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Four Winds Residential Home

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 3 and 5 February 2015. Breaches of legal requirements were found.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. People were not protected against the risks of receiving care that was inappropriate or unsafe. Assessments of the needs of people were not current so did not meet individual needs or ensure the welfare and safety of people. People were not protected against the risk of the unsafe use and management of medicines. There was no safe system in place for the recording and administration of medicines. The provider did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care provided for them in accordance with the Mental Capacity Act 2005. People were cared for by staff who were not always supported or trained to deliver care safely and to an appropriate standard.

After the comprehensive inspection on 3 and 5 February 2015 we received concerns in relation to the safety of the electrical installation.

As a result we undertook this unannounced focused inspection on 21 April 2015 to monitor improvement and assess current risk.

This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Four Winds Residential Home on our website at www.cqc.org.uk.

Four Winds is a residential care home registered to provide care for up to 26 people some of whom were living with dementia. At the time of the focused inspection 19 people were living at Four Winds Residential Home.

Two registered managers were in post and had been registered since June 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.

We found that the provider had put documentation in place with regard to a summary of people's capacity but this was not in line with the MCA (2005) as it was not decision specific. Care plans were written from the perspective of the person and stated, 'I would like…, I agree to…' but there was no recorded signature or record of how people had consented to this decision.

Summary of findings

Staff were asked about Deprivation of Liberty Safeguards (DoLS) and how this impacted on people's care. Staff knew that many of the people cared for had a DoLs authorisation in place but could not describe the impact this had on their care.

Assessments of the needs of people were not current so did not meet individual needs or ensure the welfare and safety of people. We found there was a brief consideration of risk recorded on care plans but risks had not been assessed in a robust and effective manner. Control measures to manage risks had not been assessed and recorded. We saw that one person needed to be transferred using a hoist and sling but this had not been risk assessed.

There continued to be no risk assessment or audit of people's moneys that were managed and stored by the home.

Improvements were needed as people were not protected against the risk of the unsafe use and management of medicines. There was no safe system in place for the recording and administration of medicines. We found that medicines continued to be managed in an unsafe manner. We saw that one person had not been receiving one of their routinely prescribed medicines. We asked about this and were told, "Oh, I think it's because they take another medicine for the same thing." There had been no medical advice sought about this decision. Another person had attended a medicine review and the dosage of one of their medicines had been reduced. It had taken the provider over seven weeks to reduce this medicine.

We saw four bottles of medicine which had no opened date recorded on them, so people were at risk of receiving medicines that had passed their shelf lives.

Recording of the administration of as and when required medicines (PRN) was inconsistent and there were no protocols in place for the administration of this medicine.

We found improvements were needed to support and train staff to deliver care safely and to an appropriate standard. We found that the provider had a comprehensive training programme in place and a lot of training had been delivered to staff. All staff who had been in post for over a year had received an annual appraisal although supervisions had not been completed since February so were due for April.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others and improvements were required in this area. The provider had introduced a medicine audit which was going to be completed on a monthly basis. We saw that this had been completed once and had identified actions in relation to medicine management. As this had only been completed once we were unable to assess its effectiveness.

A manager's checklist had been introduced but we found the policy instructions on how to use this were confusing in terms of time frames for completion. Registered managers had completed this and had identified some actions but there was no standardisation in the area's that needed to be audited or the quality they were expected to achieve.

Prior to the focused inspection we also received concerns in relation to the electrical safety of the building. We found that there were two major concerns that were defined as dangerous and required immediate action. We also found the list of potentially dangerous work requiring urgent action had increased.

The emergency lighting was tested and we found that 50% of the fittings failed within half an hour. We also found that one of the fire alarm detectors was not working. This left people at risk of significant harm.

You can see what action we told the provider to take at the back of the full version of the 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. We found that people remained at risk of receiving unsafe care and treatment.

Brief consideration of risks were recorded however this was ineffective in appropriately assessing and managing risks.

There continued to be risks associated with the safe management, recording and administration of medicine.

The electrical safety of the building was not being appropriately managed, nor were the emergency lighting and the fire alarm system.

Is the service effective?

The service was not always effective. We found that some action had been taken to improve the effectiveness of the service.

Staff were more conscious of asking people's consent but we saw no recorded best interest decisions. Staff knew people had Deprivation of Liberty Safeguards in place but they did not know who or how they impacted on their care.

People had not signed their care records.

Training plans were in place and we saw that a lot of training had been delivered or was booked.

Appraisals had been completed and the supervision process was being reviewed.

Is the service responsive?

The service was not responsive. We found that some action had been taken.

Care plans had been re-written from the perspective of the person but they did not routinely detail specific strategies for staff to follow.

One person's personal preferences were detailed in their care plan but they had not been followed which placed them at risk of unsafe care and treatment.

Is the service well-led?

The service was not well led. We found that some action had been taken.

A service manager's checklist had been introduced with the aim of auditing systems to improve quality.

Systems that were in place at the comprehensive inspection remained and continued to be ineffective in ensuring the service operated safely.

Four Winds Residential 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 undertook an unannounced focused inspection of Four Winds Residential Home on 21 April 2015. This inspection was completed to monitor improvements to meet legal requirements and to assess current risk following our comprehensive inspection on 3 and 5 February 2015.

We inspected the service against four of the five questions we ask about services: Is the service safe? Is the service effective? Is the service responsive? Is the service well-led? This is because the service was not meeting some legal requirements.

The inspection was undertaken by two adult social care inspectors; a Specialist Advisor who was an electrician and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was dementia care.

Before the inspection we reviewed notifications received about the service. Notifications are changes, events or incidents the provider is legally required to let us know about.

During our inspection we spoke with the two registered managers, one senior care staff, activities co-ordinator, two care staff, ten people who lived at Four Winds Residential home and two visitors.

We looked at care records for six people; the medicines records for all people using the service; staff records including training matrix and appraisal and supervision matrix; quality assurance and audit documents. We also looked at an action plan provided to us by the registered managers.

Is the service safe?

Our findings

During our comprehensive inspection on 3 and 5 February 2015 we found the service was not safe as the provider had breached Regulations 9 and 13. In particular, people were not being protected against the risks of receiving care that was inappropriate or unsafe. People's needs assessments were not current. Therefore they did not meet individual needs or ensure the welfare and safety of people.

We also found that people were not protected against the risks of the unsafe use and management of medicines. There was no safe system in place for the recording and administration of medicines.

During the focused inspection on 21 April 2015 one person said, "I feel safe enough here, not frightened or anything, they [staff] are kind, it's just that I'm getting too old to do much and it makes me sad." Another person told us, "The girls are very kind, I feel quite safe here."

We found the provider continued to breach the regulations.

We found that potential risks had not been assessed fully and in a timely manner to keep people safe. For example, one person's records showed they had fallen on 14 March 2015 and had broken their ankle. We tracked this person's care records and saw that a document titled, 'risk of falls' had been completed on 2 April 2015, over three weeks after the fall. This person had a cast on their leg and was currently not weight bearing which was not considered in the risk assessment. We saw no evidence of a specific risk assessment in relation to the use of the hoist and sling.

A mobility care plan had been put in place on 9 April 2015. This stated the person had been assessed by an occupational therapist. It also stated they required assistance from two carers to use a hoist and sling when being transferred. However, there was no specific strategy for staff to follow in relation to how to manage the person's mobility or how to use the specialist equipment. We saw no evidence of an occupational therapy assessment. The person had been assessed by a physiotherapist on two occasions.

The provider had completed an incident report following the accident. They had also notified the Care Quality Commission and the Health and Safety Executive as required.

We found poor recording of accidents in relation to falls. One person had a 'New Sore Form' and a 'Pressure Area Check' form in their care records. Both these forms related to a fall the person had had not to a pressure sore. It was recorded that a referral had been made to the falls team however this was not in the file. We spoke to one of the registered managers about referrals to the falls team and they were able to produce a faxed referral.

There continued to be no analysis of accidents and incidents completed since the last inspection. One of the registered managers advised the analysis would start in April. They confirmed the information had not been transferred to the accident and incident file. They showed us documentation they intended to use to capture this information.

The falls prevention and risk assessment policy stated 'Each service user is to have a fracture and falls risk assessment conducted at the time of the admission. This risk assessment is provided by the falls team and should also be completed along with care home falls action plan.' We did not see any evidence of a 'care home falls action plan' during the focused inspection.

We concluded it would be difficult to complete a comprehensive analysis of accidents and incidents due to a lack of collated information. People remained at risk of not receiving the care or support they needed to keep them safe and prevent future accidents.

We found that the providers approach to risk management was still not effective or robust. Care plans we viewed did not contain detailed risk assessments. Brief considerations of risks had been recorded on each care plan. However, this was limited and did not provide specific control measures to evidence how risks were being reduced and actively managed. For example, one care plan stated, 'I would like staff to follow the above instructions to help me reduce the risk.'

One of the registered managers said, "We have been concentrating on updating the care plans and then we are going to move on to the risk assessments." This meant risks continued to be ineffectively assessed and managed, which placed people at risk of receiving unsafe care and treatment.

The comprehensive inspection found no procedures for the safe keeping of people's finances. During the focused inspection one of the registered managers said, "We don't

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have risk assessments in place; we'll look into producing an assessment." The registered manager also said they counted the money but did not complete documented audits. We saw a provider action plan which stated, 'risk assessments for all residents who required support with their finances (with LPA details) would be completed by 21 May 2015 and had 'commenced'. LPA means lasting power of attorney and gives a named individual authorisation for managing the person's finances in their best interest. This meant people remained at risk as finances were not being safeguarded.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following concerns raised about the electrical safety in the home a site inspection was completed.

The electrical installation condition report completed on 28 February 2014 described the condition of the installation as 'unsatisfactory.' The provider had put in place an 'urgent action plan' with remedial timeframe's dated 27 February 2015 in relation to the condition of the electrical works.

During the focused inspection we identified two areas of electrical safety that were defined as dangerous and required immediate action. We also found the list of potentially dangerous work requiring urgent action had increased. The provider confirmed that the work requiring immediate action would be completed within a two week timeframe. The failure to complete urgent electrical work left people, staff and visitors to the home at risk.

The emergency lighting was switched to test. We found that more than 50% of fittings failed within 30 minutes. The test duration time should be three hours. The emergency lighting log book showed seven lights had been reported as faulty on a monthly basis for between four and 10 months. This meant the provider had failed to maintain the emergency lighting in a safe manner. People were at risk of unsafe evacuation as they may not be able to see a clear exit route.

We tested the fire alarm detectors and noted that one did not operate. The 'faults and engineer's visits' log did not show a detector fault as being logged nor did the 'schedule of testing.' It was recorded on the manager's checklist that weekly fire alarm tests were carried out by an external company. It stated that no action was required and was initialled by one of the registered managers. This meant people were at risk of a fire not being detected immediately which may delay evacuation.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted that the sitting room where nearly all people were spending their time was incredibly warm and airless. One staff member attempted to open windows but could only open two. The room became increasingly hotter as the day wore on. We saw no thermometers in the room. The registered manager was asked how the heat in the room was regulated. They said, "We just turn the radiators down." There were no thermometers in the room. The registered managers were advised about the heat and they said, "I've just asked staff to go round with cold drinks and ice-lollies and to get some air through the room." We did not see evidence of this. It was noted that staff were seen with cold drinks but they were not routinely offering drinks to people and there was no freely available drinks for people to help themselves. One person said, "Has someone lit a fire in here, it's too hot."

One person in the sitting room was feeling faint at lunch time. Care staff sat with them for a while and then left. The person was asked if they wanted to finish their meal but they said no. We saw the cook bring them some water and a plate of sandwiches. The person wandered in and out of the sitting room and did not eat her meal. We did not see any further staff support until the person passed an inspector and held on to them for physical support. At this point the inspector alerted for staff support.

During the comprehensive inspection we found that there was no robust system in place for the accurate recording, administration and management of medicines.

We found contradictory information in one person's care plan and risk assessment for medicines which left them at risk of receiving unsafe care and treatment. The risk assessment stated staff to should dispense the medication and leave it on the bedside table for the person to take before going to sleep. This document had a monthly evaluation which stated 'no changes required to risk assessment.' The medicine care plan stated 'I have given permission for the Senior Care Team at Four Winds to audit, order and administer my medication as I feel that I may

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forget to take it or take the wrong medications at the wrong time.' The risk assessment on the care plan stated 'I would be at risk of my health deteriorating if the care team did not follow my instructions stated in the above care plan.'

We reviewed Medicine Administration Records (MARs) and found one person had not received one of their routinely prescribed medicines since the start of the MAR. This had been coded as Q which meant not required. When asked about this the senior staff member said, "I'm unsure as to why this was the case. They then added, "They have another medicine for the same reason so maybe that's why." We checked the medicine notes for this person and could see no instruction from a medical practitioner as to why they should not receive their prescribed medicine. One of the registered managers stated this person's care plan was in the process of being updated. We saw no evidence to confirm that a qualified practitioner had given instruction for this medicine not to be administered.

During the last inspection we reported that we saw no evidence of care plans or protocols for 'as and when required medicines.' The registered managers had an action plan which stated, 'PRN medication care plans have been put in place in service users individual care plans.' We saw no evidence that these had now been developed. The senior care worker was asked about the administration of these medicines. They said, "Everyone who has prn medicine can say if they need it." One of the registered managers said, "We could put that information in with the medicine care plans couldn't we."

MAR charts for the recording of administration of 'as and when required' medicines were checked. We saw there were inconsistencies. A coding system was used to record when some people had not required their medicine. For others nothing was recorded. The senior staff member said, "I think staff follow on from the previous record so if it was recoded they carry on using it, if it wasn't they don't." The action plan stated that 'senior staff have been informed that no blank spaces are to be left on the MAR chart.'

We were unable to establish whether some medicines were safe to use. Some medicines did not have an opened date recorded on them. Another medicine had a specific instruction to 'discard four weeks after opening.' The date of opening was not recorded on the bottle. Therefore staff were unable to establish how long it had been open for. This meant the person was at risk of receiving medicine that had passed its 'shelf life.'

One person had a medicine review record dated 26 February 2015 which stated their medicine dose should be reduced. There was a record on the medicine notes dated 19 April 2015 to instruct staff to reduce this medicine. When asked about this one of the registered managers said, "I know, there was a delay in receiving the review forms and us acting on it." This meant it took over seven weeks for the action to reduce the medicine to be completed.

The provider had continued to breach the regulations relating to the management and administration of medicines so people remained at risk from unsafe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a medicine administration round. The senior care staff administering medicines washed their hands and wore personal, protective equipment. They checked the Medicine Administration Record (MAR) against the medicine before administering and used the 'dot and pot system' so they knew what had been offered. They were gentle, supportive and appropriate in their approach and gave people the time they needed to be comfortable with taking their medicine. For people who had prescribed 'as and when required' medicines like pain relief tablets they asked the person if they needed it.

During administration one tablet was dropped on the floor. We asked the staff member about the procedure they followed in this situation. They said, "Envelope it up and keep it in the locked box on the wall. Replace the missing medicine and inform the pharmacy that we need a new one." We observed the staff member recording this on the reverse of the MAR to state a new tablet needed to be ordered. We saw secure storage in the medicine room where tablets for disposal were kept until the pharmacy collected them.

We asked a senior staff member about the medicines training they had undertaken. They told us they had completed, "A distance learning course, level three unit in administering medicines, competency assessment by the pharmacy and in house training." We noted that this staff member's name was not recorded on the training matrix viewed as part of the inspection process.

A medicine audit had been completed on 26 March 2015. It recorded competencies, evidence and identified gaps. The competencies included checking for signatures on MARs,

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checking fridge temperatures and correct disposal of drugs liable to misuse (controlled drugs). The medicine audit had identified missing signatures on five peoples MAR charts. A further medicine audit tool recorded the issues identified and the action to be taken.

Is the service effective?

Our findings

During our comprehensive inspection on 3 and 5 February 2015 we found the service was not effective as the provider had breached Regulations 18 and 23. In particular we found that the registered managers did not have suitable arrangements in place for obtaining people's consent in relation to the care provided for them in accordance with the Mental Capacity Act 2005 (MCA). We did not see any evidence in care records of how people with the capacity to make decisions were involved in consenting to the care they received.

We also found that people were cared for by staff who were not always supported or trained to deliver care safely and to an appropriate standard.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find.

We found the provider had continued to breach the regulations. Where people lacked the capacity to make decisions there was no evidence the provider was acting in accordance with MCA. For example, we saw one person's care plan in relation to nutrition stated, 'Due to historic weight loss I have agreed to a diet chart.' There was no documented evidence of a best interest consideration in relation to this decision. We spoke to the registered manager who said, "The care plan is in the process of being updated."

For another person there was no evidence of best interest decision making in relation to the use of bed rails.

People who were able to, had not signed their care plans to confirm to show their consent. For example, one person's mobility care plan stated that whilst they had their leg in a cast they had asked to use a ground floor room. This person had the capacity to make this decision. However, there was no record, by way of them having signed the care plan to indicate that this was their wish.

Care plans contained a place for people to sign but we saw that none of the care plans had been signed by people. One of the registered managers said, "We are going to get people's family or representative to sign them." They were asked why it needed to be a person's family member if they had capacity themselves. The response was, "Oh no if someone has capacity then we'll ask them to sign." We saw no evidence of this.

We asked the registered managers about consent and they explained that there was a capacity assessment sheet being completed for people. We saw this summary sheet in people's care records.

These documents did not follow the principles of the Mental Capacity Act (2005) Code of Practice as they were not being completed in relation to a specific decision and there was no record of participation or consultation with others.

We spoke with two staff members. We asked them if they cared for anyone who had an authorised Deprivation of Liberty Safeguard (DoLS) in place. They responded that lots of people did. We asked them to tell us who but they were unable to say. They were then asked what the DoLS authorisation meant for people's care but they didn't know.

This was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent.

We saw some improvements had been made in relation to the delivery of training and support for staff. There was lots of information on training events on the walls, including mental capacity and DoLS. One registered manager said, "There is some training to prioritise, like the mandatory training, person centred care planning, dementia care and challenging behaviour training. Those are all booked." They added, "There are four sessions this week and some next week and the week after."

We saw that safeguarding training and DoLS training was being held on the day of the inspection. One of the registered managers said, "I did mine last week."

The training matrix showed an ongoing programme of training for all staff. Training had taken place for health and safety, MCA and DoLS, safeguarding and dementia care. One of the registered managers said they were sourcing other courses for mental health and risk assessments. They advised they had booked a number of courses through a local provider as staff preferred face to face training.

The training policy contained details of the provider's commitment and responsibility for staff development and mandatory training. Reference was made to another

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named manager from a different residential home within this document which did not relate to Four Winds Residential Home. This meant the policy may not have been specific to Four Winds Residential Home. The policy also stated that new staff were to receive a phased induction over a six week period. We saw that inductions had been completed with new staff. Competency observations had a tick recorded against them when subjects were completed there was no information in relation to the quality of the observation and any future action that may be needed.

We saw a supervision log which identified all staff and the dates they had received supervision. At the time of the inspection no supervisions were recorded as having been held in April 2015. The last recorded supervisions for staff were February 2015. One registered manager said, "They are being changed. The commissioner suggested we have a set of questions that we go through every other month, then an in-depth supervision at 6 months and an appraisal annually. Every other month we'll do an observation of practice."

Appraisal records confirmed that staff had received an appraisal which included discussions around care plans, job knowledge, work planning and teamwork. One of the registered managers said, "Everyone who has been in post a year has had one, everyone else is being done now."

Is the service responsive?

Our findings

During our comprehensive inspection on 3 and 5 February 2015 we found the service was not responsive as the provider had breached Regulation 9. In particular, we found that people were not being protected against the risks of receiving care that was inappropriate or unsafe. Assessments of need in the form of care plans and risk assessments had not been appropriately updated to reflect people's current needs. This put the welfare and safety of people and care staff at risk.

At the focused inspection we found risks to people using the service were not managed safely. This was because care planning did not adequately address people's needs and preferences and were not always up to date. We found that care plans had been recently re-written from the perspective of the person receiving the care. However, some care plans did not detail the specific strategies needed to support people. For example, we saw an epilepsy care plan re-written on 13 April 2015 which had no information on how to care for the person if they were to experience a seizure.

The goal was for the person's epilepsy to be managed effectively. The care plan described the frequency of seizures as 'infrequent'; the last recorded seizure was 'over a year ago.' It stated the person's epilepsy was managed by medication. There was no information on this care plan to inform staff how to support or care for the person should they experience a seizure. The risk assessment/ management plan stated, 'I may be at risk of experiencing further seizures/fits should the above Care Plan not be followed.' This meant the person was at risk of receiving unsafe care and treatment as the care plan did not provide staff with a plan of care to follow should the person experience a seizure.

Other assessments we viewed did not contain up to date information. For instance, we saw a temporary moving and handling assessment for one person dated 20 March 2015. This stated 'bathing n/a due to cast.' We asked one of the registered managers about this person's personal care. They said, "That is no longer the case as we now have a hospital plan for bathing and toileting." This meant staff did not have access to the most up to date information about how to support this person with their personal care needs.

Records we viewed showed that people did not always have their preferences met. For one person we saw a personal hygiene care plan which stated that the person needed staff to assist them. It stated the person's preference was to have a shower twice a week; however on reviewing the bathing chart we saw that the person had only had one shower in a ten day period.

The risk assessment included on this care plan stated 'I could be at risk of possible self-neglect and poor hygiene standards if the above instructions were not followed. The care plan is to be followed to ensure a person centred approach.' The person was at risk of self-neglect and poor hygiene as the care plan had not been followed nor had their preference of a shower twice a week been met. This same concern had been raised during the comprehensive inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's care records contained a document which detailed their personal preferences in relation to opening the post, attending hairdressers, having their laundry completed, visiting the chiropodist and contact with their family. This document also covered preferences for their diet, voting, privacy, favourite past and going to the optician.

We viewed one person's care records that we had seen during the comprehensive inspection. There was a document dated 15 April 2015 which directed staff to sign to say they understood the direction of updated care plans. This document had been signed by 11 of 30 staff.

A personal profile which detailed the persons date of birth, the date they moved to the home, their religion, their next of kin, who their keyworker was and contact details for their doctor was in place as was a 'This is Me' document had been completed which included the person's life history.

The medical history form had been re-written and the language used was respectful and appropriate. It detailed that the person had a diagnosis of epilepsy, learning disability and anxiety and depression. It also recorded the person's medical diagnosis including the details on a number of previously broken bones as the person had a diagnosis of osteoporosis.

Is the service well-led?

Our findings

During our comprehensive inspection on 3 and 5 February 2015 we found the service was not well-led as the provider had breached Regulation 10. In particular, we found the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. The quality of the service was not regularly and robustly assessed and monitored.

At the focused inspection we asked if any audits had been introduced since the last inspection. One registered manager said, "The medicine audit and the monthly manager's checklist has been reintroduced."

We viewed these and saw that a medicine audit had been completed and had identified some missing signatures on people's MARs. The managers checklist had also reviewed medicine records on 25, 26, 31 March 2015 and 16 April 2015. On all these dates it was noted that either controlled medicines had not been counter signed or there were missing signatures. The action plans included to speak to the senior staff member responsible as soon as possible and to discuss at the senior staff members team meeting.

We could not asses the effectiveness of these audits in relation to the safe management of medicines due to their recent introduction. However we did find concerns with medicines administration during this focused inspection. (See our findings under Is the service safe).

There was a file containing the manager's monthly checklists. The file contained a document titled 'Three monthly manager's analysis matrix (checklist).' This had been started from April 2015 and was next due in July 2015. At the beginning of the file was a manager's check list policy dated June 2011. This stated 'The procedure [is] to enable the manager to carry out regular evaluation twice weekly. Checks can be made on any area of care and the home. A minimum of 4 care plans must be evaluated during the 1 week period.' The two registered managers described this as a monthly checklist but this did not tally with the policy instruction of the schedule of audits in the file which highlighted quarterly audits. There were clear discrepancies around the timeliness of the completion of this checklist/audit.

The checklist completed for 'care plans and temporary care plans' had not evaluated four care plans during a one week period in line with the provider's policies and procedures. It stated, 'all residents care plans current' as the topic to be evaluated. The outcome was, 'residents care plans being re-written with family and resident promoting a person centred approach.' The action plan was, 'to continue with this task until completed – due by 31 May 2015.' There was no evidence of the quality or appropriateness of care plans and no assessment as to whether they were meeting people's needs.

The check list consisted of sheets with headings such as quality assurance, fire alarm tests, policies, medication and MAR sheet check, care plans and temp care plans. The detail recorded was in relation to the date, the topic to be evaluated, the outcome and the action plan. There was no structure to this checklist in terms of what needed to be audited and no standards to audit against. Therefore the audit may not be robust to ensure sustained improvement in quality is achieved.

During the comprehensive inspection on 3 and 5 February 2015 we saw care records contained documents titled 'Monthly senior checklist'. This was a list of checks that seniors were completing, such as checks of care plans, weight, nutritional assessments and skin care assessments. There were no actions recorded on these charts. During the focused inspection we saw these remained a tick box to confirm that documents were in place. There continued to be no evidence to suggest these checks were used to assess quality or to analyse information to assess if any action was needed. This process had not improved since the comprehensive inspection.

A document titled 'Health and safety checklist' continued to be in use. It detailed which checks needed to be completed on a daily basis and had been signed to say all checks such as window locks, communal lighting, fire exit door and alarms had been completed. This document had not been reviewed since the comprehensive inspection and there was still no space on the checklist to record any action that needed to be taken and whether this had been completed. During the inspection we found that emergency lighting was not effective, nor were all the fire detector points in working order. These had not been identified during the checks we viewed records for. This meant there continued to be an ineffective system in place to ensure risks were appropriately managed and actions completed.

Is the service well-led?

It had been identified that there was no system in place to version control policies and procedures to ensure they were up to date with current legislations this continued to be the same. We saw that the safeguarding policy had been re-written but it did not contain a printed date of issue nor was it version controlled. A falls prevention and risk assessment policy was in place but it did not have a date on the policy. However the attached staff signatures indicate the earliest signature was 26 March 2015. A Mental Capacity Act policy had been put in place since the last inspection.

We asked if there was a service improvement plan in place following the last inspection. The registered managers showed us an action plan. This plan was emailed to us on the day of the focused inspection, 21st April 2015. We saw that of 40 actions two had a 'date completed' recorded, two recorded the date completed as 'ongoing' and one was 'complete and ongoing.' The provider update gave more detail on progress made but the majority of actions had not been completed even though one of the registered managers said, "The majority of the action plan is done."

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 good governance.

Since the comprehensive inspection one to one meetings with people had been introduced and these were to be completed on a quarterly basis. The meetings that had been completed since the last inspection focused on meal times and meal choices.

Quality assurance surveys were being sent to family and people on a quarterly basis. There was a white board in the entrance way which gave a summary of what had been found during the last survey. The things done well were recorded as cleanliness, quality of care, friendliness of staff and response to phone calls. It was stated that improvements were needed to meal choices.

We saw no evidence of group meetings for residents and relatives to attend.

One staff member said, "Management are easy to talk to, there is always someone about."

Another staff member said, "It's a good home, I like working here."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have effective systems to assess or mitigate risks to the health and safety of people who used the service. The provider did not ensure the safety of the premises. The provider did not ensure the proper and safe management of medicines.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining and acting in accordance with, the consent of service users in relation to the care provided for them in accordance with the Mental Capacity Act 2005.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not being protected against the risks of receiving care that is inappropriate or unsafe. Assessments of the needs of people were not current so did not meet individual needs or ensure the welfare and safety of people.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People were cared for by staff who were not always supported or trained to deliver care safely and to an appropriate standard.

The enforcement action we took:
We took enforcement action which resulted in the cancellation of the providers registration.