Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Euroclydon Nursing Home

Hawthorns, Drybrook, GL17 9BW

Tel: 01594543982

Date of Inspections: 26 June 2014
25 June 2014
23 June 2014

Date of Publication: September 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Safety and suitability of premises	✗ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Chantry Retirement Homes Limited
Registered Manager	Mrs Helena Majcan Hadzihajdic
Overview of the service	Euroclydon is a care home for 48 older people with nursing and residential care needs, some of whom may be living with dementia.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 June 2014, 25 June 2014 and 26 June 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by commissioners of services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Two adult social care inspectors carried out this inspection during the hours of one night and during one day. An expert by experience spoke with people about their experiences of the service. The focus of the inspection was to answer five key questions; is the service safe, effective, caring, responsive and well led?

Below is a summary of what we found. The summary describes what people using the service and the staff told us, what we observed and the records we looked at.

If you want to see the evidence that supports our summary please read the full report.

Is the service safe?
The service was safe because people's rights and dignity were upheld. CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Two applications had been appropriately made. Proper policies and procedures were in place. Consideration of deprivation of liberty principles was reflected in people's care plans. Relevant staff had been trained to understand when an application should be made and how to submit one.

The service was safe because managers ensured learning took place following accidents and incidents. Arrangements for listening to people's concerns and complaints were in place, although, because of the way these were categorised, there was a risk that some

may not be managed appropriately. We made the provider's representative aware of this during the inspection process. The service was safe because people's risks were assessed and managed. When people exhibited behaviour that could be perceived as challenging this was safely managed by the staff.

The service was not safe in relation to how some people were moved. Some poor moving and handling manoeuvres were observed and these were potentially harmful to people. We made the provider aware of this so that they could address this. A lack of cleanliness and robust infection control practices meant the home was not safe. People were not living in a clean environment and were not adequately protected from potential infection. We issued a compliance action in relation to this and the provider must tell us how they plan to address this.

Is the service effective?
The service was effective because people told us they were happy with the care they received and felt their needs had been met. People were supported to partake in various activities and one person said, "I do all sorts of things I have never done before. I like doing painting and have some up on the wall". The service was effective because the staff knew the people they were looking after well. One visitor said, "This place is as good as I have seen. They deal extremely well with the person I am visiting". The service was effective as it enabled people to have trips out and visit the local community.

Is the service caring?
The service was caring because staff interacted with people in a kind and helpful way. Staff responded to people who were exhibiting behaviour that could be perceived as challenging in a non-threatening and respectful manner. The service was caring because staff recognised people's diverse needs and abilities and supported and managed these without prejudice or judgement. All the people we spoke with spoke fondly about the staff. The service was caring because people's preferences and choices had been identified, recorded and the care and support provided took these into account. One person said "very happy to be here" and another said, "I am very content here". The service was caring because staff worked sensitively with people and with those who were less able to verbally communicate.

Is the service responsive?
The service was responsive because it worked with other services and professionals to ensure people's needs were met. People had access to appropriate services and professionals when needed. The service was responsive because staff recognised people's altering needs and abilities and adjusted their support/care accordingly. Staff responded to needs that required additional support, for example, one to one care when someone's needs were particularly complex. The service had not been responsive to the altering moving and handling needs of two people and this was rectified during the inspection.

Is the service well-led?
The service was well led because arrangements were in place for staff to meet and discuss issues with the management. Meetings were used by managers to communicate to staff specific guidance or to discuss areas they wanted addressed. Staff had opportunities to raise concerns or make suggestions. There was evidence of a good working relationship between the representative of the provider and the registered manager of the service. The service was well led because there were arrangements in place to follow up action plans and longer-term improvement plans. The service was well led because audits/checks were carried out to ensure care was provided correctly and to a

good standard.

The service was not well led in respect of the management of on-going maintenance issues which were having an impact on people's safety and other arrangements such as infection control. We issued a compliance action in relation to the poor maintenance we observed and the provider must tell us how they plan to address this. During the inspection the Health and Safety Executive took regulatory action to protect people.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 15 September 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Environmental Health and Health and Safety Executive. We will check to make sure that action is taken to meet the essential standards.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were also taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We gathered evidence about this by talking with people who use the service and their visitors. We inspected people's care records and we observed interactions between staff and the people who use the service.

We found people who were able to verbalise their preferences and choices were able to do this. We observed people using the environment in different ways. For example, some people preferred to remain in their bedroom, others were seen using the conservatory, the garden and the lounges. Some people chose to join in activities and others chose not to. In both the main part of the home and the dementia care unit, if people wished to smoke, they could do so outside and with support if needed. People who required support to make choices were provided with this. We observed staff asking people where they wanted to sit and what they wanted to do. Those that could not independently join in activities were asked if they wished to join in or not. When talking with people about the activities in the home one person said, "I do all sorts of things I have never done before. I like doing painting and have some up on the wall". Another person said, "I please myself here, I keep to myself, I have three meals a day, I have my own room and television".

At lunch time we observed people being provided with a choice of two main courses. If they did not like either of these they had a choice of alternatives. This meant people were treated as individuals and they were supported to express their preferences and choices.

People were supported in promoting their independence and community involvement. One person told us they had enjoyed a trip out in the mini bus and they hoped to go again soon. Another person told us there had been a lack of outings when the old mini-bus had broken down, but another mini bus had been purchased and people were going back out. We observed people being helped to maintain their independence particularly at meal-times. Where help was required this was provided in a dignified and respectful manner. An action plan showed that consideration had been given to producing pictures of food to help

people living with dementia make meal choices.

People's diversity, values and human rights were respected. People's diverse needs were recognised and supported by the staff. People using the home had many different needs and abilities which were managed by the staff. Some people were verbally challenging and we observed staff responding calmly and respectfully to this. This meant staff responded to people's diverse needs without prejudice or judgement. The provider may find it useful to note that the garden was not ideally designed to meet the needs of those with dementia. One example was a path which led down to a fence which cut across the path. The service's larger garden and its path had been separated so as to provide a safe and enclosed garden for people who used the dementia care unit. As the path did not lead to anything such as a seat or a return path and the fence had not disguised by planting, this could present to some as a dead-end. This potentially could cause confusion and distress to people with dementia who may need direction to return to their starting point. The communal room in the dementia unit was suited to people with dementia. It was a large, open plan, space large enough for the number of people who used it to move around it freely. Different areas were clearly defined for example a kitchen area, lounge area and dining area. There was a separate conservatory which provided an area away from the main living space, noises, and other people if preferred. There were word and picture signs in place, for example indicating where the toilet was.

We found people's bedrooms were personalised, in that they had people's personal items in them. One room was particularly sparse but the person using the room told us they preferred their room uncluttered with personal effects.

Where people were unable to understand their care options there was evidence to show their representatives had been consulted. There was evidence to show, where people had refused care, this had been respected. Where this was the case, because people lacked the mental capacity to understand what care they required, records showed staff tried to provide this later when the person was more able to engage with them. We spoke with one person who had full capacity to make choices about their care. They told us when they were having a day when they felt unwell, and did not want to get up, the staff respected their wish. They explained that on days when they felt well enough to get up staff helped them to do so.

We observed people's privacy and dignity being respected. These were simple observations such as staff knocking on people's bedroom doors and waiting for a reply before entering. We observed staff speaking to people quietly about their care or daily choices. We observed staff covering people's legs with blankets or adjusting their clothing to maintain their dignity. The provider may find it useful to note that, on one occasion, we observed a member of staff entered the bedroom of a person we were talking with. They proceeded to carry out the task they had come to do without asking the person or us if this was a convenient time.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We gathered evidence about this by talking with the registered manager and talking with members of staff. We also spoke with people who use the service and their visitors. Where people were not able to verbally express their views, because they were living with dementia, we observed how staff interacted with them and cared for them. We inspected relevant care records.

One person said "very happy to be here" and another said, "I am very content here, you know what to expect when you come to a place like this and I have no complaints at all. I get everything I want, I have a shower every week and you get to choose if you want a woman or a man to see to you". One visitor said, "It is lovely when I visit, my relative has had a shower and is wearing clean clothes. I did have to push them (staff) to sort out a physical problem, one of the family spoke to the doctor and it is now being seen to". Another visitor said "I have no worries about my relative's care". This person told us staff kept them informed about what was happening with their relative. We spoke with one person who told us the care and attention they were receiving was much better than the last place they were in.

We observed staff interactions and how they cared for people. These observations showed that some staff were more skilled at communicating with people than others, but that all interactions were kind and helpful. Some people exhibited behaviour that could be perceived as challenging and the staff that intervened in these situations did so with patience and skill. One member of staff was observed to be caring for one person in a particularly effective way. This person had very complex needs and required constant supervision and guidance. We observed this being provided without causing the person further distress or irritation. One visitor said, "This place is as good as I have seen. They deal extremely well with the person I am visiting".

We inspected the care records of eight people, four of these people were living with dementia. Seven of the records had been regularly reviewed and updated, either on a monthly basis or as the person's needs had altered. One person's had not been and we made the registered manager aware of this during the inspection. They told us they would make sure these were updated. Care records were personalised which meant they

recorded people's specific likes, dislikes, behaviours and care guidance was specific to the individual needs. This gave staff very specific information about the individual and meant care could be tailored to their specific needs and abilities. For example, one member of staff had observed, that when one person took their socks off in the evening, this seemed a better time to approach them and help them to bed. Changing abilities were also recorded. For example, one person's records showed, at times, they could shave themselves independently and at other times they could not. The recorded care demonstrated that the level of support had adjusted according to the person's ability. This meant staff understood people's needs and responded to their changing needs and abilities. The care records showed people had access to health care professionals when needed, which included their GP, mental health specialists and the speech and language team. A chiropodist and ophthalmic and dental services were also available.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw risk assessments in place which gave staff guidance on how to meet various risks such as those associated with falls, developing pressure ulcers and poor nutrition. The cook told us how people who required additional calories were provided with fortified foods, for example cream added to mashed potato or soup. Some people had been provided with foods they could eat whilst walking. Snack foods were observed in the dementia care unit as being accessible to the people who used this unit. Equipment had been put in place where people were at risk of developing pressure ulcers and, at the time of the inspection, no-one had a pressure ulcer.

One member of staff was aware that the moving and handling needs of two people had altered but guidance for staff on how to manage these had not. We were told that, because of this, staff were not using moving and handling equipment where it was needed. Arrangements were made during the inspection to review and update these assessments. Following a review the assessments gave staff the option to use equipment (hoists) when needed. We observed four situations where inappropriate and/or out dated moving and handling practice was used. This involved people being manoeuvred by two staff, holding the person under their armpits, and pulling one person up from a chair by their hands/forearms. The provider may find it useful to note that these observations and a delay in updating people's relevant assessments meant some people were not always being moved appropriately or safely. We did also observe appropriate and safe manoeuvres.

Concerns had been raised with us regarding a lack of moving and handling equipment. We established during the inspection that there were seven working hoists. The registered manager told us this was sufficient for people's assessed needs. We found all hoists had been checked/serviced by an appropriate company in April 2014.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. We found applications had been submitted to the local supervisory body in respect of one person. These were awaiting assessment although there had already been discussion about these with the registered manager. Proper policies and procedures were in place. Deprivation of liberty principles were reflected in people's care plans. Relevant staff had been trained to understand when an application should be made and how to submit one.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance could not be/had not been followed. People were not cared for in a clean, hygienic environment.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not effective systems in place to keep the environment clean and reduce the risk and spread of infection. Although the service had relevant policies and procedures in place, these had not been successfully implemented. Cleaning schedules were in place and an infection control audit had been completed in May 2014 but these arrangements had not resulted in a clean environment at the time of the inspection.

We gathered evidence about the level of cleanliness and infection control practices by talking with the registered manager, members of staff and a representative of the provider. We also spoke with people who used the service and their visitors. We inspected relevant documents and records and made observations as we inspected the environment. One person said, "It is probably the filthiest place I have been in". Another person, whilst telling us they were happy with the care, said "other family members complain about the unpleasant odour". Two people who used the service told us their bedrooms were cleaned regularly.

The registered manager told us they monitored the cleanliness of the home. They showed us an infection control audit which had been completed in May 2014. They told us this had led onto a recent update of relevant policies. The policy updating had taken into account Department of Health (DoH) guidance for infection control in care homes published in February 2013. The audit had also highlighted the need for cleaning schedules and these had been devised. When completed it had recorded no offensive odours.

The registered manager explained that some staff had altered their roles recently from cleaning to care. This had required new cleaning staff to be recruited. By the time of the inspection new cleaning staff had been recruited but evidence showed that they had not been able to keep the environment suitably clean. We observed several stained carpets and areas of the home had offensive odours. Where we observed stains on furniture or carpets we took the registered manager to see these. We asked staff how they cleaned spillages of body fluid, such as urine, off the carpets. Staff had various ways of doing this, some using dry and wet wipes. Staff explained that when the carpet cleaner was working,

the cleaning staff used this to clean the carpet more thoroughly. Protective gloves were available for staff to wear when carrying out this task. Staff however told us the carpet cleaner had been out of order. One staff member said "it's been an on-going problem, sometimes working and sometimes not". There was no record of daily, weekly or monthly general on-going carpet cleaning. The result had been that several carpets looked stained and several areas had offensive odours. Following our visit to the service the provider's representative informed us that a new carpet cleaner had been on order at the time of the inspection and confirmed this had since arrived.

The specific products described in the DoH 2013 guidance for the management of body fluid spillages, and decontamination of equipment used to collect body fluids, were not available in the service at the time of the inspection. Heavily stained and unclean urinal bottles were seen in use, which showed that the arrangements in place were not adequate enough to provide people with clean urinals. We asked several members of staff how they cleaned urinals and commode pans. Staff were adopting different, unhygienic ways of rinsing these out. Toilet brushes and water was used by most. Some staff told us detergent was not available and the sluices often did not work. One member of staff explained that cleaning products were locked in the domestics' cupboard but were not available where they cleaned the above items. A member of staff admitted to swilling out a commode pan with water, down a sink. This meant good infection control practices could not be followed.

Some equipment in use was unable to be properly cleaned because of its condition, such as a rusted shower chair. There was evidence to show that it was not possible to keep several people's personal bathrooms/toilets adequately clean. The poor condition of some floor coverings as well as lifted or perished seals at the base of several toilets contributed to this. Cracked tiles and perished wall plaster behind toilets also added to the inability to keep these areas suitably clean.

We found some good practice in place. This included segregation of soiled laundry and the use of plastic gloves and aprons when providing personal care or serving food to avoid cross contamination. We also observed staff washing their hands. There was a contract in place for the disposal of clinical waste.

The arrangements in place for reducing the risk of Legionella in the hot water and cold water had not been adequate enough. Samples of water taken in March 2014 showed the water was contaminated and the system needed cleaning. At the time of the inspection we were told what action had been taken following the positive result. This information was shared with the Environmental Health Agency. Reassurances were given to us by Public Health England that the Legionella isolated was not the type that caused fatalities. The Health and Safety Executive subsequently took regulatory action and also gave the provider further advice on how to manage these risks in their system. This meant action was being taken to protect people from further risk.

There was no evidence to show that people had suffered more infections than would normally be expected from the above shortfalls. However people who used the service were older and, therefore, potentially more susceptible to the risks of infection.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors had not always been protected against the risks of unsafe or unsuitable premises.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We had received information of concern about a lack of maintenance arrangements. We gathered evidence about this by talking with the registered manager and a representative of the provider. We also spoke with the staff. We inspected relevant documents and records and made observations as we inspected the environment. We requested additional information from the provider following our inspection.

There were maintenance arrangements in place but these were not meeting the needs of the service. The service employed one full-time maintenance person. The maintenance book showed that this member of staff had many on-going, day to day, maintenance issues to manage. Longer-term action plans showed there were plans to address issues relating to the heating system in September 2014. The inspectors found the first floor in the main building to be very warm and staff confirmed that there were problems in regulating the heating in this area of the home.

We had received information of concern that the lift had broken down on 20 April 2014 resulting in people who used the service having to sleep in armchairs in the lounge. Another person had contacted us to confirm the lift had broken down on another occasion in 2013. We spoke with the provider about this and they confirmed the lift had been breaking down. They also confirmed that a servicing contract had always been in place. After the breakdown in December 2013, which the provider explained happened five days after the lift had been serviced, they had decided to get a second opinion on the lift's condition. An examination against the Lifting Operations and Lifting Equipment Regulations 1998, was carried out on the lift on 24 April 2014. This recorded the lift as safe to use but requiring work, which had to be carried out within a stated period of time. The provider confirmed that the lift company were ordering the parts required and the work would be carried out before September 2014. This showed the provider had an appropriate servicing contract in place. It also showed that, when problems with the lift continued, the provider took action to address these. It was not therefore possible during this inspection to evidence that the work required on the lift had been fully completed.

We found examples of inadequate maintenance which included cracked and loose tiles in shower and toilet areas. The floor covering in a wet room was lifting and split, exposing the floor underneath to water. The shower had a continuous leak of water. One person's personal toilet area, attached to their bedroom, had a constant flow of water. The person in this room was unable to express a view on the noise this made. Bubbled wall plaster was seen in another person's personal bathroom, behind the toilet. Flaking plaster was seen in another person's toilet area. A radiator cover in one bathroom was broken.

We had received information of concern about the poor maintenance of the dementia care unit's garden. Risks relating to trips and falls were observed. Examples seen and which were not cordoned off were raised paving slabs, and a tree stump. A patch of ground was covered in weeds and brambles and lengths of roofing felt were on the path. An entry in the maintenance book recorded "patio slabs were being pushed up by tree". The record recorded remedial action which was the cutting down of the tree. When we spoke with the registered manager about these risks they told us people did not use the garden unsupervised so the risk of trips and falls was reduced. We were informed that action had been planned to address the risks in this garden once the warmer weather arrived. We saw several recent entries in people's care records recording the fact they had used this garden. Not all records made reference to people being supervised. This evidence showed that the maintenance of the dementia care unit had not been adequate enough and that parts of it had always been unsuitable for use by people with dementia.

Paths in the main garden contained stones and debris from the borders that were being worked on, making them potentially unsafe for people to walk on.

Whilst walking around the building at 5.30am we were able to enter the building from the outside. Staff explained they had not been able to secure the building for some "considerable time now". Minutes of a staff meeting in May 2014 showed that staff raised concern about the security of the home. On the second day of this inspection (26 June 2014) we were shown a confirmation of order, dated 25 June 2014, for the fitting of various windows, doors and locks. The security of the building, at the time of the inspection, and for an undefined period of time before this, had been compromised. It was not possible during this inspection to evidence that the work required had been fully completed.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We received information of concern that people on the dementia care unit were not adequately supervised at night. We had also been told that, at times during the day time, the unit had no staff present when staff went for their break.

We gathered evidence about how people were supervised at night by one Inspector remaining on the unit between 11.45pm and 5.30am on our first visit. On our second visit one Inspector and an expert by experience visited the unit during the day to see what staff were present. We spoke to day staff and the home's night staff. We spoke to the registered manager and inspected relevant records including people's records.

There were enough qualified, skilled and experienced staff to meet people's needs. During the night visit we did not encounter any people who lived on the unit walk into the main communal area where we were situated. People's records showed that, on many occasions, people were helped to bed and slept without disturbing. Where this had not been the case the records showed that people had been attended to and helped to re-settle. Staff were not located in the unit at night but carried out monitoring checks and responded to pagers which were linked to door alarms in the unit.

The pagers were carried by staff and activated by bedroom doors opening in the unit. We observed staff responding to their pagers during the inspection, although the staff confirmed that the night was relatively quiet. Staff also carried out scheduled checks which we were told by the registered manager were hourly. Records of the times of these checks showed they were not always hourly. Staff told us whilst they aimed to check on an hourly basis, if they were attending to people elsewhere in the building they had to finish what they were doing before they could carry out a check. They explained if their pager activated their aim was to get one member of staff to the unit as soon as possible. The records showed that the scheduled checks had sometimes been 15, 20 or 30 minutes late. A few larger recorded gaps in checks times were seen. When recorded these were between 1am and 3am. We spoke with the registered manager about this and they told us they had also identified this when checking records on random and unannounced night visits. The registered manager told us this was typically when the night staff started to take their breaks.

One Inspector remained in the main building of the home during the first visit and witnessed the night routine. There were four night staff on duty which staff told us was usual and which the staff rosters confirmed. There was one additional member of staff specifically present to provide one to one care to a person with complex needs. This member of staff did not participate in the night routine. We observed staff responding to people's needs and call bells and pagers being answered. Staff also checked the dementia care unit. Staff organised their breaks from 1am onwards and we saw the above routine continued. The registered manager told us they would expect staff to continue attending to people's needs whilst colleagues took their breaks. Staff showed us a list of some non-care tasks that were expected of them but they told us that people's care came first. The registered manager considered there to be enough staff on duty at night and that people on the dementia care unit were not assessed as having "high level needs".

One incident had been at night on the dementia care unit and had resulted in staff needing to attend. We could not evidence that this incident took place because of a lack of staff numbers or staff not responding to their pagers. The door alarm arrangement, in this case, would not have alerted staff to the problem as the person had not left their bedroom. Some action had been taken to avoid a reoccurrence.

Other information of concern told us the dementia care unit was left unsupervised during the day hours when staff took a break. Staff rosters for the day time hours on the unit, over an eight week period, recorded more shifts than not, with two staff on duty during the day hours. The registered manager told us it was their aim to have two staff on duty in the unit at all times but this was not always possible. They explained that, if staff in the main building required help and there were two staff on duty in the dementia care unit, one member of staff had to go and help. From the staff rosters we were given it was not possible to tell which days a member of staff had left the unit to help in the main building. We were also told that if the dementia care unit required helps staff from the main building attended. Staff we spoke with told us this was a "fairly frequent occurrence". Staff and managers told us there were arrangements in place to relieve a member of staff for breaks if they were on their own in the unit. During the inspection we were not aware of the unit being unattended.

At the time of the inspection we observed people's needs being met and staff responding to call bells. The registered manager considered there to be enough staff on duty to meet people's needs, as did one other senior member of staff when asked. We asked people who use the service if staff were available for them when they needed help and most told us they were. One person said "the activities co-ordinator does a fantastic job during the week" but went on to explain they felt there was a lack of activities at the weekend. Another person told us they got "very bored" at weekends for the same reason. One other person said, "it can be up to 10-15 minutes after ringing the bell that they arrive. Another person said "it does get you down if you ask for something and they (staff) go out of the door and forget, it's because they are so busy". Another person told us they tended to take their relative to the toilet because staff were so busy.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

We gathered evidence about how the registered manager and provider monitored the quality of the service provided and how refurbishment and improvement was planned. We did this by talking with the registered manager and the representative of the provider. We requested various action plans and other relevant evidence in relation to this.

The registered manager provided us with a copy of the plans of refurbishment and estimates of costs for works spanning between 2012 and 2015. The document however did not provide enough detail about what had been completed so we requested further information from the provider's representative. A list forwarded to us made it clear what refurbishment had taken place in 2013. This had included new fencing in the garden, purchase of 25 new lounge chairs, a new activities room with equipment, decoration and full refurbishment of the main lounge area, small lounge and conservatory. Some bedrooms had been fitted with new carpets and vanity units. The plans showed that part of the water and heating system was due to be upgraded September 2014. This meant there were refurbishment and improvement plans in place and that some work had already been completed.

The registered manager told us they met regularly with the provider's representative. We saw minutes of meetings that showed progress against longer-term improvements and the findings of various audits/checks were discussed. The registered manager explained that she was able to make requests for equipment and this was purchased. For example several electric profiling beds had been purchased with others planned.

We saw examples of monthly audits which included audits of care plans, the medicine records, and system and wound care. Additional audits, completed by the registered manager, included health and safety audits, checks on bedroom safety and infection control. Where audits had been delegated to other staff to complete the contents were checked and then signed off by the registered manager. Where needed action plans were devised following the audits and we saw examples of these; some completed and others were work in progress. Accidents and incidents were recorded and monitored by the

registered manager who looked for patterns and trends so that actions could be put in place to avoid reoccurrences. This meant there were arrangements in place to monitor care practices as well as other systems that helped to keep people safe.

We saw a copy of the monitoring visit completed in May 2014 carried out on behalf of the provider. We also saw a copy of the registered manager's quality audit/check carried out in May 2014. Neither made comment of some of the maintenance issues we observed during this inspection. The poor maintenance we observed, such as the cracked tiles and bubbled plaster behind toilets and the poor condition of some floor seals around toilets, had a direct impact on whether these areas could be kept suitably clean. The provider may find it useful to note that the arrangements used for monitoring these particular areas are not effective.

Staff meetings took place on a regular basis and the minutes of these meetings showed that staff, at all levels, were able to raise issues and/or discuss things that were relevant to them. They showed that actions were taken by the provider in response but that some had been delayed. For example, the replacement of various doors and locks in order to keep the building secure.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. During the provider's monitoring visit in May 2014 people who used the service were not asked for their views on the services provided, but staff were. A copy of the registered manager's monthly quality audit for May 2014 showed that a few people who used the service were asked for their views. The registered manager told us she gained people's views of the service by operating an open door policy. She also explained that several relatives communicated with her by email. The registered manager explained that, if relatives wished to speak with her in more detail or she wished to speak with them, she would arrange a face to face meeting. More formal survey questionnaires were used to seek people's views. In March 2014 the registered manager asked for people's views on issues relating dignity. The results had been collated and were shown to us. Feedback from people who used the service following this was collated and people considered their quality of life at the service as being eight of ten.

People were able to raise concerns/complaints and these were acknowledged. Three had been recorded in 2014 but the provider may find it useful to note that there was no recorded evidence that one of these had been addressed. When asked if there had been any complaints the provider's representative said no. This contradicted information we had received. The registered manager explained that concerns were categorised as a complaint, if, the person stated they were making a "formal complaint". In this case their issues would be recorded in the complaint file. All other concerns were recorded in people's care files. Three sets of concerns had been recorded. One set was about an aspect of care. It had been recorded that staff were to be reminded to carry out a certain area of care. There were no records confirming staff had been reminded and the person's care plan had not had additional guidance added. The second concern had recorded that a statement had been taken and a certain person needed to be spoken to. This had been recorded in the person's care file and therefore it was not confidential as it was accessible to other staff. The third set of significant issues had been recorded. A meeting had been held between the registered manager and the person who had raised the concerns. We were told that the situation remained unresolved.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: The registered person had not taken reasonably practical steps to ensure people who use the service, people employed to work in the service and others were protected against the risk of exposure to a health acquired infection. There were not effective systems in place to maintain appropriate standards of cleanliness and hygiene in relation to the premises occupied and the equipment used. Regulation 12(1)(a)(b)(c) (2)(a)(c)(i)(ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person had not ensured that service users and others having access to the premises were protected against risks associated with unsafe or unsuitable premises by means of appropriate measures in relation to the security of the premises, in adequate maintenance of the proper operation of the premises and of the surrounding grounds. Regulation 15(1)(b)(c)(I)(ii)

This section is primarily information for the provider

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 by 15 September 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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