

Dr S Seyan and Mr J Kotecha

# Trent Lodge Residential Care Home

## Inspection report

6-8 Essex Road  
Enfield  
Middlesex EN2 6TZ  
Tel: 020 8367 2159

Date of inspection visit: 21 and 22 January 2015  
Date of publication: 31/03/2015

### Ratings

#### Overall rating for this service

Inadequate



Is the service safe?

Inadequate



Is the service effective?

Requires Improvement



Is the service caring?

Good



Is the service responsive?

Inadequate



Is the service well-led?

Inadequate



### Overall summary

This unannounced inspection took place on 21 and 22 January 2015 and was undertaken by two inspectors.

At our last inspection of this service in March 2014 the provider was not meeting all the regulations we looked at. We found that assessments of risks to people had not always been updated in response to people's changing needs and following significant events affecting health and safety. Prior to the inspection in March 2014 we issued the provider and registered manager with a

warning notice regarding their continued breach of regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2010. At this inspection we found that the registered manager and provider were still in breach of this regulation.

Trent Lodge provides accommodation and personal care for up to 16 older people. There are 14 rooms, two of which are shared rooms.

# Summary of findings

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.

Although people told us they felt safe at the home, 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 as well as 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 this inspection.

The registered manager and staff at the home had not always identified and highlighted potential risks to people's safety.

People and their relatives said they had good access to healthcare professionals such as doctors, dentists, chiropodists and opticians. However, some communication difficulties between the service and the local district nurse team left people at unnecessary risk.

Food looked and smelt appetising and the cook was aware of any special diets people required.

People told us they liked the staff who supported them and staff listened to them and respected their choices and decisions.

People and their relatives said they were satisfied with the numbers of staff and that they didn't have to wait too long for assistance when they needed help.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and told us they would presume a person could make their own decisions about their care and treatment. They told us that if the person could not make certain decisions then they would have to think about what was in that person's "best interests" which would involve asking people close to the person as well as other professionals.

People using the service and their relatives were positive about the registered manager. They confirmed that they were asked about the quality of the service and had made comments about this. However, the registered manager and provider were not always carrying out their legal responsibilities for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service was run.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These breaches were in relation to people's care and treatment, the management of medicines, individual risks to people's safety, managing environmental risks, communication with other visiting healthcare professionals and the safe recruitment of staff. You can see what action we told the provider to take at the back of the full version of the report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

The service was not safe as risks to people's safety were not always assessed properly.

Medicines were not stored securely.

People told us, and records showed, there were enough staff at the home on each shift to support them safely.

Inadequate



### Is the service effective?

The service was not always effective as poor communication between the service and some healthcare professionals left people at unnecessary risk.

People were positive about the staff and felt they had the knowledge and skills necessary to support them properly.

Staff understood the principles of the Mental Capacity Act 2005 and told us they would always presume a person could make their own decisions about their care and treatment.

People told us they enjoyed the food which looked and smelt appetising. The cook was aware of any special diets people required either as a result of a clinical need or a cultural preference.

Requires Improvement



### Is the service caring?

The service was caring and people told us the staff treated them with compassion and kindness.

We observed staff treating people with respect and as individuals with different needs and preferences. Staff understood that people's diversity was important and something that needed to be upheld and valued.

Staff demonstrated a good understanding of peoples' likes and dislikes and their life history.

Good



### Is the service responsive?

The service was not responsive as not every person's care plan was detailed and care plans did not always reflect all the care needs people had.

Some care plans had not been updated appropriately.

We observed that staff interacted well with people; conversing with them and giving them individual attention.

People told us they had no complaints about the service but said they felt able to raise any concerns without worry.

Inadequate



# Summary of findings

## Is the service well-led?

The service was not well-led because the registered manager and providers did not have a system in place to monitor and audit health and safety practices at the home.

The registered manager and providers were not meeting their legal obligations to meet the requirements of the Health and Social Care Act 2008 and associated regulations.

Staff told us that there was an open culture at the home and they would be comfortable about raising any concerns.

Inadequate



# 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 checked 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.

This unannounced inspection took place on 21 and 22 January 2015 and was undertaken by two inspectors.

Before our inspection we reviewed information we have about the provider, including notifications of any safeguarding and incidents affecting the safety and wellbeing of people. Prior to this inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We met and spoke with 12 people who used the service and six relatives and friends of people using the service so they could give their views about the home.

A few people could not let us know what they thought about the home because they could not always communicate with us verbally. Because of this we spent time talking with them and observing for non-verbal signs that they were happy with their care and the staff who supported them.

We also observed interactions between people and the staff who were supporting them. We wanted to check that the way staff spoke and interacted with people was having a positive effect on their well-being.

We spoke with five staff as well as the registered manager and the two providers of the service.

We met with a social care professional who was visiting Trent Lodge on the day of the inspection and we asked for their views about the home.

We looked at eight people's care plans and other documents relating to their care including risk assessments and medicines records. We looked at other records held at the home including staff meeting minutes as well as health and safety documents and staffing files.

After the inspection we spoke with the safeguarding lead and commissioning manager from the local authority.

# Is the service safe?

## Our findings

Although people told us they felt safe at the home, the registered manager and providers were not managing risks to people's safety appropriately.

The areas that were not being managed appropriately 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 this inspection.

We checked eight care plans and saw that people had individual risk assessments. For example, there was a "handling and mobility" risk assessments for people with restricted mobility. This assessment reflected whether the person required walking aids such as a Zimmer frame or a wheelchair for transportation and other relevant information for the safety of the person during movement and transfer.

However, not all risks had been identified and assessed appropriately and in some cases no risk assessment had been carried out. For example, no detailed risk assessments had been undertaken for a person with leg ulcers or for those who were prone to falls. In the case of a person with leg wounds, no risk assessment had been carried out to highlight the person's discomfort and requirement for pain relief, nutritional and hydration needs. This was needed to prompt staff to provide the person with the care they needed. Staff needed to monitor the person's nutritional and hydration intake daily to enhance the healing process regarding their leg ulcers.

Most risk assessments had a section for reviews but these were often completed 'No change' when in fact there had been changes in people's care needs.

For two people who had experienced repeated falls since moving into the home, their risk assessments should have been reviewed and updated regularly but this had not been done.

For example, we saw that one person had fallen out of bed five times since November 2014. In the section of the accident record that prompts management to look at ways of reducing the likelihood of falling again, it had been recorded that the community nurse should be called out to

assess the person's bed and environment in order to see if their risk of falling could be reduced. However, it was only when we pointed this out to the registered manager that a referral was made to the community nursing team.

This person's risk assessment had not been updated to reflect the number of falls they had experienced.

The registered manager and the staff confirmed there were no falls management or falls prevention protocols in place to guide staff how to support people and how to protect them from further falls. They had not been referred, for example, to their GP so they could have access to the falls clinic. This showed that people who were prone to falls and those who had experienced repeated falls were exposed to the risk of not receiving appropriate care and treatment.

We saw that risk assessments and checks regarding the safety and security of the premises were not always up to date or being reviewed. For example, the weekly fire alarm checks had not been carried out since November 2014. When we asked the registered manager to carry out this check on the day of the inspection, she did not follow standard fire safety guidelines (Fire Safety Risk Assessment: Guidance for Residential Care Premises 2006) and only checked one fire alarm point. This meant that she would not know if another fire alarm call point was working or not in the event of a fire. Fire safety guidelines state that a rolling programme of checks of each call point should be undertaken each week.

When we checked records in relation to the maintenance of fire extinguishers we found that these had not been serviced since 2013. The manager told us she thought they had been serviced after that time however there were no records to confirm this. Fire safety guidelines (Fire Safety Risk Assessment: Guidance for Residential Care Premises 2006) state that fire extinguishers should be checked and maintained yearly.

People who used the service did not have individual emergency evacuation plans. This plan would alert staff and emergency services, such as the fire brigade, about how each person should be evacuated safely in an emergency. For example, the plans should state if people could mobilise independently or if they required assistance.

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

## Is the service safe?

We also checked records in relation to the management of medicines at the home.

On the first day of this inspection, we found the medicines storage cupboard was unlocked. When we asked a member of staff to demonstrate how they locked the cabinet, we observed they had difficulty locking it. We noted that, unless one of the two doors was bolted from the inside, the cabinet could be opened easily, even when locked. People's prescribed medicines, including antidepressants and analgesics, were stored in the same cupboard and people walked by this cupboard to access the dining room. We saw that this cupboard was locked appropriately on the second day of the inspection.

We checked the locked drug trolley kept in the dining room. The drug trolley was firmly attached to the wall when not in use. A member of staff said medicines that were currently in use were kept in the drug trolley. We checked the drug trolley and found that most of people's prescribed medicines had been delivered using a monitored dosage system with each person's name clearly written on the pack. We were told there were no controlled drugs in use at the present time.

A second storage cabinet was used to store medicines in containers as they arrived from the pharmacy. This was a wooden cabinet which was locked when not in use. These medicines might be left for one to two days until a member of staff could transfer them to the other storage facilities. This cabinet was kept in a side area which was part of the laundry room.

The temperature of the drug trolley was monitored daily and records showed had been maintained below 25°C. This ensured all medicines in use were effective. However, the temperature of the storage cabinets in the corridor and in the laundry room had not been monitored.

All medicines administered had been recorded and each entry had been signed appropriately by a member of staff. A member of staff confirmed there had been no errors in administration for some time. There were no gaps found in the medication administration record (MAR) charts.

However, we found repeat medicines prescribed to be taken 'when required' had been delivered monthly, even though people had not been taking them. We found one person had 104 Co-Codamol tablets in the stock cabinet

which had not been used, as the MAR chart showed the person had not required them. Staff confirmed the person's own doctor had not been notified to review these medicines.

Staff told us medicines were only handled and administered by trained senior care workers. We saw the medication training certificates issued by the local pharmacist, who confirmed the training had been repeated every three years.

There were no members of staff designated to carry out regular checks that medicines were administered and recorded appropriately. A member of staff told us they usually checked daily at change of shift. However, there were no systems in place and no regular audits by the registered manager or providers to ensure medicines were recorded, handled and stored securely and administered to people safely and appropriately.

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

We checked five staff files to see if the service was following robust recruitment procedures to make sure that only suitable staff were employed at the home. Of the five files we looked at only one contained all the information required. All files contained a criminal record check and proof of identity. Four files did not contain two written references and two files did not contain any appropriate references. Each file contained a letter to the staff member from the provider stating that they would only be offered employment when satisfactory references had been provided including a reference from the person's last employer. We saw that staff had been employed at the home without satisfactory references. The provider was not following their own recruitment policy.

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

All of the staff we spoke with could clearly explain how they would recognise and report abuse. They told us, and records confirmed that they received regular training in safeguarding adults. Staff understood how to "whistle-blow" and were confident that the management would take action if they had any concerns. Staff were aware that they could report any concerns to outside organisations such as the police or the local authority.

## Is the service safe?

Everyone we spoke with told us they liked the staff. One person said, “Staff are all very kind and helpful and polite.” No one we spoke with had any concerns about how they were treated by staff.

People and their relatives told us they were satisfied with the numbers of staff and that they didn’t have to wait too long for assistance. One person told us, “There always seems to be enough staff.” Another person commented, “Help is always there if you want it.”

Staff did not raise any concerns with us about staffing levels at the service. We observed staff during the inspection and saw that, although staff were busy, they were not rushing and were able to spend some time with people.



# Is the service effective?

## Our findings

People told us they had been supported to access healthcare services, including referrals to GPs and community nurses. We saw evidence of people receiving treatment from the chiropodist and the dentist, which had been documented in their care plans.

On the first day of the inspection we saw staff accompanying people to hospital appointments. One person told us, "The GP comes if you want them."

All referrals to GPs and the outcomes of GP visits had been recorded in a separate folder but were not always reflected in people's care plans.

The care plan for one person mentioned weekly visits by a community nurse, as the person had required regular wound dressing. However, the registered manager told us that there was not always effective communication with the community nurse team. She told us that staff were not aware of how people seen by the community nurse team were progressing as the community nurses did not always talk to staff before they left the home.

However, we found this information in the community nurse's progress notes which they left at the home. We saw that important information from the community nurse's progress notes was not being transferred to the person's care plan or being read by staff. This meant that staff were not aware of how the person's wound was improving or not as they did not read the community nurse's notes or monitor the person's wound with the community nurse. This lack of effective communication between the home and the community nurse team had been the subject of a recent safeguarding concern.

This was a breach of Regulation 24 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People who used the service and their relatives were positive about the staff and told us they had confidence in their abilities. One person told us, "Staff are lovely, always very helpful and friendly."

Staff were positive about the support they received in relation to supervision and training. One staff member told us, "Now the training is good." Staff told us that after our inspection in January 2014 they had attended a number of training courses in the areas they needed in order to

support people effectively. However, given the number of falls that people had experienced at the home there was no record of any staff training in the risk assessment and prevention of falls.

Staff told us about recent training they had undertaken including safeguarding adults, first aid, dementia care and moving and handling. Staff told us that this training had increased their confidence in, for example, moving and handling. People told us the staff used the hoist properly and safely. We observed staff assisting people using the hoist and this was being carried out carefully and at the person's own pace.

We saw training certificates in staff files and staff told us they attended refresher training as required.

Staff confirmed they received regular supervision from the registered manager and told us they could discuss what was going as well as look at any improvements they could make. They said the registered manager was open and approachable and they felt able to be open with her. The registered manager told us working practices were discussed in supervisions however staff did not have yearly appraisals.

Staff were positive about their induction and we saw records of these inductions which included health and safety information as well as the organisation's philosophy of care. One staff member who had recently completed their induction said the process had made them feel much more confident.

Staff understood the principles of the MCA and told us they would always presume a person could make their own decisions about their care and treatment. They told us that if the person could not make certain decisions then they would have to think about what was in that person's "best interests" which would involve asking people close to the person as well as other professionals.

We spoke with the registered manager about Deprivation of Liberty Safeguards (DoLS). These safeguards are put in place where it might be necessary to restrict a person's access to areas within the home or stop them from leaving the home because they would not be safe on their own.

The registered manager told us that there was no one at the home under a DoLS and no restrictions were in place for anyone. She told us that people could leave the home when they wanted and those who were potentially at risk if

## Is the service effective?

they left the home unaccompanied did not want to leave. However, we saw that at least one person who was confused walking about the home for most of the day. We asked the registered manager to risk assess people's ability and safety in leaving the home unaccompanied and, if anyone required a restriction for their own safety, we asked that the registered manager make the appropriate referral to the local authority.

We did not see any consent forms with regards to care and treatment in people's care plans. However, there was a form for people to sign as to whether they would like a copy of the contractual agreement the provider had with the funding local authority.

We observed staff asking people for permission before carrying out any required tasks for them. We noted staff waited for the person's consent before they went ahead. People told us that the staff did not do anything they didn't want them to do.

The staff had a good knowledge of people's appetite, their favourite dishes and their likes and dislikes. People were positive about the food provided. One person commented, "The food is good, there is a nice variety." Another person told us the food was "nicely cooked".

We observed bowls of fresh fruit on each of the tables in the dining room. There was a selection of drinks readily available for people to help themselves. During our visit, we observed people having fresh fruits between mealtimes.

We were invited to sample the lunch menu which was hot and tasted very nice. One person commented, "It's always hot and you get a choice."

Each person's care plan included a section on 'eating and drinking' which showed basic information such as the person's food and drink preferences, their likes and dislikes and any special dietary needs they had.

Staff said the people currently resident in the home had no issues with eating and drinking, so their food and fluid intake had not been recorded. People told us they were given a choice of dishes. We observed a member of staff going round asking each person to choose from the menu for the day. One person told us they disliked pasta and minced meat and staff had respected their wishes and ensured they were given alternative dishes.

People's weight had been checked monthly and recorded. Staff said there had been no concerns in regard to people's weight but a referral to the GP would be made if there was a concern about a person's excessive weight gain or loss or if a person had a poor appetite.

**We recommend that the service finds out more about training for staff, based on current best practice, in relation to the risk assessment and prevention of falls.**

# Is the service caring?

## Our findings

People told us they liked the staff who supported them and that they were treated with warmth and kindness. One person told us, “The staff are lovely, always helpful and friendly.” Another person commented, “They are motherly.” A relative commented, “The staff have the patience of saints.” Another relative told us that the staff were “thoughtful”.

People told us that staff listened to them and respected their choices and decisions. People who used the service and their relatives were also very positive about the manager and told us she was very caring and kind.

People confirmed that they were involved as much as they wanted to be in the planning of their care and support. People told us they looked at their care plans when they had reviews with their social worker each year. The manager said that people were consulted about their care every six months when their care needs were reviewed. However, we could not find any written evidence in care plans to demonstrate that the person had been consulted or had been involved in their care and treatment reviews.

We saw there were meetings with the registered manager and people who used the service. Minutes of these meetings showed that people were given opportunities to make suggestions for improvements and that the registered manager also shared information with people about aspects of the service.

There was no evidence in people’s care plans of referrals or input from advocacy services. We saw a poster about local advocacy services on the top of a large notice board in the entrance hall and asked the registered manager to lower this poster so that people could see it more easily.

We observed staff treating people with respect and as individuals with different needs and preferences. Staff understood that people’s diversity was important and something that needed to be upheld and valued. They gave us examples of how they respected people’s diverse needs, such as by making sure people’s cultural and religious preferences were maintained when they moved into the home even though the person may not remember this due to their cognitive impairment. For example, one person told us, “They [the staff] make a fuss of me. They help if you want help. I go to church and they have a service here.”

We observed staff respecting people’s privacy through knocking on people’s bedroom doors before entering and by asking about any care needs in a quiet manner and without being overheard by anyone else. Staff were able to give us examples of how they maintained people’s dignity and privacy not just in relation to personal care but also in relation to sharing personal information.

Staff understood that personal information about people should not be shared with others and that maintaining people’s privacy when giving personal care was important in protecting people’s dignity.

# Is the service responsive?

## Our findings

Staff confirmed they had read the revised care plans since the last inspection, but we found not all the care plans had been revised and improved other than the introduction of a person-centred format for people with dementia.

There was no evidence in the care plans that the service had followed best practice guidelines such as the Malnutrition Universal Screening Tool (MUST), used to assess people with a history of weight loss or poor appetite, and the Waterlow scoring tool for pressure ulcer risk assessments, recommended by the National Institute of Clinical and Healthcare Excellence (NICE).

However, we saw that the Waterlow scoring tool had been used by the community nurse for assessing leg ulcers for a person. This information and progress notes were found in the district nurse's document folder, but relevant information had not been transferred to the person's care plan to inform staff how to care for the person, who had leg wounds.

In addition, we found the service had a weekly skin care folder for people with wounds or ulcers. We were told there was only one case at that time. We noted the last entry was dated 17 January 2015 and in a section entitled "condition of skin" a member of staff wrote, "leg ulcers on both legs that are weeping" and under "treatment" it was written, "the district nurse came to redress legs weekly."

Although the member of staff had documented each visit by the district nurse, the date and information written did not reflect the notes we found in the district nurse's document folder. We found the registered manager and staff had not read what was in the district nurse's folder and some relevant information had not been transferred across either to the weekly skin care folder or reflected in the person's care plan under skin care. In fact, the district nurse had visited on 16 January 2014 at 13:15 and had written, "Both legs healing well. Right leg remains swollen."

Not every person's care plan was detailed and care plans did not always reflect all the care needs people had. Some care plans had not been updated appropriately. The care plan forms in use and the written information they contained was very basic and did not reflect people's current conditions and needs. For example, the care plan section for 'skin care needs' for one person did not reflect their bilateral leg ulcers. Their skin condition was given as

'Good' and their existing skin conditions as 'None'. In the comment section, it was stated 'The skin is in good condition and intact, apart from the legs which are being treated by the district nurses'. There was no further information provided concerning the skin conditions or the type of leg ulcers that the person had. There was no appropriate guidance for staff to action to meet the person's current needs. This care plan was dated July 2013. The registered manager acknowledged that information about people's care needs was still quite basic and that she was looking to improve this.

We case tracked three people's care plans from their pre-admission assessment to their current care and treatment. We found that, in most cases, a pre-admission assessment had been carried out but had not been documented. The registered manager confirmed the service had not made any written record of pre-admission assessments, although a visit had been made to assess people before they were admitted to the home.

In the case of three people who had restricted mobility, the care plans had included mobility and dexterity issues and documented their history of falls before moving into the home. We saw that the majority of the care plan sections for each person had been completed at the time of admission. It was stated that each section should be reviewed and updated every six months. However, in most cases the phrase 'no change' was recorded for every review.

We found some people's care needs had changed since their admission, but their care plans had not been updated to reflect their changing care needs. For example, the needs had changed for one person with leg ulcers, another with a loss of appetite and two people who had suffered repeated falls.

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

We saw from the visitors' book that friends and family were able to visit when they wanted to. Visitors we spoke with confirmed that they were made welcome and could visit at any reasonable time. One relative told us, "You can go anytime. There are no restrictions."

During the two days of this inspection, we did not see any organised activities being conducted as the activities co-ordinator was not on duty. Staff we spoke with said

## Is the service responsive?

some people preferred to sit and read. One care worker said sometimes they organised group activities such as a sing-along and a sing-along session was organised by the same care worker on day two of our inspection.

The activities folder had limited information. There was a monthly summary chart which showed the activities each person had been involved in. Staff said that not all activities had been documented, only those organised by the activities co-ordinator were recorded. However, we observed staff interacted well with people; conversing with them and giving them individual attention.

People told us they had no complaints about the service and said they felt able to raise any concerns without worry.

One person told us, "I've got no complaints whatsoever. The food's good, everything is good." People told us that the manager always met with them and asked them if everything was alright.

According to the complaints record, the last recorded complaint was 18 months ago. However, when we asked the registered manager about this, she told us that she did not record any verbal complaints or concerns but instead dealt with these on an informal basis. This made auditing and learning any potential lessons from complaints difficult.

**We recommend that the service seek advice and guidance from a reputable source, about the management of and learning from complaints.**

# Is the service well-led?

## Our findings

People using the service and their relatives were generally positive about the registered manager. One relative we spoke with told us they felt that sometimes there were problems with communication between the registered manager and staff. They told us that they had not been notified when their relative had fallen. Other relatives told us the registered manager was very caring.

From evidence we gathered before and during the inspection as well as discussions with the local safeguarding and commissioning authority we had concerns that the registered manager and providers of the service were not managing the service safely. This was because the registered manager and providers were not carrying out regular health and safety audits or effective reviews of people's individual risks and general environmental risks.

There were no regular checks being undertaken to check the continued safety of medicines management, fire precautions, accidents and incidents, staff recruitment, care delivery and changes to people's risk assessments. For example, as a result of not checking or auditing the service on a regular basis, medicines were not being stored safely, fire systems and some equipment were unsafe, staff recruitment procedures were not being safely followed and risks to people's individual safety were not always being reviewed or updated.

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 other professionals called in to help minimise the risks.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The Care Quality Commission has issued compliance actions and taken enforcement action against the registered manager and providers since January 2014. Despite this the registered manager and providers continued to be in breach of regulations that should be protecting people using the service.

Staff were positive about the registered manager and the support and advice they received from her. They told us that there was an open culture at the home and they did not worry about raising any concerns.

There were staff meetings taking place and we saw that staff were able to comment and make suggestions for improvements to the service. The last staff meeting had taken place in October 2014.

Staff told us that they were aware of the organisation's visions and values. They told us that the registered manager always tells them that, "The residents always come first. It's their home not yours." Staff told us they enjoyed working at the home and that they worked as a team.

The service had a number of quality monitoring systems including yearly surveys for people using the service, their relatives and other stakeholders. These surveys were in pictorial form with various facial expressions from happy to sad. Relatives we spoke with confirmed that they were sent a quality survey however no one could remember receiving any feedback about the survey although we saw a summary had been completed after each survey.

We saw minutes of meetings with people who used the service. The last recorded "Resident and Relative" meeting was in September 2014. People told us that the registered manager and providers took into account their views about the service. A relative we spoke with told us the registered manager spent time with them and said that the registered manager "listens".

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 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines  Service users and others were not protected against the risks associated the unsafe storage of medicines.  Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers  Service users and others were not protected by effective recruitment procedures and practice.  Regulation 21 (a) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010 Cooperating with other providers  Service users were not protected against the risks associated with the effective communication with other healthcare professionals.  Regulation 24 (1) (c).



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

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

The registered person failed to ensure that each service user is protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the carrying out of an assessment of the needs of the service user and the planning and delivery of care in such a way as to meet service user's individual needs and ensure their welfare and safety.

**Regulation 9(a)(1)(b)(i)(ii)**

#### The enforcement action we took:

We served a Warning Notice on the Registered Provider on 26 February 2015, to become compliant with the regulation by 26 March 2015.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers

The registered person failed to ensure that each service user is protected against the risks of receiving care and treatment that is inappropriate or unsafe by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

**Regulation 10(1)(b)(2)(a)(c)(i)**

#### The enforcement action we took:

We served a Warning Notice on the Registered Provider on 26 February 2015, to become compliant with the regulation by 26 March 2015.