

Serene Care UK Limited







# Abbey Rose

## Inspection report

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### Ratings

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

### Overall summary

The inspection took place on 22 and 23 November 2014 and was unannounced.

Abbey Rose provides accommodation and personal care for up to 24 people. The home provides care for older people which includes people living with dementia. There were 21 people living in the home at the time of our inspection. Communal facilities in the home included a lounge, dining room and a garden.

The home had a registered manager. 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 2008 and associated Regulations about how the service is run.

At our last inspection of Abbey Rose in May 2014, we found the provider was in breach of regulations in relation to people's care and welfare, the management of medicines, staffing and assessing and monitoring the

# Summary of findings

quality of the service. We asked the provider to take action. Following the inspection, the provider sent us an action plan. They told us they would meet the relevant legal requirements by 22 August 2014.

During this inspection we found that the provider had continued to be in breach of the regulations. We also identified further breaches of regulation in relation to people's consent to care and treatment, safeguarding people from abuse, staff training and notifications. You can see what action we told the provider to take at the back of the full version of the report.

People were not safe because procedures to promote their safety and welfare in the home were not followed and risks were not managed effectively. Although staff knew how to report any concerns about abuse, when a person reported that some money had gone missing, staff did not report this to the relevant authorities.

People did not always receive the care they needed because their care plans were not followed. Staff were not always aware of people's needs which put them at risk of unsafe or inappropriate care. We also found that people's mental capacity to make some decisions about their personal care had not been fully considered. There were no plans in place to ensure decisions were made in their best interests and took account of risks to their welfare.

People were at risk of not receiving appropriate medicines and creams to meet their needs. Information about people's medicines and creams was not always accurate or complete.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The purpose of DoLS is to ensure that people who are deprived of their liberty have their rights upheld. Although the provider had made previous applications on behalf of people who they believed were deprived of their liberty, people's care plans had not been reviewed in light of the Supreme Court Judgement in March 2014

which extended the definition of DoLS. This meant there were potentially people in the care home who did not have the capacity to make a decision about living there but were not protected by DoLS.

People's needs were not always met by staff with the appropriate training. Staff told us they felt supported by the home's care manager and felt they could go to them if they needed advice or help.

People told us that staff were friendly, polite and helpful and we observed examples of staff responding to people in a caring and positive way. However, people's needs for support and attention were not always met because staff were not available or were focused on other tasks. There were not always enough staff available to support people and attend to their needs promptly.

Although people had some choices about their care, improvements were needed to ensure that there was a fully personalised approach to the support provided. For example, staff expressed concern that people who stayed in their bedrooms received little interaction or opportunity to engage in activities. This was confirmed by a person who lived in the home who commented that they had "no social interaction with others." Improvements were needed to ensure the service responded to people's different social and emotional needs.

People told us they felt able to speak with the care manager about any concerns and had confidence they would listen to them. We saw that, in most cases, action had been taken where people had made comments or raised concerns.

Improvements were needed to the leadership and management of the service. There was no effective system for analysing accidents and incidents to ensure risks to people who used the service were reduced. Communication between the registered manager and staff required improvement to ensure staff had regular opportunities to discuss issues and concerns and were engaged in the development of the service.

# 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.

Risks to people's care and welfare were not always managed effectively.

Procedures were not always followed to ensure people were protected from harm.

There were not always enough staff available to support people when they needed assistance.

Inadequate



### Is the service effective?

The service was not always effective.

Improvements were needed to ensure that people who did not have the mental capacity to make a decision to live in the care home were protected by Deprivation of Liberty Safeguards (DoLS).

The service had not always considered people's mental capacity to make decisions about their personal care. Risks to people's welfare had not always been taken into account when they refused care.

Some staff had not completed appropriate training. This meant there was a risk that people's needs would not be met because staff would not know how to support them.

People were generally satisfied with the food provided at the home.

Requires Improvement



### Is the service caring?

The service was not always caring. People enjoyed some positive relationships with staff whom they described as friendly, compassionate and polite towards them. However, there were times when people did not receive the attention or support they needed. This left people without anyone to hear them or reassure them.

Requires Improvement



### Is the service responsive?

The service was sometimes responsive to people's needs and preferences. However, improvements were needed to ensure that the care provided was fully personalised and took account of people's social and emotional needs.

People told us they felt able to discuss concerns with staff and we found most people's comments and concerns were addressed.

Requires Improvement



### Is the service well-led?

The service was not always well-led because there were no effective systems to manage risks across the service.

Requires Improvement



# Summary of findings

Communication between the registered manager and staff required improvement to ensure staff had regular opportunities to discuss issues and concerns and were engaged in the development of the service.

The registered manager did not notify us when they were absent from the service as they are required to do by law.

# Abbey Rose

## 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.

The inspection took place on 22 and 23 November 2014 and was unannounced. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we asked the provider to complete 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 also reviewed information we held about the service including notifications from the provider relating to people's care and welfare.

During our inspection, we spoke with four people who lived at Abbey Rose. Some people who lived in the home were not able to tell us about their experience of living there so we also spent time observing them and the care they received. We spoke with four people's relatives who were visiting the home and five care staff. We looked at records about ten people's care including care plans, risk assessments and information about their medicines. We looked at recruitment records for four care staff, duty rotas, staff training records and information about the management of the service. Following our inspection we requested further information from the registered manager but we did not receive this within the required timescale.

# Is the service safe?

## Our findings

At our last inspection on 15 May 2014, we had concerns about the care and welfare of people who used the service, the management of medicines, staffing and the way in which the quality of the service was assessed and monitored. These were breaches of regulations 9, 10, 13 and 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action. During this inspection, we found that the provider had made some improvements to the management of medicines and they had plans in place to improve staffing levels. However, the action taken was not adequate to meet the requirements of the regulations. We identified continued breaches of these regulations and breaches of other regulations related to people's safety in the home.

People were not safe because procedures to promote their safety and welfare in the home were not always followed. Staff told us they would report any concerns about people's safety to a senior member of staff or to an outside agency such as the local authority or Care Quality Commission. This was confirmed by the care manager who told us they would contact the local authority's safeguarding team to report any concerns about people's welfare. However, records showed that, earlier in the year, a person had alleged that a small amount of money had gone missing from their bedroom. Although the care manager told us they had not reported the incident on the person's request, this meant the provider had not taken appropriate action to protect people who lived in the home.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks in relation to people's care and welfare were not managed appropriately. Staff told us that one person was at high risk of falls. Records showed they had fallen 17 times in the previous seven weeks with most falls occurring in the lounge. Although records showed that health care professionals had been consulted in relation to the concerns, the person's care plan was not being followed to ensure risks were minimised. The person's care plan referred to the use of an alarm mat and cushion when they were in the lounge which would alert staff when they got up. These were not in place. Staff told us these had been removed because the alarms kept going off. They told us

this was happening either because other people were interfering with the equipment or the person themselves was shifting their weight on their chair. The removal of the alarm mat and cushion meant that staff were not being alerted when the person got up from their chair. The failure to follow the person's care plan put them at increased risk of falls.

One person's care plan indicated they were at risk of having an epileptic seizure. The care plan said they would become drowsy and incoherent when they were having a seizure and detailed the action staff should take. We spoke with three staff, none of whom were aware that anyone in the home had epilepsy. For example, one care worker, said, "I'm not aware of anyone", while another care worker explained that they had not had the time to read people's care plans in detail. This meant there was a risk that staff would not identify that the person was having a seizure and, therefore, would not take appropriate action to keep them safe. We also noted that the person's care plan referred to seeking urgent advice from the GP in the event of a seizure lasting more than five minutes or a delayed recovery. There was no guidance in the care plan about when staff should call for an ambulance which put the person at risk of not receiving emergency treatment when they needed it.

The provider had not carried out a risk assessment to determine whether staff had adequate training in first aid to meet people's needs in an emergency. One member of staff told us there had been "no practical first aid training for a long, long time", while another member of staff said, "There's no practical first aid training here." This put people at risk of not receiving effective support in an emergency.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely and temperature checks of the medicine storage areas were carried out each day. The checks showed that medicines had been stored at the correct temperature. However, staff did not know the correct maximum temperature for the safe storage of medicines. This meant there was a risk that staff would not take action at the appropriate time to ensure medicines were stored safely if the room temperature increased.

## Is the service safe?

People were at risk of not receiving their medicines as prescribed. One person told us they were worried about being constipated. Staff were aware of this and told us they were prescribed laxatives during the day and as required at night to help with their constipation. However there was no information in their care plan about when staff should give them their night time laxatives to ensure the risks of constipation were minimised. Another person's care records said they were allergic to penicillin but this conflicted with information on their medicines records which stated there were no known allergies.

People were not always getting the creams they required to prevent their skin breaking down. For example, one person had been assessed as needing a cream applied on their legs. This was because they had a skin infection which meant that their skin was at risk of becoming dry and damaged. There was no care plan in place to instruct staff about where, how and when to apply their cream. We spoke with three members of staff, two of whom were not aware that the person required creams. Care records did not show that their creams were consistently applied. For example, there were no records of creams being applied on four out of seven days in the previous week.

Another person's care plan said their skin was prone to being sore. The care manager told us they had creams applied every time their continence pad was changed. The person's care records did not reflect this and showed a total of seven entries over the previous week.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not always enough staff available to help people. We observed people sitting in the lounge and found there were periods of time, up to 20 minutes, when there were no staff nearby. This was important because we noticed people becoming unsettled and requiring support while they were in the lounge. For example, there was an incident where one person removed another person's walking frame which left them without the equipment they needed to mobilise safely. One member of staff told us this happened regularly while another care worker said that this person needed staff to keep "an eye on them" because they could become agitated. However, our observations showed there were often no staff around to ensure

situations did not escalate or to intervene if necessary to keep people safe. We observed that people who spent time in the lounge did not have access to a call bell to ensure they could call for help if required.

We observed one person who was sat in the lounge for 20 minutes. They were calling out for staff and said repeatedly, "Nobody comes in here much. Nobody to ask. Nobody's telling you anything." There were no staff around to respond to their calls, or reassure them, for the whole 20 minutes we were observing them.

Staff told us there were not always enough staff on duty to support people, particularly in the afternoons when people needed support with their evening meal, medicines and personal care. One member of staff commented that this had an impact on people who used the service because they were not always able to respond promptly when people needed help. They told us, "Bells always going, having to ask people to hang on. We have to keep asking residents to wait." Another member of staff said, "There are not enough staff for the type of people we have coming in... they have more needs." In particular, staff told us they were unable to give people the support they needed with eating. One member of staff explained, "There are three or four who need feeding. We haven't got the time to sit and feed everybody." Another member of staff commented, "Some residents you have to help feed but can't." This meant there was a risk that people were not receiving the support they required.

The care manager told us that plans were in place to increase the number of staff on duty in the afternoons which staff agreed would make a difference to the support they could provide. The care manager showed us a new rota which they told us had been designed to include an additional member of staff on duty in the afternoons. The new rota was due to start the following day. However, when we looked at the rota for the next two weeks, we noted that afternoon shifts at the weekends were still covered by three staff, one of which was an agency member of staff. Additionally, eight weekday shifts included a care worker who had started working in the home the previous week, did not have any previous experience of working in care and had not completed their induction training. The care manager acknowledged that they had not been able to

## Is the service safe?

cover all shifts with enough suitably experienced staff. This meant there were not always enough staff, with suitable qualifications, skills and experience, to meet people's needs.

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received support from permanent staff who had been recruited safely. Appropriate checks had been carried

out on staff before they started work in the home. These included checks with the Disclosure and Barring Service (DBS), references and checks on people's identity. The care manager confirmed that people did not start work in the home until these checks had been completed. This helped ensure that staff employed to work at Abbey Rose were suitable to work there. Although the care manager said that information about agency staff was sent through to the registered manager who would assess their suitability to work in the home, information about the agency workers was not available in the home at the time of our inspection



# Is the service effective?

## Our findings

People were not always cared for by staff with relevant training to carry out their work. There was an induction training programme for new staff and distance learning packs available for all staff on various subjects including mental capacity, medicines, moving and handling, diabetes and dementia. Although staff told us they had completed some training, staff had not completed all relevant training. For example, most staff who worked in the home had not completed training in tissue viability, diabetes, mental capacity or dementia. The care manager acknowledged there were some gaps in people's training and told us that it had been difficult to encourage staff to complete training booklets in their own time. They said they would be putting plans in place to rectify this during 2015.

Improvements were needed in relation to the implementation of Deprivation of Liberty Safeguards (DoLS). These safeguards aim to protect people in care homes and hospitals from being inappropriately deprived of their liberty. They can only be used when there is no less restrictive way of supporting a person safely.

It is the provider's responsibility to review existing care and treatment plans for individuals to determine if there is a deprivation of liberty and make applications to the local authority, where appropriate. Although the provider had made previous applications on behalf of people who they believed were deprived of their liberty, people's care plans had not been reviewed in light of the Supreme Court Judgement in March 2014 which extended the definition of DoLS. This meant there was a risk that the rights of people who did not have the capacity to make a decision about living in the home were not protected.

People were not always supported by staff to make decisions appropriately. Some people who lived in the home had dementia. This meant it was difficult for them to make informed decisions about their care and treatment. Staff told us they were aware of the importance of offering people choices in a way they would understand. For example, one member of staff described how they took into account people's communication needs when they offered them a choice of clothes. They described how one person would make a choice using non-verbal communication so it was important to watch them carefully to observe their response. They also told us that they used their knowledge of people's likes and dislikes to

help ensure people's care was carried out in the way they preferred. However, another member of staff raised concerns that, although there was a list of people who required help with having a bath, they had never seen them asked if they wanted a bath. They expressed concerns that staff were making decisions on people's behalf, without asking them what they wanted. Records about people's care did not always indicate whether they had been offered support with their personal care and whether this support was accepted or declined.

The Mental Capacity Act (2005) provides the legal framework for acting on behalf of individuals who have been assessed as lacking the mental capacity to make specific decisions for themselves. People's care records contained information about their capacity to make day to day decisions about their care, for example, whether they were able to express a preference for having a bath, shower or strip wash. However, people's mental capacity to refuse support with their personal care had not been considered. For example, one person's pre-admission assessment said they needed assistance with their personal care and were at risk of self-neglect. However, staff told us that it was difficult to encourage them to accept assistance with their personal care and they became aggressive if staff tried to help. The person's mental capacity to refuse personal care had not been assessed and there was no information in their care plan about how risks to their welfare could be minimised. It was not evident, from looking at care records or talking with staff, that the person was receiving sufficient support with their personal care.

Another person was identified as at risk of pressure sores. Their care plan said they should be supported to change position every two hours to reduce the risk of their skin becoming sore. Staff told us that this did not always happen. One member of staff said, "It doesn't really happen here", while another member of staff said the person sometimes declined to be moved so staff did not do it. There was no system in place for staff to record when the person was repositioned to ensure their care plan was being followed. There was no plan in place to ensure that decisions in relation to their repositioning were made in their best interests.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 9(5) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

## Is the service effective?

People had access to food and drink. A recent survey of people's views had been carried out which assessed people's satisfaction with the food provided. The results showed that 81% of people said the food was either good or excellent, with others responding that the food was satisfactory.

The comments we received about the food were generally positive. One relative said, "The food is good. It's presented well." They told us their family member had a good appetite and they felt confident they were getting enough food to meet their needs. Another relative told us that the food was of "good quality." A person who lived in the home described the food they were given as "adequate, on the whole not too bad." Where a person had left some food on their plate, we observed staff discussing this and consideration being given to using a prescribed food supplement to boost their nutritional intake.

People had access to health care services, such as GPs and nurses, as required. One person explained that community nurses visited them regularly as they had sore legs which needed dressing. A relative told us, "Yes, they call the doctor." Records were maintained of appointments made

with various health care professionals and staff regularly sought advice when they had concerns. For example, staff told us that, in response to concerns about a person's food intake, they had called a doctor out to prescribe an increase in their food supplements. Where there were difficulties accessing specific health care services for individuals, staff had continued to follow this up to ensure they received appropriate support. For example, one person had experienced a delay in accessing podiatry services so staff had liaised with their GP to ensure an appointment was arranged.

Staff received support from the care manager both informally and through regular supervision sessions. Staff told us they would approach the care manager if they required support and felt confident they would receive the help they needed. For example, one member of staff said, "If I've got a problem, I go to [the care manager] – they will do what they can." Records showed that supervision sessions included discussions about care practice, completion of training packs and procedures in the home.

## Is the service caring?

### Our findings

The service was not always caring because people's social and emotional needs were not consistently met. For example, one person asked a member of staff to play a game but, because the member of staff had to prepare tea, they were told to wait for another care worker. No-one came to play a game with them. We also observed that staff were focused on tasks during lunch which resulted in the meal time being held mainly in silence with little social interaction between people.

However, there were occasions when staff interacted with people in a caring and positive way. For example, they stopped what they were doing and showed concern for a person who was coughing. They noticed when a person was sitting in the lounge with bare feet and went to fetch a pair of socks to ensure they were comfortable. Staff shared a laugh and a joke with a person while providing their care which made it a positive experience for the person concerned. They also spoke with people in a way they understood during a game which made sure people were included. This contributed to positive relationships between staff and residents.

People were able to receive visitors who spent time with them in the lounge or in their bedrooms. We observed people receiving visitors throughout the day. A relative told

us, "They welcome families" and commented that there was good communication between themselves and staff about their family member's care. However, another person's relative told us that, while they had previously been able to visit their relative when they wanted and been involved in their life, things had recently changed. They told us they now felt restricted in what they could do with their family member in the home and did not feel as welcome.

The service used a framework called a dignity in care tool to promote positive relationships between staff and people who lived in the home. The tool was used to check that new staff were providing care in a way that was respectful and promoted people's dignity. For example, staff were encouraged to knock on people's doors before entering their room, communicate with them in an appropriate way and maintain people's privacy. Staff had been assessed through observation and discussion when they started working in the home to ensure they understood how to treat people with respect.

# Is the service responsive?

## Our findings

At our last inspection on 15 May 2014, we found that the provider did not always have regard for people's complaints about the service. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We asked the provider to take action. During this inspection we found that staff were listening to people's comments and concerns. However, issues raised were not always resolved to people's satisfaction.

People told us they felt comfortable speaking with staff, or the care manager, about any concerns. One person, for example, described the care manager as "very understanding and responsive...a person you can approach and you won't get any problems." Another person's relative commented that they would feel happy raising concerns and gave us examples of issues they had raised with the care manager which were being dealt with. However, one person described having a mixed experience of raising concerns because an issue they had raised recently had not resulted in positive change.

People's preferences were taken into account in relation to their care. For example, people had a choice about where they preferred to eat their meals and, where one person wanted to be independent with one of their medicines, they had been enabled to do this. However, the home's activity programme required further development to ensure it was tailored to people's individual needs. The

activity programme for the previous month included two visits from musicians, a Bonfire Night tea party, a sing-a-long and a reminiscence session. A person who lived in the home explained that they enjoyed watching the musicians who came into the home but, otherwise, did not have any social interaction with others. They also told us there were no opportunities for them to go out of the care home unless they were taken out by friends and family.

Staff told us they took responsibility for organising games if they had time. However, they recognised there were not enough activities for people. One member of staff told us that they could "only fit in activities for 10 or 20 minutes at a time" while another member of staff noted that activities only tended to happen in the mornings due to staffing levels. A further member of staff observed that people who spent time in their bedrooms did not receive enough stimulation and were not always invited to join in activities taking place in the lounge. This was particularly important because some people were living with dementia and needed support to take part in activities to improve their quality of life and reduce the risks of isolation.

We observed people in the lounge spending large amounts of time in front of the television although most of them were not watching it. Staff initiated a game with people on one day before lunch which people enjoyed. The care manager told us they were currently looking at ways of developing the activity programme and had started to research ideas that could be implemented at Abbey Rose.

# Is the service well-led?

## Our findings

The registered manager was also the nominated individual for the service which meant they were in day to day charge of carrying on the service as well as responsible for overseeing its management. It also meant they were the main point of contact for the Commission and, therefore, responsible for notifying us if they planned to be absent from the service for a continuous period of 28 days or more. The care manager told us that, during the summer, the registered manager had been absent from the service for a period of five weeks. The registered manager failed to notify us of this absence and the arrangements made for managing the care home while they were away.

This is a breach of regulation 14 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager was also a registered person in respect of another home. This meant they were not based at Abbey Rose all the time. Staff told us that the registered manager visited the service for a maximum of 16.5 hours each week. They told us that, because of this, people saw the registered manager as a remote figure rather than the person responsible for managing the home. This was emphasised further by the care manager having many delegated responsibilities for the running of the service on a day to day basis which included providing a 24 hour on call service to the home at all times except when they were on annual leave. The home's staff rota showed they also took responsibility for providing care to people when the home was short-staffed. A member of staff told us, "[care manager's name] does everything...and holds this place together." Another member of staff said, "[The care manager] is lovely but they have a lot on their plate." People who used the service told us that it was the care manager, rather than the registered manager, who they went to about any issues or concerns.

The care manager told us that staff had been unhappy in the past year and had not liked some of the changes within the service. They told us it had been difficult to retain care workers and five staff had left the service over the past six months.

Staff told us about some of their concerns which included concerns about staffing and their pay. They told us they did not have regular opportunities to discuss their concerns directly with the registered manager. One person said,

"Sometimes [the registered manager] comes in and goes in the office...they say hello...but they don't discuss the home. I wish they would. They need to be more involved here, not leave everything to [the care manager]. They need to pull their weight a bit." Another member of staff said, "It's not often you see the big bosses in but when you do, they don't seem very approachable."

Records showed that the registered manager had not attended a staff meeting since February 2013 although there had been six further staff meetings since this time. Staff told us there had been times when the registered manager had been in the building but had chosen not to attend. A member of staff described feeling "annoyed" about this while another commented that this did not motivate other members of the team to attend. There were no surveys to capture staff's views about what was working well in the home and areas for improvement. There was also no system for capturing the views of staff who had decided to leave their employment in order to promote staff retention and a stable workforce.

There was no effective system for analysing accidents and incidents to ensure appropriate action was taken to reduce risks. We looked at information we held about the service and found that between June and November 2014 there had been six incidents which had resulted in serious injuries. This information had not been analysed by the service to identify any common themes or patterns. We also looked at records relating to the person who had fallen 17 times in the last seven weeks and found that most of the falls occurred in communal areas and were not witnessed by staff. This pattern had not been identified by the service to ensure that consideration was given to reducing risks in communal areas of the home. The failure to analyse information about accidents and incidents meant that action could not be taken to identify any recurring themes and reduce risks across the service.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that, in recent months, there had been some improvements made by the registered manager and provider. A person who lived in the home told us about plans to upgrade the lighting to make sure it was bright enough while a relative noted that new chairs had been

## Is the service well-led?

purchased for the lounge and dining area. A member of staff also commented on the new chairs which they told us were easier to clean and informed us that they were now getting more staff.

The provider and registered manager had listened to some feedback from other agencies. For example, the care manager told us about the action they had taken, following a monitoring visit from the local authority, to improve the

handling of medicines in the home. This had included the purchase of a new refrigerator for storing medicines, a new process for carrying out checks and improved records. They also told us that, following concerns raised by people at the last inspection, a ramp and handrail had been built to ensure people could access the garden when they wanted. This showed that the provider and registered manager were taking action to make improvements.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements 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 (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment  How the regulation was not being met:  People were not safeguarded against the risk of abuse because processes did not operate effectively to investigate an allegation of abuse. Regulation 13(3)
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care  How the regulation was not being met:  People did not always receive care that was appropriate or that met their needs. Regulation 9(1)  Care and treatment was not always designed to ensure people's needs were met. Regulation 9(3)(b)
Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance  How the regulation was not being met:  Systems and processes were not established to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(1), (2)(b)
Regulated activity	Regulation
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  How the regulation was not being met:

This section is primarily information for the provider

## Action we have told the provider to take

Care and treatment was not provided in a safe way for service users because medicines were not always managed properly and safely. Regulation 12(1), (2)(g)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not always deployed in order to meet people's needs. Regulation 18(1)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

How the regulation was not being met:

The registered person had not acted in accordance with the Mental Capacity Act (2005) in designing and providing care to people who lacked capacity to make decisions about their care. Regulation 9(5)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 14 CQC (Registration) Regulations 2009 Notifications – notice of absence

How the regulation was not being met:

The registered manager did not notify the Care Quality Commission of their absence from the service, or the arrangements made for the management of the service, when they were absent for a continuous period of 28 days or more. Regulation 14(1)(b), (3)