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Trent Lodge Residential Care Home

Inspection report

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Ratings

Is the service safe?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

After our inspection of 21 and 22 January 2015 the provider wrote to us to say what they would do to meet legal requirements for the continued breaches we found.

We undertook this unannounced focused inspection on 29 April 2015 to check that the most significant breaches of legal requirements, concerning the management of risk, which had resulted in enforcement action, had been addressed.

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 Trent Lodge Residential Care Home on our website at www.cqc.org.uk.

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this service.

Trent Lodge provides accommodation and personal care for up to 16 older people. There are 14 rooms, two of which are shared rooms. At the time of our inspection there were 13 people residing at the home.

There was a registered manager in post. 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 and associated Regulations about how the service is run.

We found that the provider had followed their plan in relation to these regulations. This means legal requirements for the management of risk had been met.

We saw that individual risks to people's safety were being explored, assessed and information recorded about how these risks might be minimised.

Summary of findings

When people's needs changed information was now being accurately recorded and staff were told about any updates in handover meetings.

The registered manager and provider had implemented a monthly health and safety audit. This audit covered a number of areas including checks on medicines, equipment, the environment, care plans and fire safety. These checks were being carried out and where issues or problems had been identified we saw that action was being taken to address these.

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 safe. The risks to people's safety and welfare were being assessed, and recorded and action was being taken to reduce risks.

Requires improvement

Is the service well-led?
The service was well-led. The registered manager and providers had implemented a system to monitor and audit health and safety practices at the home.

Accidents and incidents were being monitored and analysed in an attempt to reduce the likelihood of the accident or incident reoccurring. Action was being taken to make sure people that had an accident were referred to the appropriate healthcare professionals to look at ways of reducing any further accidents.

Requires improvement

Trent Lodge Residential Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook an unannounced focused inspection of Trent Lodge Residential Care Home on 29 April 2015.

This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 21 and 22 January 2015 had been made.

During the course of the inspection we looked at six people's care plans and related risk assessments. We also checked other records in relation to environmental risk assessments, fire records, accident and incident records and monthly audit checks.

We spoke with the registered manager, the newly appointed deputy manager, two staff and three people who used the service.

We checked the provider's action plan which they sent to us following the inspection we undertook in January 2015.

Requires improvement

Is the service safe?

Our findings

At the last inspection of this service in January 2015 we found that the registered manager and staff at the home had not always identified and highlighted potential risks to people's safety. Because this was a continued breach of regulation and because of the serious nature of the breach we took enforcement action against the registered providers.

At this inspection we found that the registered persons had implemented systems to identify risks to people's safety, care and treatment, and had taken action to mitigate them.

The registered providers had obtained an on-line care planning and risk assessment system. This system incorporated a number of individual risk assessments for each person using the service. We saw that the registered manager and deputy manager had reviewed people's care plans and undertaken risk assessments in relation to moving and handling, nutrition, and pressure care as well as falls assessments.

In addition to these general risk assessments that had been completed for everyone, the registered manager and deputy manager had looked at other risks to people's safety that were centred on the individual. For example, a risk assessment had been completed for someone who used the stair lift in the home. We saw that individual risks to people's safety were being explored and assessed and information was recorded about how these risks might be minimised.

We saw evidence that both care plans and risk assessments had been discussed with the person or their relatives if they were unable to contribute or understand the process due to their cognitive impairment.

The registered manager and deputy manager were positive about the new care planning and risk assessment system. They told us this was a much more detailed and systematic approach to the care and safety of people using the service.

Staff we spoke with were aware of the risks people at the home faced. They told us they had read care plans and that people's risks were regularly discussed at handovers. Staff could explain what actions and safeguards were in place to reduce risks. For example one staff member told us about a person with limited mobility and how this increased that person's risk of developing pressure sores. The staff member told us that this person was being seen by the physiotherapist to improve their mobility through exercise and that this person had an air mattress to reduce pressure when they were in bed. The staff also understood that good nutrition was important to maintain healthy skin areas. This information that the staff member told us matched the information in the person's care plan.

Staff were positive about the improvements to the service since our last inspection. One staff member told us, "Everyone is talking to each other and we are working as a team. People have benefited a lot."

At the last inspection we were concerned that people's care plans were not being updated as their needs changed and any changes were not communicated to staff.

At this inspection we saw that when people's needs changed information was now being accurately recorded and staff were told about any updates in handovers. The deputy manager showed us the record of staff handovers and we saw that updated information was given to staff and they signed when they had received this information.

We saw examples in people's care plans where information about their care needs had been updated. We saw that one person had lost weight over a short period of time. The deputy manager had told staff to monitor this person's weight weekly and their food and fluid intake had started to be recorded. They had been seen by their GP who had then referred them to a dietician.

Another person had come back from a hospital stay with reduced mobility. As a result their care plan had been reviewed and revised to state that more staff support was needed for this person. Staff told us that they had been updated about this person's care needs at handovers. This person was also referred to physiotherapist and to their GP to see if the medicines they were taking were contributing to their reduced mobility.

Requires improvement

Is the service well-led?

Our findings

At the last inspection of this service we found that there were a number of checks and procedures that the registered manager and providers were not following that put people at unnecessary risk. The areas that were not being checked properly included people's individual risk assessments, environmental risk assessments, the management of medicines, accidents at the home and staff recruitment.

There were no regular health and safety audits being undertaken which should have picked up the areas of concern that we found during the inspection.

At this inspection we saw that the registered manager and providers had implemented a monthly health and safety audit. This audit covered a number of areas including checks on medicines, equipment, the environment, care plans and fire safety. These checks were being carried out and where issues or problems had been identified we saw that action was being taken to address these. For example, records showed that there had been a problem with the stair lift. This problem had been picked up and action had been taken to fix the lift.

We also saw that fire safety checks were now taking place on a regular basis. Following concerns about fire safety we had at the last inspection in January 2015 and a subsequent inspection by the fire brigade, 11 recommendations had been made to improve fire safety. We saw that these matters were being addressed and regularly monitored through the new health and safety auditing process.

At the last inspection in January 2015 we had serious concerns because there was no system in place to review accidents and incidents that people had at the home. This meant that people were sometimes suffering similar accidents that might have been prevented if the registered manager or providers had checked the records to see if any patterns could be identified or if other professionals were called in to help minimise the risks.

At this inspection we saw that every accident that was recorded included an analysis of what had happened and if there was anything that the management and staff could do to prevent a reoccurrence or minimise the identified risk. In particular, we saw that appropriate action had been taken to support a person who had suffered two falls recently.