Findings of CQC visit on 20th January 2016

What have CQC told us?	What have we said we will do?
Is the service effective? Requires Improvement People were not always supported in line with the mental capacity act 2005 (MCA). People told the inspector that staff asked for their consent before delivering care tasks and staff were able to describe how they supported people to make choices about their day to day care. However, where care records indicated a person may lack capacity to consent to some aspects of their care, capacity assessments had not been completed and there was no evidence of a best interests decision making process being carried out by professionals and family members. Staff were not aware that families could not give consent on a resident's behalf unless they had the legal authority to do so.	We will complete mental capacity assessments for all residents and record best interests decisions when required. We will re train nurses and care staff on mental capacity. The area support manager (Ramla Saleh) will work with nurses to further support their understanding of mental capacity, deprivation of liberty and power of attorney.
Is the service safe? Requires improvement People were not always protected from the risks associated with the administration of their medicines. On two units the inspectors observed that the administration of medicines was interrupted whilst nursing staff supported people with personal care or completed other tasks. On one occasion a nurse dispensed some medicines and took them to a resident. The inspector noted that the nurse did not return to the	We have reminded all staff that when nurses are undertaking medication administration they should not be interrupted unless there is an emergency.

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trolley to sign the resident's administration chart. The inspectors looked at the chart and saw that some morning medicines had been signed for and others hadn't. The nurse confirmed they had not given the person all of their medicines at the same time because they had been interrupted. The inspectors said that these frequent interruptions meant there was an increased risk of medicine administration errors and poor recording. On one occasion the inspector observed the nurse had left the medicines trolley unattended for 10 minutes. Although the trolley had been locked, the keys had been left in the lock. These meant medicines were not stored safely. Not all nurses who were on duty and responsible for administering medicines could tell the inspectors about residents individual protocols for medicines to be taken as required (PRN). Nurses who were aware of the protocols showed the inspector residents PRN protocols were kept in a folder in the clinical room. The nurses did not have this information on the medication trolley as they were administering the medicines. The inspector said this meant there was a risk PRN medicines might not be administered consistently or when required by the person.	We have reminded all nurses of the organisations policies and procedures and the Nursing and Midwifery (the nurses' registering body) code of conduct in relation to the safe administration of medicines and the fact that medication trolleys must always be secured when they are not present. Protocols for 'as required' medication are now kept on the medication trolleys. The area support manager (Ramla Saleh) will work with nurses to develop their leadership and organisational skills
Is the service safe? Inadequate Warning notice Issued CQC say that the registered person did not always take proper steps to mitigate the risks associated with residents care. This related to the medications observations above plus the following observations: A resident who spent all of their time in bed who was identified as being	We immediately ensured that a change of position chart was put in place.

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at very high risk of developing pressure ulcers had a care plan and pressure relieving mattress in place, but did not have any record of changes in position. The inspectors observed this resident for five hours and saw that they did not have their position changed. Staff were unclear about whether the resident needed to change position.	We reminded nurses and care staff of the importance of re-positioning people living with pressure ulcers at 1-1 supervision. A support manager (Ramla Saleh) was allocated to the home. She is supporting the nurses with developing their skills as leaders to enhance the communication between nurses and carers. We commenced refresher training for nurses and carers on the importance of monitoring people's skin and helping them to change position on 16th February. Our quality team are reviewing what happened to establish why it happened and what we can do to prevent it happening again.
The inspectors read the care plan for a resident who was identified as being at high risk of falling. The care plan said that the persons call bell should always be within their reach when in their room. The inspector visited the resident's room. Staff entered to assist the person with personal care and to help them to the dining room. They did not ensure the person had their call bell within reach.The inspector heard another person calling for assistance from their room, the person said they were cold and could not reach their call bell. They alerted a nurse who got the person a blanket. The nurse left the room but did not place the call bell in reach until prompted by the inspector.	We retrained all staff on the importance of ensuring all residents call bells are within their reach if they are able to use them. The manager and nurses now check that call bells are correctly positioned during their daily checks
The care quality commission have said that we need to address the above issues by the 5th April 2016.	The action plan is in place and will be completed by the requested date