Review of compliance

Mr T & Mrs S Kandiah Remyck House	
Region:	South East
Location address:	5 Eggars Hill Aldershot Hampshire GU11 3NQ
Type of service:	Care home services without nursing
Date the review was completed:	2 February 2011
Overview of the service:	Remyck House is a privately owned care home registered to provide residential care for up to twenty nine older persons some of whom may have dementia. The home is located in the North Hampshire of Aldershot with easy access to town centre shops and other communal facilities. The towns of Farnborough and Fleet are within ten minutes drive, Guildford twenty minutes drive as is the M4 motorway giving easy access to London.

Summary of our findings
for the essential standards of quality and safety

What we found overall

We found that Remyck House was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because of concerns raised with us which were identified in relation to:

- Care and welfare of people who use services
- Meeting nutritional needs
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Staffing
- Supporting workers
- Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit in December 2010. We observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

What people told us

During our visit to the home, we found that only two residents of the thirteen residents being accommodated were not suffering from advanced dementia and were able or prepared to talk to us.

Of these two, one was prepared to talk to us. This individual expressed neither negative or positive opinions about the service they were receiving and added very little to the other evidence we gathered during our visit.

What we found about the standards we reviewed and how well Remyck House was meeting them

This review assessed whether Remyck House provides care to people that meets essential standards of quality and safety, respects their dignity and ensures their rights. This review focused on nine regulations and associated outcomes that most directly relate to the quality and safety of care, because we had concerns. We have major concerns with seven of these standards. The areas of particular concern include care planning which is not up to date, residents are at risk of poor nutrition, there are poor standards of cleanliness and hygiene, medicines are not managed well and there is insufficient staff to meet the needs of the residents.

Remyck House needs, therefore to take action to be compliant in the areas identified. We will monitor its plans to address the concerns raised in this report and take additional action if necessary

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

People are not receiving regular reviews of their needs and any associated risks. The quality of care being provided is poor; care plans are inadequate, incomplete and inconsistent with the physical, mental and social needs of the residents and do not reflect the wishes of the residents.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Outcome 5: Food and drink should meet people's individual dietary needs

People are at risk of poor nutrition and dehydration due to poor food stocks and menu planning at the home. Residents are not provided with realistic menus nor offered a choice of food and it is not clear how their diverse needs are being met as a result of the lack of adequate arrangements in place.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Outcome 7: People should be protected from abuse and staff should respect their human rights

Staff have received safeguarding training, safeguarding policies and procedures are in place and staff are aware of what they needed to do should they witness or suspect any resident is at risk of being abused.

Overall Remyck House is compliant with this essential standard

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

People are at risk of acquiring an infection due to poor standards of cleanliness in communal areas and in rooms made ready for new residents. There is no evidence of compliance with the Department of Health's Code of Practice on the prevention and control of infections and related guidance.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

People are at risk due to the poor storage of medicines in the home and the failure by staff to remove and dispose of medication prescribed for residents no longer at the home. Staff have not had recent training in the administering of medication and medication records are not complete or accurate. There is no evidence of policies and procedures being implemented to ensure staff are aware of the need for safe storing handling, administration, recording and disposal of residents' unwanted medication.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People are at risk from scalding in the bathroom due to the temperature of the hot water supply.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

We found that there is insufficient staffing at the home and agency staff are being employed without the right knowledge, experience, qualifications and skills to support people. The rotas are not clear and staff new to the home are not given the appropriate induction. There is no registered manager, although a new manager started working at the home after our visit.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

People are at risk as staff are not being properly supported nor trained or supervised to deliver good care.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential
Records being kept at the home are incomplete, out of date and do not reflect a true picture of the assessed needs of residents and the care being delivered.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Action we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*.

Outcome 4:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

- Experience effective, safe and appropriate care, treatment and support that meet their needs and protects their rights.

What we found

Our judgement

There are major concerns with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

During our visit to the home on 6 December 2010, we found that only two residents of the thirteen residents being accommodated were not suffering from advanced dementia and were able to talk to us. Of these two, one was prepared to talk to us. This person could not remember if they were asked about their care plan and needs. They told us that apart from being bored, the care was “OK” but did not elaborate further apart from saying the care staff worked hard.

Other evidence

During our visit to the home, we looked at a sample of four residents’ care plans and in all cases, the care plans were incomplete, out of date and did not reflect residents’ current needs. We were unable to find any evidence to confirm that residents’ mental health, falls, moving and handling, nutrition, and risk assessments had been carried out. Where a need and or a risk had been identified for a resident there was a lack of information on how this was to be managed contained within the care plans. The life histories and end of life wishes also lacked detail and in some instances were missing altogether from the care plans we reviewed on our visit.

There was also no evidence in the plans viewed that people were consulted about

their plan of care and how this was to be delivered.

As part of our review, we spoke to local authority care managers who informed us that they shared our concerns about care plans at the home.

When we spoke to care staff during our visit, they told us that assessments were not carried out correctly and staff were 'just copying from previous assessments on the record' and that, since the last registered manager had left, no one was checking them.

Throughout our visit, we observed minimal interaction between the care staff and residents, who in the main spent their time sleeping or staring into space. There was no evidence of a programme of activities on the day we visited. There were also no activities designed for persons with dementia and no evidence that external agencies such as the Alzheimer's Society had been contacted for advice and guidance on what to provide.

Care staff at the home told us that there was no planned programme but they did sometimes arrange bingo or a film and told us that this should improve as a new activities coordinator was due to start work at the home within the next two weeks.

Since our visit a new manager has been appointed and is applying for registration. In the short time the manager has been in post, she has identified a number of shortfalls and produced a plan on how to resolve problems quickly. Social Services had requested a formal action plan from the manager detailing how she intended to correct the problems outlined and ensure future compliance.

Our judgement

People are not receiving regular reviews of their needs and any associated risks. The quality of care being provided is poor; care plans are inadequate, incomplete and inconsistent with the physical, mental and social needs of the residents and do not reflect the wishes of the residents.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are major concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

When asked about the food during our visit to the home, one resident told us “It’s ok” and ”I eat what’s put in front of me”. Others told us the food was “edible - what can you expect for a place like this”. They said that they were “glad they did not have to pay for it” and “the food is not very good”, was “OK sometimes, and we get enough but there is little choice”.

Other evidence

Prior to our visit to the home, we had been told that the food budget had been cut. We had also been told that the provider had refused to buy a blender to puree food for a resident who could not chew and who was only eating porridge resulting, in her losing at least two stone in two months and we had no evidence that nutritional assessments were being carried out.

During our visit, when asked for the daily menu, the cook told us that they did not have a menu for the week as the provider had not sent one. We were told the cook was responsible for preparing, cooking and ordering supplies from a menu drawn up by one of the providers which was then faxed to the home. The cook also told us her hours had been reduced to only five hours a day and she was unable to fulfil her duties and sometimes the order which she drew up was cut by the providers without discussion.

The duty roster for the previous weekend showed an agency cook had been due to work from 0800-1300. The cook told us the agency worker did not turn up until 0915, by which time care staff had already started to prepare the midday meal, affecting the care and support they were able to provide to a very vulnerable group of residents.

Staff also told us that the food budget for dry food had been reduced by £100 per week and that the meat orders had also been cut.

On the day of our visit, the cook also told us that she did not know what to make for lunch that day as there was very little food available and had to make use of only mince, potatoes and peas. When we asked to see to see what food was available, the staff showed us the larder and we found that it was almost bare, with insufficient contents to produce a meal for the fourteen residents at the home that day. The fridge and freezer also contained very little food.

In the absence of a menu for the week we visited, we were shown a menu for the previous week. Although it looked well balanced, staff reported that the menu was not followed as they used whatever food was available. Staff also told us that people were not offered a choice of food as this was not possible due to the reductions in the food budget.

Staff told us that a food delivery was due that day but had been delayed. One of the providers was at the home that day and made no effort while we were there to ensure back up supplies were obtained should the delivery not arrive, which was concerning given the lack of food in the home.

Later on the day of our visit, the provider brought us a copy of the food order for the current week that his wife had prepared. This indicated that people would be having prawn cocktail for their teatime meal. We brought to the provider's attention that the menu which by then had been provided did not reflect what food was available in the kitchen. When the food delivery did arrive later in the day, the food delivered also did not include what was planned for the teatime meal.

Recently, a resident had been admitted to hospital with dehydration. At the time of our visit there was no water or soft drinks available in the lounge. When we pointed this out the matter was rectified.

On the day, as a result of the above concerns about the lack of food in the home, we made an urgent safeguarding referral to Social Services who arrived at the home to review the situation and make alternative arrangements to residents had sufficient food.

Since our visit, we have been advised by the local Social Services department that the food stocks had been much improved and adequate to feed all of the residents. They told us that water and soft drinks were also readily available on their

subsequent visits. We were also advised that nutritional assessments on all residents were now being carried out by the home.

Our judgement

People are at risk of poor nutrition and dehydration due to poor food stocks and menu planning at the home. Residents are not provided with realistic menus nor offered a choice of food and it is not clear how their diverse needs are being met as a result of the lack of adequate arrangements in place.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 7:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:

- Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

During our visit, only one person was prepared to speak to us. This person told us they felt safe in the home and had not observed any fellow resident being treated in an unkind or harsh manner either verbally or physically.

Other evidence

From information received by us prior to our visit and after talking to staff during our visit, we were satisfied that staff were aware of the home's safeguarding policy and how to report instances of abuse they suspected or witnessed.

When we looked at staff training records during our visit, they confirmed all staff had received training in the procedures to follow should they witness or suspect any resident was being abused. During our visit, we spoke to three staff and they were all able to confirm their training and demonstrated how to carry out their training into practice.

Our judgement

Staff have received safeguarding training, safeguarding policies and procedures are

in place and staff are aware of what they needed to do should they witness or suspect any resident is at risk of being abused.

Overall Remyck House is compliant with this essential standard

Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

There are major concerns with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us

We did not, on this occasion, speak to people about cleanliness and infection control so cannot report what the people using the service said.

Other evidence

Prior to our visit to the home, we had no evidence of non-compliance in this outcome area. During our visit, we did a tour of the home which appeared clean and tidy and in which no unpleasant odours were present. All of the communal bathrooms and toilets seen were clean and in some instances had been disinfected that morning.

Care staff were seen to use disposable gloves aprons and antiseptic hand gel, of which there was an ample supply spread around the home and were able to demonstrate awareness about the importance of hand washing.

However, in the communal bathrooms we found loose bars of soap in sinks, a tooth brush, a razor, toothpaste, a resident's cream dispensed 10 months previously with no date of opening on the container, and an unnamed pot of another type of cream, communal shampoo and two packets of incontinence pads. All of these items posed a high risk of spreading infection.

During our visit, we also viewed three empty rooms which we were told were ready for admissions. In the first room, there were brown stains on the bed under sheet and duvet cover. A small table was also falling apart. In the second room, the plastic cover on the mattress was stained and crumpled. In the third room, when we lifted a cushion in a chair, a large unpleasant brown stain was seen on the underside of the cushion and which appeared to be dried faeces. There was also damaged furniture in the room as the bedside cabinet was broken and had a drawer missing. These rooms had not been cleaned and prepared properly for any potential resident and presented a potential risk of infection.

In a corridor, we observed the frame and sling of a hoist that was dirty which provided another source of cross infection. Staff told us there was no cleaning programme in place and they were unsure whose responsibility it was to clean the hoist. In talking to staff, it was clear no one person had been designated as having a lead role for infection control in the absence of a registered manager and no one was aware of the Department of Health's Code of Practice on the prevention and control of infections and related guidance. There was no cleaning schedule and no system of auditing compliance with the code of practice.

Since our visit, the new manager had informed us she was now the nominated person with lead role for infection control and had ordered an up to date copy of the code of practice.

Our judgement

People are at risk of acquiring an infection due to poor standards of cleanliness in communal areas and in rooms made ready for new residents. There is no evidence of compliance with the Department of Health's Code of Practice on the prevention and control of infections and related guidance.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 9:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
- Will have their medicines at the times they need them, and in a safe way.
- Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with outcome 9: Management of medicines

Our findings

What people who use the service experienced and told us

We did not on this occasion speak to people about management of medicines so cannot report what the people using the service said.

Other evidence

Prior to our visit, we had received concerns about the levels of medication prescribed and administered to two residents who appeared to their families to be very drowsy and sleepy. As a result of these concerns, we undertook an audit of the residents' medication and the record keeping.

We found no audit trail records of residents' medications delivered to the home or returned to the pharmacist when no longer required. Two plastic bags full of one medicine were found in a cupboard that had originally been prescribed to two residents, who according to the care staff had died some months previously. Medication prescribed for one resident was found on the floor. Care staff said that this person for whom they had been prescribed had not been resident at the home for at least six months.

Some creams and ointments that were not shown as having been prescribed on

medication administered records (MAR charts) were being administered to residents. We found there was no guidance for staff on when to administer medication to residents prescribed by the GP as "when required ". Large quantities of a painkilling drug were found at the home. Some of this was prescribed for a named resident, whilst other tablets were found loose and could not be accounted for. When we checked MAR charts they were incomplete and inaccurate and did not match the stocks held.

In another instance, another resident had been prescribed a particular tablet. The MAR chart showed that they had been receiving this medication twice a day. Staff confirmed the condition requiring the medication no longer existed but continued to administer the medication no longer required. This practice could have been detrimental to the individual's health and welfare.

On the day of our visit, the MAR charts recorded a painkiller not given at midday to a resident. When we asked staff why this was missed we were told that the painkiller had been administered but not signed for.

With regard to the concern about levels of medication prescribed and administered to two residents who appeared very drowsy and sleepy, one had since left the home and the other person's medication had been reviewed by the GP and a senior health care professional employed by the social services department..

We were also concerned about the level of training staff received and their lack knowledge of medicines being administered. One member of care staff who had been responsible at times for administering residents' medication told us no one in the home had completed medication training to her knowledge in the previous six months. This statement was confirmed by the staff training record.

Our judgement

People are at risk due to the poor storage of medicines in the home and the failure by staff to remove and dispose of medication prescribed for residents no longer at the home. Staff have not received recent training in the administering of medication and medication records are not complete or accurate. There is no evidence of policies and procedures being implemented to ensure staff are aware of the need for safe storing handling, administration, recording and disposal of residents' unwanted medication.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:

- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us

We did not on this occasion speak to people about the premises so cannot report what the people using the service said.

Other evidence

Whilst we had not intended to review this outcome area, during our visit, we found that the temperature of the hot water supply to the hand basin and bath in a bathroom on the first floor (which we were told was only used by one resident) was very hot putting the user at risk of scalding as neither the hand basin nor bath had been fitted with thermostatic control valves.

Our judgement

People are at risk from scalding in the bathroom due to the temperature of the hot water supply.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are major concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

One resident told us the staff were “OK “but apart from this remark would not comment further.

Other evidence

Social Services told us that there was a high staff turnover at the home and there were low levels of staff on duty each day with only two staff on shift and no manager available at all. They were concerned about this due to the layout of the home and the risk this may cause to residents. Four of the residents also required two care workers to help them. Since the intervention of Social Services in the two weeks prior to our visit, the number of care staff had been increased to three. Any additional hours were being covered by agency staff or existing staff working overtime.

When we visited the home, there were three care staff on duty, of which one was from an agency. There was also a receptionist responsible for the telephone, a chef, a kitchen assistant, a cleaner and a laundry assistant. We viewed the duty roster which we found very confusing as it was difficult to understand who was working at the home and in what capacity.

When we asked who was in charge of the home, the senior carer told us it was not her and the manager had left. After further discussion, she agreed she was responsible for the residents' care only.

It was also difficult to assess how many hours people were working as the rota only recorded people's first names. We spoke to a care worker from a local agency who confirmed that this was the first time that she had been to the home. She told us she had received no induction when she arrived and had only been given a very basic list of the residents' needs.

When we checked the records at the home, we found no information about this agency worker and no written confirmation from the agency that all necessary checks had been carried out in relation to each staff member being supplied, including registration with the Independent Safeguarding Authority. There was also no information about this care worker's skills or experience.

Whilst observing staff through out the visit, we saw no evidence of staff engaging with the residents apart from assisting them to the toilet or dining room.

Our judgement

We found that there is insufficient staffing at the home and agency staff are being employed without the right knowledge, experience, qualifications and skills to support people. The rotas are not clear and staff new to the home are not given the appropriate induction. There is no registered manager, although a new manager started working at the home after our visit.

Overall, we found that Remyck House is not meeting this essential standard and we propose to take compliance action to address these concerns.

Outcome 14:
Supporting workers

What the outcome says

This is what people who use services should expect.

People who use services:
- Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are major concerns with outcome 14: Supporting workers

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Our findings

What people who use the service experienced and told us
The one resident spoken to told us the staff were “OK “ but apart from this remark would not comment further.

Other evidence
At the time of our visit, there was no registered manager in post, however since our visit, a manager has been appointed and has started working at the home.

When we spoke to staff during our visit, they told us that their training was provided mostly by an outside agency in the form of reading materials, followed by a test and finally completion of a knowledge paper which was then sent away for marking by the training provider. They could not tell us what would happen in the event of a paper being failed.

Whilst a record of staff training was available, this indicated that a number of staff had not received training in key areas such as caring for people with dementia, risk assessment, mental health, coping with aggression and moving and handling. There were no records seen of staff having received training in the handling and administration of residents’ medication.

As there was no registered manager in place at the time of our visit, we found that staff were not receiving any day to day guidance or regular one to one supervision and support.

Our judgement

People are at risk as staff are not being properly supported nor trained or supervised to deliver good care.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are major concerns with outcome 21: Records

Our findings

What people who use the service experienced and told us

We did not on this occasion speak to people about records so cannot report what the people using the service said.

Other evidence

We found the record keeping within the home was of a poor standard. This was much in evidence in relation to residents' assessments, care plans, staff rotas, MAR charts, menus, and staff training records where the records viewed were either incomplete inaccurate or out of date.

Our judgement

Records being kept at the home are incomplete, out of date and do not reflect a true picture of the assessed needs of residents and the care being delivered.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	9	4 Care and welfare of people who use services
	How the regulation is not being met: People are not receiving regular reviews of their needs and any associated risks. The quality of care being provided is poor; care plans are inadequate, incomplete and inconsistent with the physical, mental and social needs of the residents and do not reflect the wishes of the residents. Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.	
Accommodation for persons who require nursing or personal care	14	5 Meeting nutritional need
	How the regulation is not being met: People are at risk of poor nutrition and dehydration due to poor food stocks and menu planning at the home. Residents are not provided with realistic menus nor offered a choice of food and it is not clear how their diverse needs are being met as a result of the lack of adequate arrangements in place. Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.	
Accommodation for persons who require nursing or	12	8 Cleanliness and infection

personal care		control
	How the regulation is not being met: People are at risk of acquiring an infection due to poor standards of cleanliness in communal areas and in rooms made ready for new residents. There is no evidence of compliance with the Department of Health's Code of Practice on the prevention and control of infections and related guidance. Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.	
Accommodation for persons who require nursing or personal care	13	9 Management of medicines
	How the regulation is not being met: People are at risk due to the poor storage of medicines in the home and the failure by staff to remove and dispose of medication prescribed for residents no longer at the home. Staff have not received recent training in the administering of medication and medication records are not complete or accurate. There is no evidence of policies and procedures being implemented to ensure staff are aware of the need for safe storing handling, administration, recording and disposal of residents' unwanted medication. Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.	
Accommodation for persons who require nursing or personal care	15	10 Safety and suitability of premises
	How the regulation is not being met: People are at risk from scalding in the bathroom due to the temperature of the hot water supply. Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.	
Accommodation for persons	22	13 Staffing

<table>
<tr><td>who require nursing or personal care</td><td colspan="2">How the regulation is not being met:
We found that there is insufficient staffing at the home and agency staff are being employed without the right knowledge, experience, qualifications and skills to support people. The rotas are not clear and staff new to the home are not given the appropriate induction. There is no registered manager, although a new manager started working at the home after our visit.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.
.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>23</td><td>14 Supporting Workers</td></tr>
<tr><td colspan="2">How the regulation is not being met:
People are at risk as staff are not being properly supported nor trained or supervised to deliver good care.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>20</td><td>21 Records</td></tr>
<tr><td colspan="2">How the regulation is not being met:
Records being kept at the home are incomplete, out of date and do not reflect a true picture of the assessed needs of residents and the care being delivered.

Overall, we found that Remyck House is not meeting this essential standard and propose to take compliance action to address these concerns.</td></tr>
</table>

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 28 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the

essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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