Prime Life Limited

Gilby House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Gilby House Nursing Home provides accommodation for up to 22 adults with care needs relating to their mental health. The home is situated in the centre of town close to local amenities and bus routes.

The service did not have a registered manager in post. There had not been a registered manager at the service for over eight months. The service had been managed during this time by a number of managers and at the time of our inspection a registered manager form another of the registered provider's services was managing the service.

The last inspection was completed in June 2014 and the service was found to be compliant with the regulations inspected at that time. This unannounced inspection took place on 6 and 9 May 2016.

The quality assurance systems utilised within the service were not effective. We found shortfalls in care and support that had not been detected by the internal audits and when areas for improvement were highlighted action was not taken in a timely way.

During a tour of the service we found concerns with infection prevention and control practices. There was no hot water available in a downstairs toilet and a first floor bathroom had numerous permeable surfaces which meant it could no longer be cleaned effectively. A legionella risk assessment had been completed in November 2015 and we saw there were immediate actions that had not been completed.

Medicines were not always stored safely. We found that temperatures in the medicines room had exceeded the manufacturers recommended guidelines. Failing to store medicines at appropriate temperatures could have an adverse effect on their potency. We found that the PRN (as required) medicine protocols lacked relevant information to ensure they were administered consistently by the nursing staff.

Some people who used the service were under a Deprivation of Liberty Safeguards (DoLS) because the care and support they required amounted to 24 hour supervision and control and was a deprivation of their liberty. We found evidence that the service had failed to support the person in line with the requirements and conditions of their authorised DoLS.

Staff knew the people they were supporting including the preferences for how care and support should be delivered. Staff described how they would tailor their approach to providing care to each person who used the service to meet their individual needs. People were treated with dignity and respect by staff during their interactions.

Care plans had been developed to meet the assessed needs of the people who used the service. However, some of the care plans we saw lacked depth and insight into how the person needed to be supported. We also found that when professionals directed staff to monitor people's conditions appropriate action was not taken.

We have made a recommendation regarding the development of behavioural support strategies.

Staff had completed training in relation to the safeguarding of vulnerable adults. During discussions it was apparent that they were aware of their responsibility to report any abuse and poor care they became aware of. Staff were recruited safely and deployed in suitable numbers to meet the assessed needs of the people who used the service.

During discussions with staff they told us they felt supported in their role. The training matrix showed that staff had recently completed relevant training to ensure they had the skills and knowledge to carry out their roles effectively.

People who used the service received a balanced diet of their choosing and facilities were provided to enable them to help themselves to hot and cold drinks as well as breakfast cereals and snacks.

The registered provider had a complaints policy in place which was available in an easy read format to ensure it was accessible to the people who used the service.

The service had informed the Care Quality Commission of accidents and incidents as well as other notifiable events as required.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some parts of the service such as a first floor bathroom could not be cleaned effectively due to numerous surfaces being permeable. This posed a cross contamination and infection control risk.

Medicines were not stored safely and instructions regarding when 'as required' medicines should be administered lacked relevant detail.

People who used the service were protected from abuse. Staff had completed training and knew how to report their concerns.

There were sufficient staff to meet people's needs and staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Some people were under a Deprivation of Liberty Safeguards (DoLS) because they required 24 hour supervision and control to ensure their safety. We found that the service failed to implement the requirements of the DoLS which put people at risk.

Staff had access to training, supervision and support to enable them to feel confident when supporting people.

People accessed a range of health professionals to ensure their day-to-day health needs were met. However, there advice and guidance was not always followed.

People's nutritional needs were met and they told us they liked the meals provided.

Is the service caring?

Good

The service was caring.

Staff had developed positive caring relationships with people

who used the service. People were treated in a kind and caring manner and were encouraged to be independent.

People were treated with respect and their dignity and privacy was promoted by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care plans were not always written to meet their individual and specific needs. Guidance in people's care plans contained generic statements

People were supported to maintain relationships with their friends and family and to take part in activities.

A complaints policy and procedure was in place which was available in an easy read/pictorial format. We saw when complaints were received they were responded to in line with the complaints policy.

Is the service well-led?

Inadequate

The service was not well-led.

At the time of our inspection there was no registered manager in post.

There was a quality monitoring system in place, however, when concerns or shortfalls were identified appropriate actions were not taken in timely manner. The quality assurance did not ensure the continuous improvement of the service.

Surveys were completed by people who used the service and their views were taken in to account.

Gilby House Nursing 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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 6 and 9 May 2016 and was unannounced. The inspection was carried out by two adult social care inspectors on the first day and one adult social care inspector on the second day.

Before the inspection we spoke with the local authority safeguarding team, contracts and commissioning team and community mental health staff to gain their views of the service. We looked at the information we held regarding the service and the information the service notified us of.

At the time of our inspection visit there were 18 people living at Gilby House Nursing Home. We used a number of different methods to help us understand the experiences of the people who used the service. We used the Short Observational Framework for Inspection (SOFI) in the lounge and dining areas. SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We spoke with four people who used the service and two relatives. We spoke with the manager of the service, a regional director, the clinical lead, three care workers and two members of the registered provider's estates teams.

We looked at four people's care records and their associated medication administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 to ensure that when people were assessed as lacking capacity to make their own decisions, best interest meetings were held in order to make important decisions on their behalf.

We looked at a selection of documents relating to the management and running of the service. These included four staff recruitment files, training records, staff rotas, minutes of meetings with staff and people who used the service, quality assurance audits and maintenance of equipment records. We completed a tour of the premises to assess the cleanliness and infection control practices.

Requires Improvement

Is the service safe?

Our findings

A person who used the service told us they felt safe; they said, "The staff are ok they make sure we are safe and help us a lot." When we asked two visiting relatives if they thought their family member was safe living in the service they told us, "Oh yes, he is very safe here."

We completed a tour of the service and found communal areas were clean and a number of areas had recently been redecorated. However, an upstairs bathroom contained several permeable surfaces. The chipboard bath side had come away from the bath, there was a hole in the wall where the door handle had broken the plaster work, the waste pipe attached to the back of the toilet had a textured tape wrapped around it and the bath hoist had flaking paint and was rusting in areas. None of these surfaces could be cleaned effectively and posed a cross contamination and infection control risk to the people who used the service. The top of the ground floor bay window was visible from the bathroom (as it was directly underneath the bathroom window) and we noted it contained stagnant water, litter, debris and an old beer.

There was a dedicated laundry room for people who used the service to use if they wished, we saw that mops were stored in the room and were hung appropriately to enable them to air dry. The sink in the room contained grime and had not been cleaned for some time. The plaster work had blown in areas including next to a downstairs radiator. This meant the surface was permeable and could no longer be cleaned effectively.

We found that the hot tap in a downstairs toilet did not work, which meant anyone who used the toilet would not have been able to wash their hands effectively. We raised this with the manager who asked the maintenance person look into the issue. We were informed that an isolating valve in a person's bedroom had been closed which had affected the water supply in both rooms. This was confirmed when the person who used the service informed the manager that the hot tap in their room was not working. The maintenance man opened the valve which rectified the problem.

We looked at a Legionella risk assessment that had been completed in November 2015. The report stated several areas required immediate attention. We were told by a member of the registered provider's estates management team, "We do have outstanding actions, some have been completed and some we still need to do." We were also told that although internal discussions had taken place regarding how and who would undertake the required improvements. We saw that no practical action had been taken and one of the immediate actions still required addressing. Failing to take action in a reasonable timescale regarding immediate concerns increased the risk to the people who used the service.

We checked the arrangements for the ordering, storage, administration and destruction of medicines with the service. There was a dedicated medicines room for the storage of medicines and specific arrangements were in place for controlled drugs and medicines that required to be kept at cooler temperatures. The room and fridge temperatures were recorded daily; when we checked the charts we found that on three occasions in the last week the temperature in the room had exceeded the manufactures storage guidance and the fridge temperature had exceeded the required range of between 2 and 8 degrees. This meant that medicines

within the service had not be stored effectively which could affect their potency.

We reviewed people's Medication Administration Records (MARs) and PRN (as required) medicines protocols. The PRN protocols we saw lacked detail and failed to contain appropriate guidance regarding when the medicine should be administered. The clinical lead told us, "I do agree the protocols are not detailed enough, they don't contain enough information" and went on to say, "If I am candid, I don't think the night staff understand how to use PRNs." We saw that one person had been administered PRN medicines to help them relax and alleviate any agitation each evening for an extended period. When we checked the daily reports we saw that the person had not displayed any behaviours that would warrant the PRN medicine being administered. When we asked the manager they told us, "It was highlighted by the person's social worker during a review, I spoke to the nurses and they described to me the behaviours the person was exhibiting and the PRN was administered correctly."

The above information demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, safe care and treatment. The action we have asked the registered provider to take can be found at the end of this report.

On the second day of our inspection the clinical lead asked us to review an updated PRN protocol which they had completed. The protocol was clear and provided the necessary instruction to ensure PRN medicines could be administered in a consistent way.

We observed how medicines were administered and saw that people were invited to the medicines room where they received their medicines and were afforded the opportunity to speak to the nurse or clinical lead. People were asked how they were and offered pain relief as required. We checked the Medication Administration Records (MARs) for four people and saw that they were completed without omission.

We discussed our concerns regarding the storage of medicines with the manager and the regional director who told us the registered provider was aware of this issue and were ordering an air conditioning unit to alleviate the problem.

During our tour of the premises we found electrical cupboards were not locked, which meant they were accessible to the people who used the service. We found the boiler room was not locked. The locking device had been broken on the top floor fire escape, which meant people could leave the building via the fire escape and it would not be apparent how they had left.

Staff were recruited safely. We checked four staff files and saw evidence that appropriate recruitment and selection processes had been followed. The files we saw contained the required pre-employment checks such as suitable references and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record check on individuals who intend to work with vulnerable adults, to help employers make safer recruitment decisions.

We saw that staff were deployed in suitable numbers to meet the assessed needs of the people who used the service. The 18 people who used the service were supported by the manager, a nurse and two care staff and additional ancillary staff ; five people received one to one support at various times of the day. The manager told us, "We have reviewed the one to one times for people to make sure they receive the support at the times of the day they need it most." The regional director told us, "The [registered provider's] HR team develop the staffing levels with my input."

During discussions staff told us they knew how to recognise and report abuse and described the signs and

symptoms to look for that may indicate someone was being abused. They also told us they were aware of the registered provider's whistleblowing policy and whistleblowing hotline and understood their responsibility to report any abuse or poor care they were aware of.

Requires Improvement

Is the service effective?

Our findings

People told us they enjoyed the food and found the choices offered satisfactory. Comments included, "The foods fine, it suits me"; "They make sure we are well fed" and "It's not restaurant standard but it's good for what it is." One person told us they did not like what was on offer for tea but staff would make them something else.

Two visiting relatives told us, "I think the staff are very capable."

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 people lack the capacity to make 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). At the time of the inspection there were a number of people who had DoLS authorisations in place.

DoLS are granted when people lack capacity and the support they require amounts to 24 hour supervision and control. One person who was under a Deprivation of Liberty Safeguards had left the service unsupported on a number of occasions. The service had failed to take appropriate action after the person had left the service unattended to ensure that further reoccurrences could not take place. This meant that the registered provider was not protecting the person in the way the DoLS assessors had recognised as in their best interests and, additionally, necessary to prevent harm to the person and a proportionate response to the likelihood and seriousness of the risk. The service was not working within the principles of the MCA and the authorisations to deprive a person of their liberty were not being met.

The application for a DoLS showed that the service believed the person lacked capacity and required 24 hour supervision and control to keep them safe but when the person absconded from the service reasonably practicable action was not taken to prevent any future reoccurrence. The notification submitted to the Care Quality Commission stated, 'The assessment completed by the Best Interests Assessor has evidence that RN needs a considerable amount of support at all times to meet his social and healthcare needs and to maintain his safety to prevent harm occurring.'

The regional director told us, "The first incident occurred when the person was out on the monthly trip with other residents and they left the group. After the second time, we put the window restrictors on their bedroom window." The manager said, "When they got out last week we thought it was out the main door and we put in 15 minute observations but they got out again the next day. We knew about that straight away because of the observations." The clinical lead commented, "Obviously the 15 minute observations are quite restrictive but we realised they had gone out the window and called the estates team to get restrictors fitted

to the window."

The manager told us that the window the person had left through was now restricted and that the person would not be able to exit the service in the future. However, we saw that other ground floor windows had not been fitted with restrictors so they could have been used as an exit point by the person who as stated in the DoLS required 24 hour supervision and control to ensure their safety. We highlighted this issue to the manager and regional director on the first day of our inspection and on the second day saw that a full review of the ground floor windows was undertaken to ensure they could not be used as exit points.

The above information demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, need for consent. The action we have asked the registered provider to take can be found at the end of this report.

Throughout the inspection we heard staff gaining people's consent before care and support was provided. People who used the service or people appointed on their behalf had signed their care plans to indicate they had read and understood them.

We saw evidence to confirm staff had completed relevant training to enable to them carry out their roles effectively. Records showed staff had undertaken training in relation to safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, mental health, health and safety, moving and transferring, infection control, fire and food hygiene.

During discussions staff told us they had the opportunity to develop their skills and complete relevant nationally recognised qualifications. They also told us they felt supported in their role and received regular supervision and annual appraisals.

The manager told us, "We do themed supervisions, and attitude, ability and attendance reviews; because I am new here I have attended training with the staff so I get see their learning styles and their attitudes." The regional director said, "We do need to develop the one to one diary because it has lapsed with the change of management but I am confident the staff are well supported."

Plans were in place to continue to improve the knowledge and skills within the service which we saw evidence of. The manager told us, "You can see from the records we have done quite a bit of training since I've been here. We had a visit from the commissioners when I first started and they said they were happy with everything but there were gaps in the training which we have now completed."

People received a balanced diet of their choosing. Self-service area's had been created so people could help themselves to drinks and make their own breakfasts. We saw that the dining room was set with four main tables which could seat up to four people. The atmosphere was relaxed and staff sat with people and talked about their day, what they had been doing and what they planned for the afternoon. The freshly prepared meal included a choice of fried fish, chips and mushy peas or fish pie with the chips and mushy peas. The pudding was sponge and custard. Staff told us if someone didn't like either of these another option would be provided.

Staff did not rush people and everyone was afforded time to eat their meals at their own pace. One person came to the dining room to collect their meal then went and ate it elsewhere in the building. Staff told us this was their choice. Others ate their meals in their rooms as they did not like to come to the communal dining area.

We saw evidence in people's care files that their health and social care needs were met by a range of healthcare professionals including GP's, dieticians, consultants, social workers, psychiatrists and care co-ordinators. However, we saw an entry in the daily notes which indicated a GP had visited one person following a period of illness and had diagnosed that the person had experienced a 'vascular seizure'. The GP had requested the staff to monitor the person for the next few days, however, we could find no evidence this had been done, and upon speaking with the nurse and the manager established no monitoring system had been put in place.

Good

Is the service caring?

Our findings

People who used the service told us the staff who supported them were kind and caring. One person said, "When I'm having a bad day I know I can rely on the staff for support." Another person said, "This is one of the best places I've lived." A relative told us, "The staff are brilliant, they are great with him and great with us. They all treat him really well."

Staff were seen to be kind and caring and understood the needs of the people who used the service. They were able to offer comfort and support to those people who were in distress, they described how they used one technique for comforting one person but used another for someone else. For example, one person was comfortable with physical contact but another wasn't so staff adapted their approach to suit people.

During discussions staff told us how they would treat people with dignity and respect. They told us they would always knock on people's doors before entering their rooms, that they would support people's right to privacy and speak to people in the same way they would like to be spoken to. This helped to ensure people were treated respectfully and as individuals.

During a tour of the service we saw that one person's room had two doors due to its position near the stairs and passenger lift. An alternative exit was required in case of the need to evacuate in an emergency. We saw that the locking device had been broken on the fire escape door which meant that person's room was accessible to other people. This infringed upon the person's privacy and dignity; we discussed this with the manager and the regional director who told us that the ceramic tube was broken when the person left their room to go to the toilet during the night as it was the quickest route. They confirmed that they would look into the matter to ensure the person's privacy was maintained.

People's care plans contained a 'getting to know you document' which included people's likes dislikes and preferences for how care and support should be delivered. This helped to ensure staff were knowledgeable about the people they supported and could provide the care and support they required in the most appropriate way to meet their needs.

Staff told us they encouraged people to maintain their independence and gave examples of enabling people to choose how they wanted to spend their days, or helping them to choose clothing as well as making other decisions in their daily lives. We saw that hot and cold drinks were available for people to help themselves to if they wished and breakfast cereals were held in individual dispensers which enabled people to make their breakfast independently.

The manager told us there were no restrictions placed upon visiting times, they said, "People can come anytime, day or night. People's families and their relatives can come and see people whenever they want." Two relatives we spoke with confirmed that they had always been welcomed to the service whenever they arrived and had never been told about specific visiting times.

We saw that records were stored in locked offices to ensure only relevant people had access to people's

private and confidential information. The registered provider had a confidentiality policy for staff to refer to as required. A member of staff told us, "Lots of people from the village know we are here and the service users go to the local shops and things but I would never tell anyone anything about the home or any of them [the people who used the service], we keep things confidential."

If people required additional support to make a decision they were able to access an advocate. The registered manager confirmed advocacy services were accessed for people where necessary and we saw that posters were displayed within the service to ensure people were aware they could access this support.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us they had been involved with reviews of their care and had contributed to their care plans. One person said, "We have meetings and I get to say if I like it here." Another person told us, "I know I have a care plan and I can change it if I want."

A relative we spoke with said, "He has improved a good 50 percent since he has been here, they have responded to his needs, reviewed all the medication he was on and we can really see the improvement." They also said they knew how to raise concerns and would speak to the manager or the clinical lead if they wanted to complain and were confident that they would be addressed.

Before people were offered a place within the service an assessment of their needs was completed. The assessment covered people's physical health, mental health, personal care needs, toileting, eating and drinking, social inclusion, mobility and communication. The manager told us, "We would usually be contacted by a social worker; they give us the initial information. We would then go speak to the person and their families, the nursing staff and carers who have supported them in the past to gather as much information as we could before we made the decision (to offer them a place at the service)."

We saw that the initial assessment was used to develop a number of care plans to meet the needs of the person. Information such as people's preferences, personal history and interests were also recorded. However, some of the care plans we saw were not written in a personalised way and some people's care plans contained more detailed information than others. The manager told us, "I came here in February and have been working through the care plans since then. The clinical lead and I are getting to know people before we re-write their care plans. We know they are not as detailed as they could be."

We found that some people's care plans contained duplicated information. For example one person's eating and drinking care plan, their mobility care plan and their personal care, care plan all contained the same information regarding the person's behaviours that challenged the service and the strategies and techniques staff were to use to support them. We discussed the amount of information in people's care plans and the duplication in numerous sections with the manager. They told us, "I have talked with [name of the regional director] about what you said and I will develop the care plans so they don't have the same information in each area."

One person's mobility care plan stated they had a history of disinhibited behaviour when out in the community. It also stated that the person became overly excited which could lead to aggression towards members of the public; records showed and the manager confirmed the person was verbally abusive and intimidating to the general public and people who worked in shops or businesses in the local area. The care plan provided no guidance for staff regarding how to manage the person's behaviours. Failing to provide appropriate direction to staff could lead to the person's behaviours not being managed effectively and preventable incidents taking place.

The person's mental health care plans stated staff should use diversion techniques when the person

displayed behaviours that challenged the service and others. However, the diversionary techniques that were included lacked detail about the person and were generic. We found that the instructions to staff in relation to how to support people when they displayed behaviours that challenged the service and others lacked detail and insight into the individual. For example three care plans stated staff should, 'offer the person a cup of tea', try a change of environment' and 'talk about something they like'. Failing to provide staff with appropriate guidance relevant to each person could lead to their behaviours being managed inconsistently and ineffectively. On the second day of the inspection the clinical lead commented, "I agree with your comments about the behaviour management plans and have started to ask people what their interests are and what they think could work to distract them at times of agitation."

Another person's care plan stated the person could be violent and display behaviour which could be challenging to the service. However, instructions were vague and informed staff to 'use distraction techniques' but failed to provide suitable examples that could be used to successfully distract or redirect the person. Other instructions such as 'assess their mood' were stated but included no further information as to what this mood would look like or how it would manifest its self so the staff could support the person appropriately. When we spoke with staff they told us they used various distraction techniques included offering a cup of tea, a slice of cake or music. They confirmed they had developed these themselves because there was a lack of clarity in the care plans. One member of staff said, "We just do what we think is best."

We recommend that the registered provider seeks guidance from a reputable source regarding the development of behavioural support strategies.

We saw evidence to confirm that the service had responded to be people's needs to ensure they were supported appropriately. The manager confirmed, "[Name] has one to one support and when I came that wasn't working very well, he has a set routine in the morning and that's when he had the one to one, it was pointless because the staff were just watching him watching TV. So we changed the time to the afternoon when he is more active and it has worked a lot better."

The manager also told us that a person who used the service had historically been involved in verbal altercations with another person at lunch times. They went on to describe that by staff sitting with the person and engaging them in conversation during their lunch prevented the behaviours that were challenging to the service and others. The proactive support stopped incidents taking place or escalating.

People were encouraged to follow their interests when possible, for example people attended the local church and volunteered to undertake small tasks whenever possible; the manager told us this had been a really positive experience for the people who used the service. We were told that other people had helped with the gardening and to make hanging baskets. A person who used the service told us they regularly visited local attractions and places of interest.

Reasonable adjustments had been made within the service to enable people to maintain their independence. Numerous areas of the service were sloped which ensured people who used wheelchairs could access each area without support. There was a passenger lift, hoists and bath hoists as well as plate guards, adapted cutlery and beakers.

The registered provider had a comments, complaints and concerns policy in place which was displayed within the service. We saw that the policy was available in an easy read/pictorial format which ensured it was accessible to all of the people who used the service.

The regional director told us, "We record all formal complaints and investigate and respond in line with the

policy." We saw that informal complaints were also recorded and used to develop the service when possible. After complaints had been received appropriate action had been taken such as reviewing and updating people's care plans, requesting support and guidance from relevant professionals and completing medication reviews.

Inadequate

Is the service well-led?

Our findings

A person we spoke with told us they were happy living at the service, they said, "It suits me I like it here."

Staff told us they found the manager to be approachable and they could ask for advice and guidance when required. Their comments included, "She is really nice and has made some good changes" and "I think the manager is approachable."

The service is required to have a registered manager under the registration regulations; at the time of our inspection the service did not have a registered manager. The manager was a registered manager but their registration was attached to another of the registered provider's services. The manager's application has been received by the Care Quality Commission and was being processed when this inspection was undertaken.

The quality assurance systems operated by the registered provider were ineffective. We found that internal infection prevention and control audits completed in February 2016 highlighted some of the concerns found during this inspection regarding permeable surfaces and required improvements in areas including a first floor bathroom. Failing to act on identified areas of concern increased the risk to people who used the service and showed that the quality assurance systems used lack the ability to drive improvement.

We looked at a Legionella risk assessment that had been completed by an external company which was dated as November 2015. We saw that numerous action points had been raised and asked the manager and regional director what works were still outstanding. A member of the registered provider's estates team told us, "We do have some actions that need completing, one of the issues is the report may say November but I don't get it straight away, it can be a couple of months before we receive it." We were provided with confirmation that the majority of immediate actions had been commenced but noted that appropriate action had not been taken for two months after the report had been issued.

We discussed our concerns with the manager and regional director regarding the delay to commence works that required immediate attention and received assurance that plans would be developed to ensure corrective action would be taken promptly when future concerns were raised.

Clear and contemporaneous notes were not recorded of people's care treatment and support as required. The manager explained, "When I came here [name] lost her one to one hours and her nursing care because no incidents had been recorded and the staff had not completed any ABC [Antecedent Behaviour Chart]. They thought the behaviours they saw were typical for the person so did not need recording.

A person who used the service received PRN medicines to help them relax and alleviate any agitation each evening for an extended period of time. The manager told us they had raised this with the nursing staff who had clearly described the person's behaviours and was assured the PRN medicine had been administered appropriately. However, the daily reports did not state the person was agitated or displaying behaviours that challenged the service and others. This meant that the service had failed to complete accurate and

contemporaneous notes about the people who used the service.

The manager told us, "It (the continuous administration of PRN medication) was not found by the audit, it was pointed out by a social worker; the audit would not have picked it up." The clinical lead said, "The temperatures in the medicines room must be a problem every summer, whenever it's a hot day there must be an issue. This provided further evidence that the effectiveness of the internal auditing systems were ineffective and not enabling improvements to be made where needed.

We saw that the manager had instructed staff to review some people's care plans on a monthly basis but found evidence to show this had not occurred. The manager told us, "We have re-written some people's care plans and we want to check them every month to make sure they are right. I will speak to the staff and make sure they do the reviews like I've asked."

Accident and incident audits were completed regularly; the manager explained, "I look at all of the accidents and incidents every month, I do all the safeguarding's referrals as well." The regional director told us, "I get contacted about the incidents and keep a log of what has occurred; the log is reviewed by the nominated individual." We saw evidence that the regional director had been made aware that a person who was under a DoLS had absconded from the service. Even though the incident have been reviewed by the regional director effective action was not taken to ensure the person, was supported in the way the DoLS assessors had recognised as in their best interests and necessary to protect them from harm. The failure to take appropriate action put the person at risk and highlighted the failing of the quality assurance systems used within the service.

The clinical lead told us, "The manager and I are quite new; we have done lots of audits and things are becoming apparent. We need to improve in lots of areas but I'm confident we will; we are working hard and so are the staff." The manager explained, "We are aware how much work needs doing and are trying to improve; I think we are a good service but we can get better."

The above information demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, good governance. We are currently considering our regulatory response to this breach and will report on any action once it is completed.

The regional director told us they used a risk matrix to decide where to spend their time and the level of support each service required. They also said, "We are continually working on our systems, they are a standing agenda item at our senior and operational board meetings" and "The nominated individual creates a trend analysis to ensure risks are managed within set timescales." However, the failure to take action of known risks in required timescales highlighted the improvement in this area was required.

We saw evidence that people who used the service were asked for their opinions about the service and they were acted upon. Records showed questionnaires supplied in a pictorial/easy read format were completed by people who used the service and meetings were held for people to discuss any issues they wanted to raise. New activities and the 'service user' display boards were moved and pictorial aids were added after a request in a meeting.

Staff meetings took place regularly and provided a forum for staff to discuss changes to people's care and support, training needs and any other topics they saw fit. The clinical lead explained, "I spoke with the staff and discussed how we could improve the medicines administration, everyone agreed that if we gave medicines in the medicines room and stopped the old medicines round we could focus on people as individuals and give them time for a mini consultation. We felt it was more person centred and seems to

work really well."

The manager understood and fulfilled the requirements to inform the Care Quality Commission of accidents, incidents and other notifiable events that occurred within the service as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent People who were under a Deprivation of Liberty Safeguards did not always receive the care and support stated in the Deprivation of Liberty Safeguards paperwork and therefore were not supported in line with the principles of the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service did not always receive safe care and treatment because they were supported in an environment that could no longer be cleaned effectively and were administered medicines that had not been stored appropriately.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The governance systems used in the service failed to highlights areas of concern found during the inspection. Known areas of concerns were not acted upon in a timely way.

The enforcement action we took:

We issued a warning notice for this breach which included a timescale that the registered provider must have achieved compliance by.