety whilst the fence panel was missing. The registered manager stated that no action had been taken and no assessment of the risks to people had taken place.

This is a breach of 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.

Since our previous inspection Personal Emergency Evacuation Plans (PEEPS) had been developed for people who used the service. These plans informed staff on how a person needed to be supported in the event of having to evacuate from the building in an emergency. However, no contingency plans were in place for use in the event of an emergency. A fire risk assessment completed in June 2015 by the registered manager highlighted the need for contingency plans to be put in place, however the registered manager said that this action had not been completed.

We found that potential risks to people were not always assessed and planned for. For example, we saw that new beds had been purchased for two people. The mattresses to these beds failed to fully fit the bed which resulted in a gap sufficient to cause an injury to a person. In addition, we saw that straps required to be fastened to secure the mattresses were not secure. The registered manager explained a risk assessment and guidance for the appropriate use of the bed had been developed for one person, however this information had not been shared with the staff delivering people's care and support. Failure to identify and minimise risks associated with the use of equipment put people and the staff supporting them at risk from unnecessary harm.

We saw one person sitting in a reclining chair who looked extremely uncomfortable and whose leg was caught between the foot section and the base of the chair. We brought this to the attention of staff who repositioned the person in the chair. We asked if the risks to the person using

Inadequate

Is the service safe?

the chair had been considered and staff stated they had not. This was a concern as the person had several weeks prior to this incident gained a fracture by falling from a chair. We brought this to the attention of the registered manager who stated that they would complete a risk assessment.

We saw that bedrails were no longer in use by two people who used the service. The bedrails had been removed and replaced with mats for the purpose of minimising harm if a person was to fall out of bed. People's care planning documents contained risk assessments relating to the bedrails no longer in use. No assessment of the risks from having the mats in place had been considered. This demonstrated that risk assessments in place to minimise the risk of harm were not up to date or effective.

Safe practices in relation to transporting people in wheelchairs were not always adhered to. We saw a person who used the service sitting in a wheelchair being pulled backwards by a member of staff. The person's feet were dragging along the floor as no foot rests were in place. We brought this to the attention of the member of staff who continued to pull the wheelchair and tip it backwards to lift the person's feet off the floor. This demonstrated that equipment was not being used in an appropriate manner that supported people safely.

The registered provider and registered manager did not ensure that people were protected against receiving inappropriate or unsafe care and support.

This is a breach of 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 inappropriate or unsafe.

People's medicines were not always managed safely. We checked the medicines of five people and we raised concerns regarding all five people's medicines management. Medicines were not always given as prescribed . For example, one person had not received their prescribed medicine and eye drops for five weeks as the person was usually asleep when the medicines were being administered. These medicines could have been administered when the person woke up which would have prevented the medicines being missed. The same person, who had been assessed as being at high risk from malnutrition, had not received their prescribed food supplements for two weeks as the supplements were not available at the service. Two people had not received their medicines on the day we visited and another person had not been given their prescribed vitamin supplement for four weeks as it had been recorded as 'not required'. In addition we saw that people had missed doses of antibiotic eye drops and skin creams which could reduce how effective the antibiotic worked.

We observed on all three visits that the morning medicines were being given by one member of staff and on all three occasions staff were seen to complete administering the medicines after 11am. This meant that the lunchtime medicines had to be delayed. During one visit we found the staff who were administering medicines had not given a number of medicines to several people in error. The registered manager stated that the member of staff should have been supervised by a senior member of staff to administer the medicines as they had not as yet been deemed competent to carry out the role.

Medicines were not always stored appropriately. For example, the minimum and maximum fridge temperatures were not recorded as per national guidance and therefore it was unclear whether the fridge had ever been outside of the normal range. The medicines fridge had two urine samples in it with other medicines which was an infection control risk. We found that the fridge was also wet inside, which further increased the risk of contamination.

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.

A copy of the local authority's safeguarding procedures were available within the home. The registered manager was able to tell us what action they would take if they felt that a person had been abused or were at risk from abuse. However, we spoke to two recently recruited staff who were not aware of how to report a safeguarding concern. Training records made available demonstrated that only 25.7% of staff had received current training in safeguarding. The service provider needs to make improvements to ensure that all staff are aware of safeguarding procedures to help ensure that any concerns are reported appropriately.

Inadequate

Is the service safe?

The registered manager demonstrated a clear understanding of what was required to ensure that new staff were recruited appropriately and safely. They explained that a new system had been introduced since our previous inspection to ensure that all required information for recruitment was obtained and recorded appropriately. We looked at the recruitment records for four staff who had been employed since our previous visit. Not all of the information required was available in the staff records. For example, for one member of staff there was no proof of identity or residence and there was no evidence to demonstrate that this information had been supplied or checked by the service. Another staffs record failed to demonstrate that two references had been obtained as part of their recruitment process. The service needs to make improvements to ensure that appropriate checks are carried out and recorded to ensure that only people suitable to work with vulnerable people are employed.

Inadequate

Is the service effective?

Our findings

People told us that they enjoyed the food and that they had plenty to eat and drink. Their comments included "The food is lovely", "I love the porridge" and "You get plenty to eat".

People told us that they could have their meals in the dining room, the lounge area or their bedroom and that "You have a choice". One person told us "You can have your breakfast whenever you want" and another person told us that they were able to get up and go to bed at whatever time they wished.

At our inspection in May 2015 we asked the registered provider to take action to make improvements to how people's rights were protected in relation to decision making, how people's nutritional needs were planned for and monitored and staff training.

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. Since our previous inspection we saw that ten people were subject to DoLS and that all of these authorisations were in good order.

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 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 the care planning documents of four people and could not locate any mental capacity assessments in line with the Mental Capacity Act 2005. The registered manager told us that he thought 90% of the people who used the service were living with dementia or experienced memory issues. However, he confirmed that no mental capacity assessments were undertaken within the service. Staff demonstrated a limited awareness of the Mental Capacity Act 2005. This demonstrated that the legal rights of people who used the service were not protected due to the lack of implementation of Mental Capacity Act 2005.

General consent forms were in use where family members has signed to give consent on behalf of their relative. For example, we saw that one relative had signed a "no preference" agreement in relation to the gender of staff delivering care. The registered manager told us that the family member had no statutory duty to consent on behalf of their relative. Another person's care planning documents contained a "no preference" agreement stating that the service user did not have a preference in relation to the gender of staff who supported them. The registered manager had signed this document on behalf of the individual. This again demonstrated that the legal rights of people who used the service were not protected due to the lack of implementation of the Mental Capacity Act 2015.

This is a breach of 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.

People's care planning records in relation to their capacity to make specific decisions were not consistent and therefore put the person at risk of not having their care and support delivered appropriately. For example, one person's care planning records stated in one section that they had "fluctuating capacity", another document stated the person was "lacking capacity" and a general consent form was in place that had been signed by the individual which demonstrated that the person had capacity.

This is a breach of 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.

Monitoring charts were in place to measure the amount of fluids people were drinking throughout the day. The charts in use gave the opportunity to record the minimum amount of fluid a person needed to maintain good health. However, we saw that these records failed to demonstrate that people had received the minimum amount of fluids they required. For example, one person's care plan stated that they required a minimum of 2235 mls per 24 hours but the recorded amount of fluid taken was recorded as 1645

Is the service effective?

mls. The monitoring charts were being completed by staff who had been instructed to record the amount of 300 mls and 250 mls, that people had been served but had little understanding of the purpose of monitoring how much a person had to drink. The records failed to demonstrate the different sizes of cups used to serve drinks in and in addition, the records failed to demonstrate how much fluid the person had actually had to drink. The lack of effective assessment and recording could result in a person not receiving sufficient drinks they required to keep healthy.

Records demonstrated that a number of people were at risk from weight loss and stated that people were to be weighed on a weekly and monthly basis. The registered manager said that this information was available in people's care planning documents, however these records were unavailable. The registered manager told us that they would ensure that people's weight monitoring charts would be implemented from the evening.

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 or people were not always planned for and monitored.

The registered manager told us that a new process had been implemented for staff training and that dates had been planned for staff to attend training in relation to their role. For example, the registered manager explained staff would undertake training in relation to dementia, diabetes, understanding communication, health and safety and dignity in care. We requested an up to date record of what training had been undertaken and what was planned. The registered manager supplied us with a training matrix. However, we saw, and the registered manager confirmed that the information on the training matrix was not up to date. For example, the information did not contain the names of all of the staff team.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as accurate records were not maintained in relation to the planning and delivery of care.

A senior staff member told us that they had completed training in relation to their role that included health and safety, infection control and medicines. However, we found that two recently recruited staff that were on duty had not received an induction or training in relation to their role. For example, one staff member told us that they had been told when to use protective equipment when supporting a person with a particular condition, had an orientation around the building and had been told which people were living with diabetes and that they had special diets. Another told us that they had been made aware of people who were living with diabetes. Neither of these staff had been introduced to policies and procedures within the service or had undertaken an induction into their role or received any training. A lack of induction and training into their role put staff at risk of not having the knowledge to support people safely with their care.

A matrix was available that recorded what opportunities staff had been given to discuss their role and receive supervision with their line manager. A senior member staff told us that they had received one supervision with their line manager since May 2015. The registered manager stated that they had not received any formal supervision.

The registered provider did not ensure that people were protected by ensuring that they received care and support from staff appropriately trained and supported in their role.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people using the service were not supported by staff who had always received appropriate training and support for their role.

At the time of this inspection a local community care home health team were visiting the service on a regular basis. The purpose of these visits was for health care professionals working within the community to assess and support people's care and health needs, in order for them to keep well and to ensure that people had access to services they needed.

People were seen to take their meals mainly in the dining room and the lounge. Dining tables were set with table cloths and condiments and it was evident that people viewed mealtimes as a social occasion. The menu for the day was displayed in the dining room and gave the choice of two meals for lunch and tea. People told us that they had a choice of cereal, porridge and toast for breakfast and that you could ask for eggs if you wanted them. In addition, people told us that if you didn't want what was on the lunch and tea menu you could always ask for something else.

Inadequate

Is the service effective?

Throughout our visits we saw that people were regularly offered hot drinks and biscuits. A small kitchen area was available in the dining room where people and their visitors could make hot drinks if they wished.

Requires improvement

Is the service caring?

Our findings

People told us that the staff were caring and that they felt well looked after by the staff. Their comments included "The girls [staff] are smashing", "They [staff] are kind" and "I like the staff very much, they are caring."

The registered manager told us that one person was in receipt of end of life care. No care planning information was available to demonstrate how and when required, staff were to support the person at that time of their life. The registered manager confirmed that this information was not available. Failure to have specific care planning information for people may result in not receiving the care and support they required.

People's care planning documents contained information in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). These are legal documents that record people's decisions in relation to resuscitation. Although these documents were within people's care planning files, other information contained on people's care plans contradicted the information on the DNACPR form. For example, the front cover of one person's care plan stated that no DNACPR decision form was in place. However, a copy of a decision form was contained in the actual file. The registered provider needs to make improvements to ensure that DNACPR documentation is easily accessible to staff. Failure to have the accurate information readily available may result in these decisions not being adhered too and cause unnecessary and inappropriate treatment for people.

We saw that improvement could be made in promoting people's dignity. For example, on two occasions we had to request that staff offer support to a person whose clothing had become displaced whilst they were sitting in a chair which had resulted in their underwear showing. In addition, we saw one person requiring support with their personal care needs. Staff had passed the person on a number of occasions but failed to address the person's needs which compromised the person's dignity.

We saw that two televisions were on different channels within the same room. One of the televisions had the sound turned down and was on a different channel. This resulted in people watching a programme with the sound of another programme. Two people told us that they found this difficult and confusing and demonstrated that people's communication needs had not been considered.

People were offered biscuits with their drinks throughout the day. The biscuits were given to people by a member of staff wearing plastic gloves as they took the biscuits from a box. We saw people attempt to take biscuits from the box themselves but were told by the staff to identify what they wanted then the biscuits were handed to them. No plates were offered to people for their biscuits and we saw that people were placing them on chairs and other surfaces. The use of plates helps promote people's dignity, choice, independence and minimises the risk of infection from putting foods on unprotected surfaces.

We saw that staff supported people in a kind, gentle manner. It was evident that staff who had worked at the service for sometime had built up strong relationships with people and got to know them well.

Information was available to people about the service in the form of a service user guide. The document made reference to the services philosophy of care, medicines, complaints, confidentiality and the admission process.

Requires improvement

Is the service responsive?

Our findings

At our inspection in May 2015 we asked the registered provider to take action to makeimprovements to how people's care was assessed, planned and recorded. In addition improvements were needed as to how complaints about the service were managed.

During this visit we saw that some improvements had been made in relation to planning people's care. The registered provider had introduced new care planning documentation for each person. We saw that the documentation gave the opportunity to record people's assessed personal care needs, medicines, physical and medical needs. We looked at the care planning documents of five people in detail and saw that not all of the information had been completed. The registered provider showed us a spread sheet that listed all of the documents required in people's care plans. However, the registered manager explained that the spread sheet only demonstrated that the blank documents had been placed in the file. He confirmed that there were no systems in place to identify what information had been completed on these forms.

Information that was available in people's care planning documents failed to demonstrate what support a person needed in order for the care needs to be met. For example, one person's care plan stated that staff should monitor skin and help with teeth brushing, however there was no information recorded as to what, how and when support was actually needed. Another person had an issue relating to their skin. The registered manager confirmed that a weekly record should be maintained to monitor the person's skin condition. However, these records were not being maintained and no care plan or risk assessment had been developed in relation to the skin condition.

One person had visited the home for a short stay since our last inspection. We found that their needs had been assessed but not always planned for. For example, the assessment identified needs in relation to medicines taken on a when required basis, potential times of aggressive behaviour, mood changes and disturbed sleep. None of these areas had been considered in the care planning process for the individual.

Care planning documents in place stated that they were to be reviewed on a weekly or monthly basis. However, we saw that these reviews had not always taken place. For example, people's care plans had not been reviewed since July and August 2015. Failure to review care planning documents on a regular basis may result in people's changing needs not being planned for which could result in people not receiving the care and support they required.

The registered provider and registered manager did not ensure that people received the appropriate care and support as their needs were not planned for.

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.

Two people said that they felt that there could be more "going on" around the home. They told us that they got bored of watching the TV. One person told us that they went on regular walks and read to fill their day. The other person's care planning documents included information about acitivites they liked to participate in, however none of these activities had been planned. We saw that a weekly keep fit session took place and people told us that they enjoyed the music and exercise. Little other mental and physical stimulation was available for people to participate in. We saw that at 10.30am during one visit 11 out of the 16 people sitting in the lounge area were asleep. The registered manager stated that they were in the process of recruiting staff to carry out acitivites with people.

People told us that they knew who to speak to if they had a concern. A complaints procedure was available within the service. Since our previous inspection the registered manager had introduced and maintained a record of complaints that had been made about the service. The record of complaints demonstrated that five complaints had been received by the service between June and September 2015. A register of these complaints had been maintained and demonstrated the details of the complainant, a summary of the concerns raised and the action taken following the complaint being made.

A relatives meeting had taken place prior to our visit. The registered manager said that these meetings were to be regularly arranged to ensure that people and their relatives had the opportunity to give their opinions about the service. Since our last inspection visitors and staff had

Requires improvement

Is the service responsive?

completed survey forms. The registered manager told us that they were in the process of publishing the results of these surveys and where required an action plan would be devised.

Inadequate

Is the service well-led?

Our findings

At our inspection in May 2015 we asked the registered provider to take action on how the service people received was assessed and monitor improvements in relation to how the registered provider informs the Care Quality Commission on incidents that occur in the service.

There was a registered manager in post who registered with the Care Quality Commission in August 2014. People were aware of who the registered manager was and felt that they were able to speak to them at any time.

During the first day of this inspection we spoke with the registered manager and the representative of the registered provider about their planned actions to improve the service. The representative of the registered provider told us that no formal action plan was in place as they felt that that approach did not work and that they preferred the "dynamic" approach to managing and improving the service.

No records were available to demonstrate that staff meetings had taken place. The registered manager explained that they held regular "flash" meetings. These meetings were quickly arranged to discuss and address any issues that had been identified. The registered manager confirmed that no records of these meetings were available.

No systems were in place to monitor the amount of hours that senior staff were working within the home. For example, the registered manager was working seven nights out of 14 nights in addition to their daily hours. The registered manager explained that they resided at the service through the night to ensure that people received the medicines they required when staff trained in managing people medicines were not on duty.

We saw that a number of monitoring systems and records had been introduced since our last inspection. These records involved the recording of people's food and fluid intake, personal care delivered and the cleanliness of people's bedrooms. However, these records had not been monitored appropriately. For example, the monitoring of people's fluid intake charts had failed to identify incorrect information and recording. This made the process of monitoring people's hydration levels ineffective and therefore put people at risk from unnecessary harm.

A monitoring system was in place to check that people's medicines were managed appropriately. We found that this system was ineffective as we found that people's medicines were not always managed to ensure that people received their medicines appropriately. This demonstrated that the current monitoring system in place was ineffective and put people at risk of unnecessary harm.

The current monitoring systems in place had failed to identify areas of improvements in relation to staff training, staff supervision and records relating to the recruitment of staff. Effective monitoring systems are required to ensure that staff receive the training and support they require to deliver safe care.

Identified environmental risk had not been assessed which could put people at risk from unnecessary harm. For example, no risk assessment has been completed to consider the risks to individuals' in relation to a missing fence panel that enabled people to access a railway line directly. One person had experienced a bone fracture from a fall from a chair. However, no action had been taken to consider the risk to the individual using the same chair following the fall.

Professional advice was not always followed. For example, following concerns raised regarding changes in the behaviour of a person who used the service, advice was given by a healthcare professional. The registered manager told us what actions had been discussed to support the person, however these actions had not been recorded or implemented. Failure to implement professional advice sought about situations may result in a person not receiving the care and support they require.

We saw that incident records had been introduced for staff to record situations that had arisen. We looked at a number of these completed forms and saw that the quality of the recording varied in detail, as some of the records were incomplete. In addition there was no information recorded as to what action had been taken following these incidents nor was there any evidence of any monitoring of the incidents taking place. We discussed a number of incidents that had been recorded with the registered manager who explained that he was not aware of all of the incidents recorded.

A copy of the most recent inspection report was not available for people to read. The registered manager stated that he did not have a copy of the report but he thought the

Inadequate

Is the service well-led?

registered providers representative had a copy. People and their relatives should have access to a copy of the most recent report to ensure that they are aware of the findings of the Care Quality Commission.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as insufficient and ineffective systems were in place to assess, monitor and improve the service that people receive and protect them from the risk of harm.

A relatives meeting had taken place prior to our visit. The registered manager said that these meetings were to be regularly arranged to ensure that people and their relatives had the opportunity to give their opinions about the service. Since our last inspection visitors and staff had completed survey forms. The registered manager told us that he was in the process of publishing the results of these surveys and where required an action plan would be devised.

Following our last inspection we raised concerns that the registered manager and registered provider had failed to inform the Care Quality Commission of incidents that had occurred at the service. During this inspection we found that improvements had been made in this area. However, the registered manager recognised that further improvements were needed to ensure that all statutory notifications were completed.