Wolverhampton City Council

Blakenhall Resource Centre

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

At our previous inspection on 1 April 2014 the provider was not meeting the law in relation to the care and welfare of people using the services, the management of medicines and the assessing and monitoring of the quality of service provision. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made.

This inspection took place on 22 and 24 October 2014 and was an unannounced inspection.

Blakenhall Resource Centre provides long term and short term accommodation and care for up to 29 older people who have mental health needs. There were four people living at the home on a long term basis and four people living at the home on a short term basis when we inspected.

The service had a registered manager, as required by the terms of its registration. A registered manager is a person

Summary of findings

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. At the time of our visit the registered manager was on a long term absence and the service was being managed by a temporary care manager since September 2014.

People and their relatives gave mixed views about their experiences of the service. Some relatives and people told us they were happy with the service. However, other relatives raised issues with us. This included one view that a person's health and well-being had deteriorated since their time at the service and that this was due to poor care. Other relatives told us they felt poor morale among staff was affecting the standard of care. While we observed some improvements since our last visit on 1 April 2014, we identified a number of concerns with the service.

We found that inadequate responses had been made to an incident involving a person falling. This included a failure to ensure their environment was safe and that staff had updated guidance on how to support them safely. We saw that risk assessments were not consistently updated to reflect the current risk to people's safety and well-being.

We found some improvement in the completion of people's medication administration records. However, we found further concerns around the administration of 'when required' medicines, the storage of medicines and the records maintained for people. Controlled drugs were appropriately stored and recorded.

We found there were adequate staff available to support people.

Staff knew how to identify abuse and to report it. However, we were aware of safeguarding matters that should have been reported to the local safeguarding authority, but were delayed.

Staff had poor knowledge of Deprivation of Liberty Safeguards (DoLS) and gave inconsistent answers about people who were subject to a DoLS. This meant there was a risk that people's rights would not be appropriately supported.

We found that there had been improvements in the provision, monitoring and recording of fluids given to people to drink. People's cultural preferences around food were respected.

We found that there were gaps in some areas of staff knowledge and training. Issues of performance had not always been addressed with staff by the management team.

We found staff assisted people in a caring and compassionate way. However, we observed that staff missed opportunities to interact with people more frequently in order to improve their experience of the service.

Not all relatives felt that staff listened to them when they explained the needs of people living at the home.

The personalisation of care plans had improved since our last visit. However, some care plans contained contradictory information about people's needs.

We saw some activities being provided to some people which met people's interests. However, we also saw examples of people not receiving stimulation during our inspection.

Visitors to the service told us they were welcomed by staff, which meant that people were able to maintain relationships which were important to them.

The provider had a robust complaints procedure. People had access to information about how to make a complaint.

We found a number of issues which the provider's own audits had failed to identify. We found examples of the provider not implementing the action plan they had submitted to us following our last visit. We also found that the provider had not implemented advice given by the local Clinical Commissioning Group (CCG) who buy and monitor health and social care services.

The provider had failed to notify us of issues which it was required to do so by law. The provider had also failed to send us information it we had requested within a specific timescale. The information requested was a 'Provider Information Return' in which the provider is asked to describe how they are meeting current legislation in the provision of care.

Summary of findings

We found that the provider had not fully met the action plan they had sent to us. We also found a number of additional issues during this visit. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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?

Inadequate

The service was not always safe.

There was inconsistent knowledge from staff about how to reduce risk to people. This meant that people did not always receive care in line with how risks to them had been assessed.

Medications were not safely managed and monitored so that people received their medication in a safe way which supported their health and well-being.

People were supported by safe levels of staff. Staff knew how to identify and report abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had inconsistent knowledge about people's rights, such as who was subject to certain restrictions and who was not.

There were some gaps in staff training and staff performance was not always addressed effectively.

People's health was supported by adequate nutrition and hydration.

People were supported to attend appointments with external healthcare professionals, which supported people's health.

Is the service caring?

Requires Improvement

The service was not always caring.

Relatives did not always feel listened to by staff about their opinions on the care people received.

Interactions between staff and people were caring, but limited in frequency. Opportunities for positive interactions were sometimes missed by staff.

Staff delivered care while respecting people's dignity and privacy.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always provide consistent information about people's needs. This meant that staff did not have consistent guidance in records about people's needs.

Some aspects of care planning were not appropriately updated following incidents.

Some people participated in activities, but others received little stimulation throughout the day.

Summary of findings

The provider had a robust complaints procedure. People had access to information about how to make a complaint.

Is the service well-led?

Inadequate

The service was not well-led

We found that the provider had not fully implemented the action plan they had sent us to improve on shortfalls we had found at our previous inspection. This meant there continued to be issues around the quality and safety of the service.

We found a number of concerns during our inspection which the provider's own audits had failed to identify. This meant that issues which could affect people's experience of the service were not being routinely identified and addressed.

The provider had failed to notify us of matters which they are required to do so by law, such as a person sustaining a serious injury.

Blakenhall Resource Centre

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 responsive inspection of Blakenhall Resource Centre on 22 and 24 October 2014.

The inspection team included two inspectors and an expert by experience. The expert by experience had personal experience of caring for someone using health and care services.

During our inspection spoke with five people that lived at the service and three relatives of people who were living at the service. We also spoke with the new temporary care manager, three assistant team leaders, five specialist support workers and two of the provider's senior managers.

We reviewed the care records of three people who used the service and records relating to the management of the service.

We undertook general observations in communal areas and during mealtimes. We used the Short Observation Framework for Inspection (SOFI) during lunchtime in one of the dining areas. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

At our inspection in April 2014, we were concerned about the safety of how staff were helping people to move and how people were supported if they fell. We found errors in people's medication records and how medications were stored and administered. The inspection found breaches of Regulations 9, 10 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan outlining how they would make improvements. When we inspected the service again in October 2014 we again found concerns.

We looked at the policy concerning what staff should do if someone had a fall. We saw that advice was available to staff about what they should do in the event of a fall, including any unwitnessed falls where it would not be known to staff how someone had fallen.

However, one person's care records stated they had an unwitnessed fall during a previous respite visit to the service in which they had sustained a fracture. We also learnt that this person had been found on the floor during the morning of our inspection. We looked at this person's care records and saw that provisions to prevent a recurrent fall had not been adhered to, such as their room being cleared of certain objects and potential hazards. We received inconsistent information from the staff and the manager as to how this person's risk of falls should be reduced. As a result of concerns about this matter we requested that the manager raise a safeguarding alert to the local authority.

We looked at another person's care records. We saw a West Midlands Ambulance Service patient form which showed this person had suffered a fall, filed within their care records. We saw that this person's fall risk analysis had not been updated since the month prior to this fall. This meant that guidance to staff and the risk of falls for this person had not been reassessed in the light of their more recent fall.

The temporary manager told us that a third person had recently suffered a period of instability when moving due to a change in their medication. Again, we found that this person's falls risk analysis had not been updated to reflect this, as it predated the change to the person's medication. This meant that, at the time this person was at greater risk of a fall, the falls guidance for this person had not been updated to provide staff with the information they needed to safely care for this person. The manager told us this person had recently returned to their former regime of medications and the instability in their movement had gone and they had not sustained any falls.

This demonstrated a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

During the inspection of 1 April 2014 we had found gaps in people's medication records which meant it was unclear whether people had received the medication they required to maintain their health. Since our last inspection we were made aware of several medications errors which had been reported to the local safeguarding authority. During this inspection we looked at the medication records of three people. We found no gaps in medication records on this occasion. We found that in two instances the medications did not tally with the records. This meant that it was unclear whether people had received correct medicines to support their health and well-being.

We saw that one person who had 'as required' pain relief did not have a record assessing their need providing guidance to staff about when the medication was to be given. This person could not verbalise their need for pain relief. We asked staff about how they knew when to give this person their 'as required' medication. Staff provided inconsistent responses. One member of staff told us they gave the person this medication at the maximum prescribed daily dose when they administered medications. They were not assessing whether the person was in pain and required the medication as prescribed. This meant that staff did not have the guidance they needed to know how to administer this medication as required.

We saw that one person was given their medications covertly, which meant they were given their medications without their knowledge. We saw that there was an appropriate covert medication agreement in place for this person. The agreement had involved the input of appropriate professionals including a GP and a pharmacist. However, we saw that this agreement was dated April 2013 and stated on it that it should be reviewed monthly. We could not find evidence to suggest this had been reviewed as required. Staff could not tell us if the agreement had been reviewed or whether this had impacted on the person.

Inadequate

Is the service safe?

We looked at the medications fridge, which was used to maintain the effectiveness of medications that required storage at a lower temperature. Staff were not recording the minimum and maximum temperatures of the fridge to show that medicines were kept at a consistently appropriate temperature. Staff did not know how to obtain the minimum and maximum temperature from the fridge, or how to reset the temperature recording facility. This meant that the provider could not be sure that medications remained effective through the use of correct storage.

We looked at liquid medications stored in both in the medications fridge and a trolley. We found that staff were not marking the bottles with the date on which the liquid medications were first opened. This meant that staff were not labelling medicines in a way that would show if they remained effective in line with the manufacturer's guidance.

This demonstrated a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We looked at controlled drugs kept at the service. We found that an appropriate controlled drugs register was kept and that the amounts shown in this register tallied with the amounts in stock. We also found that these medications were securely stored, as per guidance.

All people and some of their relatives felt that the home was a safe place to live. One person said, "I feel safe. I get on well with everyone". However, some relatives raised concerns. Two relatives told us staff morale was low which, "created an atmosphere" at the service. Another relative reported concerns about the standard and safety of care provided. One person told us that they felt their relative's health and well-being had declined since using the service. Our own observations confirmed some of the concerns raised by people.

Staff demonstrated that they were aware of the different types of potential abuse and how they might identify these. Staffs were aware of the need to report suspected abuse and said they would report the issue to a member of the management team. We looked at staff training records and saw that most staff had received updated training in how to safeguard people. However, the manager told us that there had been some instances where senior members of the care staff had failed to report matters which required referral to the local safeguarding authority. The care manager said that this issue was being addressed through additional guidance to staff regarding the reporting of safeguarding matters.

People told us there were adequate numbers of staff to support them. Our observations throughout the day confirmed that there was adequate staffing to meet the needs of people. Staff rosters showed that staffing was kept at a consistent level. Due to an ongoing voluntary suspension of new admissions one of the three units at the service was closed, but staffing levels remained similar. We found that staff presence was flexible across the two remaining units to cover where people decided to spend their time.

Requires Improvement

Is the service effective?

Our findings

At our inspection in April 2014, we were concerned about the gaps in some staff training. We found that people were not given appropriate hydration. People were not always given the support they required during mealtimes. We found that some people's care records were not fit for purpose. The inspection found breaches of Regulations 9, 10 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan outlining how they would make improvements. When we inspected the service again in October 2014 we again found concerns.

Staff told us that some people living at the home may not have the mental capacity to consent to specific decisions relating to their care. The Mental Capacity Act 2005 (MCA) sets out how to act to support people who do not have capacity to make a specific decision.

We spoke with staff about their understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). DoLS are safeguards used to protect people where their liberty to undertake specific activities is restricted. We found that some staff were clear about the implications of these, such as what the MCA said in terms of people's capacity to make decisions. However, we found staff were unclear about DoLS and one member of staff told us they did not know what a DoLS was. This was despite the fact that staff records showed that most staff had recently undertaken training in the subject.

We asked the manager if anyone living at the home was subject to a DoLS and they told us they did not know. We asked four members of staff if they could tell us if anyone was subject to a DoLS and they each gave us different answers. We spoke with an assistant team leader who was the identified lead for DoLS applications. They informed us that two people living at the service were subject to current DoLS. This meant that staff did not know who was subject to a DoLS.

A staff member told us that one person, who was restricted from leaving the service under a DoLS, could not be restricted from leaving the service, which contradicted the provision in their authorised DoLS. This meant that there was a risk that people who were safeguarded by provisions in an authorised DoLS would not be protected by these provisions being correctly implemented by staff. A different member of staff told us that a person who did not have a current DoLS, was subject to a DoLS which prevented them from leaving the service. This meant that there was a risk that people who were not subject to DoLS were at risk of being restricted by staff, contrary to their rights. We did not see any restricted practices during our visit which may contradict someone's rights.

This demonstrated a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We asked people if they were given a choice in what they ate. One person told us, "I can ask for anything I want". We found that a person had cultural preferences around food. We saw that this person was given an appropriate dish which supported this preference.

We looked at records and observed care delivered to people to determine whether they were receiving enough drinks in order to keep them properly hydrated to promote their health and well-being. We found that people who required encouragement to consume enough liquids were appropriately prompted, throughout our visit, to consume liquids. We saw that care records provided guidance to staff about how people were to be encouraged to drink enough liquids. Staff were able to accurately reflect how this was achieved for different people. We looked at the fluid intake records of people and saw that they were consuming the correct amount of fluids to assist in keeping them healthy.

We looked at staff training records. We saw that some gaps in staff training had recently been addressed and outstanding training was being arranged. Staff told us that they felt confident in their roles and that they received enough training to support them. We observed elements of skilled care being delivered by staff. For example, we observed safe and skilled examples of staff assisting people to move around the service. This was an improvement on what we had found during our previous inspection and staff confirmed they had received recent training in this aspect of care. Staff told us they had not received training in conditions that specifically affected the people they cared for, such as training on diabetes, although people's care records did contain guidance on how their condition should be managed.

We saw examples of care, which while compassionate, did not always use best approaches for people who had dementia. Some staff also told us that they had not

Requires Improvement

Is the service effective?

received recent and effective training in dementia care. Given the service's criteria of accepting people who had mental health issues, such as dementia, this could compromise the quality of care for people with this condition. The care manager acknowledged that this was an area which required improvement among the staff group. They showed us that new training sessions were planned to ensure staff received the type of training they needed.

Staff told us, and records confirmed that they received regular supervision. They told us they were able to discuss their training needs and matters of performance during these meetings. We spoke with senior managers during our visit. They acknowledged that there were performance issues with some staff which needed to be addressed and this had not happened in the right way previously. They undertook to address these issues.

Staff used effective communication to interact with people and understand their needs. We saw that people's preferred ways of communicating were detailed in their care records in order to provide staff with guidance about this. We found that some people used a language other than English as their first language. We saw that some staff were able to speak these people's preferred first language. We heard culturally appropriate terms of respect being used by all staff when speaking to people from different cultural backgrounds. This meant that the service was able to support and understand the needs of people whose first language was not English and respected differing cultural needs.

Records confirmed that people received the support of external healthcare professionals in order to maintain their health. We saw evidence of people receiving support from healthcare professionals in connection with their health conditions. For example, we saw that a person who had diabetes had appointments for eye health testing and foot care. We saw that people received care from opticians. We found that a person who required support to keep their skin healthy had been referred to the district nurse service. This meant that people received healthcare appointments as required.

Requires Improvement

Is the service caring?

Our findings

One relative of a person living at the service told us that communication with staff was sometimes poor. They said that they had not felt listened to by staff when they spoke with staff prior to the person starting to live at the service. They also said that staff did not always let them know what was happening with their relative. The relative gave a specific example of an incident in which there was a delay in them being informed. People we spoke with were positive about how staff interacted with them.

We saw that interactions between staff and people were caring. We heard staff talking to people in a kind way, ensuring they were comfortable. We heard staff encouraging people; one staff member told a person, "You're doing well" as they supported the person to move about the home. However, we found that interactions were limited in frequency and were not personalised towards those with more advanced dementia. The manager acknowledged that this was an area which required improvement. We found on several occasions staff were sitting in a group completing paperwork at the same time, as opposed to some interacting with people. One visitor told us that their relative had said they were lonely while living at the service.

We saw some instances when staff were effective in reacting to people's distress and dealt with this effectively. For example, we observed one person being guided back to a seating area by a member of staff. This person was expressing anxiety that their family was not with them. The staff member was talking to them in order to relieve their distress. The staff member's actions were effective and the person appeared calmer after the interaction.

We observed people being supported to eat during a mealtime. We saw that one person was being assisted to eat by a member of staff. There was no verbal interaction with this person by the staff assisting them, such as a description of what the food was or encouragement to consume it. While assisting this person, the staff member was called away to help elsewhere. The staff member left the person without any verbal interaction with them, such as to explain they were leaving them on their own.

We saw that staff were assisting people to eat while wearing rubber gloves. We saw no reason for gloves to be worn, such as a specific need to prevent cross infection. One member of staff told us they wore gloves while assisting all people to eat, due to infection control issues. We found that this was being done where infection control issues were not a potential risk. The unnecessary use of gloves in this way could affect the enjoyment of the meal and make it feel less personalised for the person being assisted.

We observed that staff delivered care discreetly. We asked staff about how they ensured people's privacy and dignity was maintained. Staff gave good examples of how they achieved this, such as ensuring doors and curtains were closed during personal care.

Requires Improvement

Is the service responsive?

Our findings

One relative of a person living at the service told us, "I feel informed about what is going on with [person's name]". Another person told us they felt ill-informed about how their relative was doing. Other people told us they were happy with the responsiveness of the service. For example, one person told us, "They pick up on things quickly". Overall, most relatives told us they felt they were kept informed of changes and enquiries were answered promptly by staff.

We saw that personalisation within care plans had improved since our last visit. For example, people's care records contained a short profile which detailed what was important to them. We saw that care needs were reviewed and people and their representatives had signed some care records to show their acknowledgement and agreement with them. Care plans for individual aspects of people's care were specific to the person and their needs, although we did find that some care plans contained inconsistent information, which did not always reflect people's current needs. This was despite the fact that some of these records had been signed by staff to indicate they had been checked. For example, one person's care plan said that they had diabetes which was controlled through diet. A care plan written for a different aspect of their care said their diabetes was controlled with medication. This meant that staff did not always have correct and consistent guidance on how to support people.

This demonstrated a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed examples of staff meeting people's needs, in line with their care records. For example, one person was said to require a special cushion to sit on to relieve pressure on their skin. We saw, throughout our visit, that this person was sitting on the appropriate cushion. We also saw that a person required support under their arm. We saw staff ensuring they had a pillow under their arm for support. This meant that staff were aware of the guidance on how some people required support and delivered this support.

A relative of one person living at the service told us, "They could do more [activities]". We observed some people taking part in activities during the day. These included a person we saw who was enjoying creating art work with the assistance of staff. We saw photographs of days out which people had participated in. However, we saw that some people received little stimulation throughout our visit, apart from during mealtimes. We saw that some people were sitting in the same seat for a period of time without any interaction with members of staff, who were near by completing paperwork. It was difficult to see how some people were being encouraged to participate in activities, such as chatting with members of staff or how they were supported to pursue their interests and hobbies. This meant that people did not always have the opportunity to take part in activities which stimulated them.

Visitors told us they were welcomed by staff when they attended the service. One relative told us, "We're always made welcome". They told us there were no bars to them visiting relatives. This meant that people were able to maintain relationships which were important to them.

We saw that the provider had a robust complaints policy. We also found that complaints were sent to the provider on a monthly basis so that they could be evaluated for trends and issues. The provider's complaints and compliments leaflets, offering advice to people on how they could make a complaint, were available in the reception area of the service. The provider produced leaflets in other formats, such as different languages. People we spoke with told us they had not raised a complaint. People told us they would be confident to talk to staff if they had any issues.

Inadequate

Is the service well-led?

Our findings

During our inspection in April 2014 we found that the provider's auditing and quality assurance systems were not identifying shortfalls in the service which we had found during this inspection. The inspection found breaches of Regulations 9, 10 and 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The provider sent us an action plan outlining how they would make improvements. When we inspected the service again in October 2014 we again found concerns with auditing and quality assurance.

Some people we spoke with told us about the culture and atmosphere at the home. While some people were positive about this aspect others were less so. One relative told us, "There is plenty of staff; some good, some bad. Some just tick the box". Other relatives told us that the atmosphere at the service suffered due to low staff morale. Relatives told us there was a lack of a 'forum' available for them to feed back their views on the service. We asked a member of staff if "residents'" meetings took place and they told us they did not.

The manager told us that no recent satisfaction surveys had been carried out with people, their relatives or other stakeholders. People and their relatives confirmed that they were unaware of any "residents'" or relatives' groups where they could offer their feedback. The manager told us that feedback was sought as part of the review of care process which was undertaken with people and their representatives, although we could not see this demonstrated in the care records we looked at.

We found that the provider had not fully followed the action plan, sent to us following our inspection of April 2014, to meet shortfalls in relation to the requirements of Regulations 10.

A new temporary care manager was in place to manage the service in the absence of the registered manager. They had begun working at the service in September 2014. The temporary care manager assisted us during our visit. People we asked were aware of who the new temporary care manager was. Staff we spoke with were complimentary about the temporary care manager.

We looked at a number of records to assess whether the provider had addressed our previous concerns, as outlined in their action plan. We also looked at the provider's current quality assurance systems, such as the audits carried out, to assess whether these were effective in identifying concerns and whether action was being taken to remedy concerns these audits may have found.

We found that not all parts of the action plan we had received from the provider had addressed our previous concerns. For example, our inspection of 1 April 2014 had found a number of gaps in people's medication records which had not been picked up by the provider's own audits. During this visit, we again found concerns will medication practice that should have been identified by a robust medication audit, which the provider had written to us to say they were implementing.

We could not calculate whether correct amounts of medication had been given. This meant that the provider would also not have been able to audit these medications effectively. There was therefore a risk that people could have been given the wrong amounts of medications without the error being discovered through appropriate auditing processes.

We looked at an infection control audit tool which had been completed by the service dated June 2014. We saw that it had identified that staff required hand washing technique training. It was noted on this audit that the matter was being addressed as training for this was "in progress". We looked at staff training records and found that only 16 out of 58 staff had completed this training at the time of our visit. This meant that the response to the issue was not being dealt with in a timely manner.

We found issues with care plans containing inconsistent or out of date information. For example, we saw that one person's record showed different care plans which contradicted how a health condition was managed. We saw that staff had signed these care plans to show they had recently been updated, but had either failed to notice the inconsistency or had failed to take action to correct the inconsistency. Although we had found some improvements in records, we also found other issues relating to records that had not been identified despite the fact that the providers had written to us to assure us action would be taken to audit care plans to identify any issues and to address them.

We found that the provider had also failed to implement recommendations made by other agencies who had assessed the service. For example, we saw that a Clinical

Inadequate

Is the service well-led?

Commissioning Group pharmacist had assessed medication practices at the service in May 2014. We found that some of the recommendations made by the subsequent report had still not been addressed by the provider, such as the correct temperature monitoring and recording of the medication fridge.

The provider also wrote to us to say they would ensure that appropriate risk assessments were completed in order to identify and manage risks to people's health and well-being. We found instances where this had not been done for people who had sustained falls.

We found that the provider's current audits were not robust and did not identify some of the concerns we had found during our visit. We found potential hazards had not been identified around the service. This included ensuring that one person's bedroom was free from potential trip hazards. It also included a cupboard containing hot piping not being locked to protect people from coming in contact with them and potentially sustaining burns. We found a used razor had been left in a bathroom. During our inspection of 1 April 2014 we had found an odour present in the reception of a corridor area. We were told this was due to work which was required to pipes below the floor, but that this work had been scheduled. During this visit we found that this work had not been progressed and the odour was still detectable, despite the care manager's efforts to minimise this through the cleaning of the carpet.

We saw that there were a number of recent matters which, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, should have alerted to us using a mandatory form. These included a serious injury and a medications error which could have affected someone's well-being. We found that these matters had not been notified to us by the provider, as required by law. This prevents us from gaining a complete picture of what is happening within a service so that risk can be effectively analysed and responded to.

We had not received a reply to our request from the service, called a Provider Information Return, which was requested for completion by a deadline under Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The care manager explained that this may have been received into the registered manager's email account to which the care manager had no access. This meant that there was no provision for the monitoring of the email account in which important matters relating to the running of the service may be received.

These matters demonstrated a continual breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The registered person must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of accurate and appropriate records.

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	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person must protect people who use the service against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the service and identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk.

The enforcement action we took:

We have served a Warning Notice on the Provider and Registered Manager for breaches of Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. The Warning Notice provides a deadline of 6 February 2015 for its provisions to be met.