Inspection Report

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

Chaseley Bungalows

9 The Sidings, Eastbourne, BN22 8QX

Tel: 01323645795

Date of Inspections: 21 August 2014
13 August 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:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	The Chaseley Trust
Registered Manager	Mr Paul McKay
Overview of the service	Chaseley Bungalows provide long term and respite nursing care for up to 13 people with physical disability.
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 13 August 2014 and 21 August 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 staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services. We reviewed information sent to us by other authorities, talked with commissioners of services and talked with other authorities.

What people told us and what we found

We carried out this inspection to look at the care and treatment that people living at the home received.

This inspection was carried out by two inspectors.

The service currently has an embargo on admissions implemented by the local authority.

As part of our inspection we spoke with senior staff members. This included the newly appointed deputy manager. We also spoke with care and nursing staff, both permanent and agency staff members.

Not everyone living at the service was able to tell us about their experiences. Those who could told us that they liked living at the Bungalows. We were told, "I am very happy here. I love it here. It's just the situations that happen now and again that cause problems." And "The permanent staff are great just not enough of them, there are too many agency staff. There are no permanent staff any more they have all gone."

The inspectors considered the inspection findings to answer questions we always ask:
Is the service safe?
Is the service effective?
Is the service caring?
Is the service responsive?
Is the service well-led?

Is the service safe?
We saw that there were systems in place to report and respond to maintenance issues if they arose. The home had implemented some quality assurance systems to assess and monitor quality of the service provided. However these had not yet become fully

embedded into practice.

We saw that there were unsafe practices in relation to medication administration and errors and discrepancies within the medication records.

Is the service effective?
We spoke with people living at Chaseley Bungalows. We were told, "The senior nurses keep chopping and changing." And, "There have been staffing difficulties, as there is no stable team of staff, but staff are available when I need them and they are mostly good."

The service used a high number of agency staff. We saw that there was not an effective system in place to check agency nurses competencies before they worked at the home. The staff training matrix did not fully reflect the training staff had attended.

Is the service caring?
We saw staff speaking to people and providing care and support. We spoke with care and nursing staff. Permanent staff were able to tell us about people and their care needs. Agency care staff were not seen to access people's care plans at the beginning of a shift. We spoke with agency care staff, one told us, "The other care staff tell me what to do."

Is the service responsive?
We looked at accidents and incidents reporting within the service. We saw that incidents had not been reported by staff in accordance with the organisations policy and procedure. When people living at the Bungalows reported to staff that they were experiencing pain or discomfort there was no documented evidence to show that staff had responded to this appropriately or in a timely manner.

Is the service well-led?
The home had a registered manager, deputy manager and one further senior staff member who was responsible for the running of the Bungalows. The senior nurse had only been working at the bungalows for a couple of weeks. In this time a number of new systems had been implemented, however, these had not yet become fully embedded into practice. It was seen that the senior nurse was extremely busy throughout the day. The senior nurse was supported by the registered manager and deputy who divided their time at the Bungalows and a second location which also belonged to the provider.

We were shown that the service asked people who used the service for their feedback, and the results of these surveys, were used to improve the service.

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 27 September 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements.

We have judged that this has a minor 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 looked at care plans and other related documentation. We saw that people had been asked to sign consent forms to show that they agreed to specific aspects of care.

We looked at a communication book which staff used to share information. We saw that for one person a member of care staff had made a decision which related to restricting this persons access to a certain beverage. It was unclear how this decision had been made. We looked at this persons care file. No information had been documented in relation to this decision and a best interest meeting had not taken place. This persons care plan did not include updated information in relation to the decision to restrict this access, or provide staff with information about when this decision needed to be reviewed.

We discussed this with the deputy manager and they told us this would be reviewed and appropriate meetings would take place to ensure that this decision had been made appropriately.

The deputy manager told us that they had attended Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. This was to be cascaded out to other senior and care staff. However, at the time of the inspection this had not taken place.

We observed a staff conversation in relation to the administration of covert medication. Agency care staff told us that they had been told how to do this by other care staff. We looked at this persons care file and saw that the decision to administer medication covertly had been made by the persons GP and next of kin. However this information was not detailed enough to inform staff how to do this safely and effectively and did not include changes to the medication being administered. This meant that clear procedures had not been followed in practice. Decisions made in relation to people's care had not been made

after appropriate best interest meetings, and decisions had not been reviewed and updated when changes to peoples care and treatment had taken place.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a minor 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

Accommodation was provided for people in individual bungalows with a call bell/bleep system to allow people to call for the assistance of staff when required. This ensured that people's independence was maintained as much as possible.

People we spoke with told us, "I much prefer it here its much less restrictive, I like to spend time on my own. I do not like people around me all the time. Staff are always available if you need them." And, "I have control over my care I say what I want and when I want it. No one tells me what to do. I have control over my life here in the bungalows."

At the time of the inspection there were nine people living at the Bungalows. We looked at two care files in full and a further one to look at specific areas of care documentation.

The deputy manager told us that they were in the process of implementing a new style of care documentation. We saw that the service had started to review and rewrite one person's care file. However, this had not been fully completed at the time of the inspection. Other care plans and documentation had not yet been updated.

Pen pictures were included in people's files. These were a precis of people's care and treatment needs. We saw that these were in the process of being reviewed. This was being done by the senior nurse and people's keyworkers. Old style pen pictures were not seen to be up to date or person centred. We looked at the new pen picture in the file which was being reviewed and saw that the new format included person centred information and had been written with the involvement of the individual, including quotes and information provided by them about their lives, finances, preferences and care needs.

We looked at care plans. We saw that people who had indwelling catheters did not have clear documentation in place. We saw that catheter changes had been documented in different areas of the care plan. One person's catheter change date had been missed. We saw in their daily records that their catheter had been changed on the 1 August 2014. However documentation stated this should have been changed on the 5 July 2014, but

was still in place until 1 August 2014. This person was now on an anti-biotic for a urinary tract infection. We saw that when this catheter change had been completed by an agency nurse they had documented in the persons daily records that they had been unable to use the appropriate sized catheter as the correct stock had not been available. However, staff told us that this had not been the case, and the issue was that the agency nurse had not known how to use the type of catheter the individual had been prescribed. We saw from documentation that this individual had needed to have the procedure repeated a second time on the same day when staff found the correct equipment. This meant that the provider had not ensured that care and treatment had been delivered to meet people's individual needs and ensure their welfare and safety was maintained. We discussed this with the deputy manager during the inspection. We were told that the newly appointed senior nurse had implemented a new logging system in the diary to ensure that future catheter changing dates are not missed.

We looked at people's daily records. Staff had documented in one person's daily records that this individual had been in pain throughout the day. However, no documentation was seen to evidence that this had been reported to nursing staff, or that actions had been taken appropriately to address this. This meant that people had not received effective care and support to ensure that their needs were met.

People were able to spend their time how they wished. We saw that one person went shopping assisted by a member of staff. Other people told us they chose how to spend their day.

We saw that people had personal emergency evacuation plans in their care files. And the service had systems in place to respond and evacuate in the event of an emergency situation occurring.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

An agency registered nurse who told us that they had worked in the home 4-5 times was in charge of the medicines on the day of this inspection visit. We asked to see how the home had assessed their competencies and understanding of this role in the home. We were shown a checklist that had been completed in conjunction with a care worker in the home. This recorded that they were aware of the home's medication policies and procedures. However there was no evidence that their competency or understanding had been checked in any way. The provider had not made arrangements to ensure that staff handling medicines had the competency and skills needed.

We spoke with four people regarding medication and three people were able to tell us about their medicines. Two people told us that they received their prescribed medicine when they needed them and as prescribed. They said, "Yes I get my medicines as I should, sometimes they are a little late but mostly on time," and "I know what I should be getting and when and If get them correctly." One person told us that there had been supply issues in the past which meant they did not always get their prescribed medicines. They went on to tell us that pain killers had been dispensed to them that morning at the wrong time. They were able to decline the medicine which was later administered at the correct time.

We looked at the corresponding records and found that this mishandling of medicines had occurred and related to a controlled drug. This showed us that prescribed medicines were not always available and medicines were not always handled safely.

We saw that suitable storage facilities for controlled drugs were provided. We checked the controlled drugs cupboards against the corresponding register and found that the record was accurate. There was a system in place to check the register on a regular basis to ensure it was accurate. We found that one entry in the controlled drug register for the morning of the 13 August 2014 recorded that a drug was administered at 06.00. The medicine administration record (MAR) chart recorded that it was administered at 08.00. The person receiving the drug confirmed that it was actually administered at 08.00,

although it had been presented to them at 05.00 in the morning. The registered nurse in charge of medicines confirmed that she and the registered nurse who had worked the night shift had administered the drug at 08.00. The controlled drug register had not been signed by the registered nurse working the day. This meant that legal register had not been completed accurately and the home's procedures on administering controlled drugs had not been followed.

The fridge used for storing any medicines requiring refrigeration was checked. We found that the temperature was being monitored on a daily basis and was being recorded. This record identified that from the beginning of June 2014 the fridge temperature exceeded six degrees centigrade. It should not exceed five degrees centigrade to ensure a safe temperature. The registered nurse in charge of the home told us that a new fridge had been ordered. This meant that any medicines that required refrigeration could not be stored safely in the home.

Each person had an individual cabinet in their accommodation to store their medicines, apart from two people who had some of their medicines stored centrally in cabinets in the office. All cabinets were locked and only accessed by a registered nurse. We found one cabinet had a broken lock and although this had been reported three days previously it had not been replaced or repaired. This meant that medicines were not being stored safely. This was identified to the deputy manager who arranged for another cabinet to be provided on the morning of the inspection visit.

We noted that the central office area where the controlled drugs were stored was having its temperature monitored. We were advised that this system was being rolled out to all areas to ensure medicines were stored at the correct temperature.

All but one person living at the home had their medicines administered by the registered nurses who worked in the home. We saw that the person who administered most of their own medicines had an individual risk assessment completed. However, it was noted this had not been updated following a decision that staff administer their injections and anti-biotic. These decisions were reflected within the daily records and the corresponding MAR chart.

We heard staff talking about one person's medicines and how these were given covertly. We saw that there was a procedure for administering medicines covertly and the practice in this case had been agreed by all relevant people including the GP and the persons appointed representative. However, there was no written guidance for staff to follow to ensure this was done in an appropriate manner to ensure this person received their prescribed medication safely.

We observed the agency registered nurse administer medicines to four people. Three within their own accommodation and one within the office area. They administered medication on an individual basis and signed the MAR chart once the administration had been completed. They checked each medicine with an accompanying care staff member who also signed a record to confirm that they had verified the medicines administered.

The registered nurse told us that they felt competent to administer the medicines and liked the double checking system with the care staff that was in place at the home. They asked people if they needed any pain killers and discussed any 'as required' medicines at the time of administration. Practice observed during the medicine administrations seen was safe.

Systems were in place to record when medicines were administered to people. We looked at the records for four people. The MAR charts we examined were started on 11 August 2014.
Each MAR chart had a picture of the person prescribed the medication. This meant that staff could identify the individual before administering medicines. The records were clear in that they were easy to follow; they had names and allergies clearly recorded.

The MAR charts provided an account of the medicines used and demonstrated that most medicines were administered as prescribed. However, we found that there were some medication administration errors and discrepancies within the records. For example, we found at 14:.30 that one person had not received their 12.00 anti-biotic. When this was raised with the agency registered nurse they told us that they thought the other registered nurse had administered this medicine. It was also noted that an anti-biotic dose had been omitted as the registered nurse on duty was unable to find the appropriate medicine. We found that one person had been without one of their prescribed medicine for three days. Although this had been noted and the registered nurse told us that they had been chasing a prescription this was evident within the records. This meant that people were not receiving their medicines in accordance with GP instructions.

We also found that one MAR chart had been amended without any rationale being recorded, a date of change or a signature indicating who had made the change. We could see that this medicine was under review with appropriate health care professionals from the daily records and discussion with the registered nurse however, the records were not clear. The lack of clear records could lead to people getting the wrong amount of medicines.

There were systems in place to order and record the medicines supplied to the home. We saw there was a record of medicines ordered and a check on the medicines received into the home.

We were told that all unwanted controlled drugs were disposed of by using a disposal kit supplied by the pharmacy. This was then recorded within the controlled drug register. When we asked what the system was to dispose of unwanted or unused medicines we were told there was no formalised system in place. This meant that the provider was not assured that all medicines were accounted for and disposed of appropriately.

For those people prescribed medicines on a 'when required' basis, we found that there was some individual guidance for staff to follow in the file along with the MAR charts. This helped the registered nurses to give medicines in a consistent manner to manage people's health needs.

We saw that appropriate information on medicines was available in the home for reference purposes. This included a British National Formulary dated September 2014. There was a list of the registered nurses who had administered medicines in the front of the MAR chart folder along with their signature. This was to clarify records for audit purposes.

We were shown the homes medication policies and procedures. These were generic and did not give staff guidance to follow at a local level. For example, the verification system used in the home was not reflected in the procedures. We were told that new procedures and protocols had been written and were being rolled out to the permanent staff working in the home. The registered nurse on duty at the time of this inspection was unable to locate these.

We saw that a full medicine audit had been completed by the clinical risk specialist for the organisation at the end of July 2014. An action plan had been developed from this which was being progressed. We also saw that procedures, audits and protocols were being developed and implemented to promote the safe handling of all medicines. These took account of an individual approach that promoted rights in relation to their medicines. This meant that the provider was working on improving the practice in the home to ensure medicines were handled safely, securely and appropriately.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs

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 looked at the staff rota for the week of and the week prior to our inspection. The deputy manager told us that there was on going recruitment in progress. However, the home had struggled to find appropriate trained staff to fill vacant positions. We saw agency staff were being used by the home on a daily basis. This included nursing and care staff.

We spoke with people living at the Bungalows. Everyone told us they liked living there. However, inconsistent staffing meant that people did not have their care provided by staff who they knew. Due to care documentation not being up to date and the high use of agency staff this meant that people had to tell staff how to provide their care. One person told us, "Last night there was an agency nurse that had never been here before and the night before there was an agency nurse that had never been here before." We looked at documentation and saw evidence that this person had needed to tell staff how to provide their care.

Another person we spoke with told us that they felt that things had recently improved and they were happier now. People told us that the lack of permanent staff was affecting the care they received as staff did not know them or their needs.

Overall people we spoke with were happy living at the Bungalows and appreciated that the management had been making changes to improve things. The provider had commenced a rotation of staff from their other registered location. People felt that this was a positive improvement and told us, "They seem to be getting there. Things are looking up and X seems to have their finger on the button they are better than some of the others." We were told by people using the service that, "There are staffing difficulties. There is no stable team of staff." And, "There are no permanent staff any more they have all gone."

The deputy manager confirmed that there had been recent staffing changes. Due to this turnover of nursing staff the service had needed to use a number of agency staff.

We saw a new staff/agency induction log used by the service when an agency worker came to work their first shift. This form was to be completed by a Chaseley staff member

and used as a checklist whilst inducting the new worker to the service. We saw that these were two pages long and included reading care documentation, fire evacuation information, an effective handover, location of policies, first aid, on call numbers, procedure for administration of controlled drugs, introduced to one resident and had their equipment explained to them, able to carry out catheter procedures, how to use handover sheet allocation of staff and how to deal with messages.

We saw that the two nights prior to our inspection a new agency nurse had worked each night shift. We asked to see the induction logs. Both had been completed by a member of care staff. We spoke with one who told us they spent as long as they were able to go through the details on the form and showing the nurse around the site. This was normally about 15 minutes. For the medical questions if the agency nurse said they did not know how to do something they would tell the nurse in charge. It was unclear how this assessed an agency nurses competencies, or ensured that they would be able to provide care and treatment safely and effectively to people living in the Bungalows.

We looked at the training matrix. This identified when staff had attended training or training updates were scheduled. We saw that when people had not attended training no evidence was in place to show that this had been followed up. We also found that the dates staff confirmed they had attended mandatory training had not been updated on the matrix. Therefore the training matrix did not give a clear accurate picture. It was therefore unclear how the provider had ensured that staff were suitably skilled and had received appropriate training to carry out their role within the service.

Discrepancies found during the inspection questioned some agency workers competencies, and did not demonstrate that the service had appropriate numbers of suitably trained staff. For example, we identified issues in relation to catheter care, controlled drugs administration and storage and poor documentation. Information had not been passed on or acted on appropriately; this meant people were at risk of receiving unsafe or inappropriate care.

We found that incidents had not been correctly reported or documented. Communication had not been appropriate between permanent and agency staff. This had led to information not being passed on correctly. Medication and care issues not being acted on in a timely manner and peoples care documentation amended and reviewed appropriately to include any changes.

During the inspection we saw that the senior nurse was looking after people, accompanying staff to assist with people or administering medicine. This meant that they were unable to observe staff when they arrived to start their shift. We saw agency workers arrive for the beginning of their shift. One agency worker was 30 minutes into their shift before they commenced work. Agency care staff did not ask us who we were and discussed confidential information in front of us in the reception/office bungalow.

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 a system in place to assess and monitor the quality of service that people receive.

Reasons for our judgement

We looked at the systems in place to assess and monitor the quality of the service provided.

There had been a number of staff changes at the bungalows. This had meant that auditing, staff meetings and care reviews had not taken place regularly.

We saw that since the new senior staff member and deputy manager had commenced working at the Bungalows new systems had been devised. However, the provider may find it useful to note that although some improvements had been made, auditing systems implemented needed time to become fully embedded. We found that there were areas that still required improvement to ensure that the monitoring of the service was robust.

Staff meetings had taken place; these included a new schedule of meetings and further ad hoc meetings used to inform staff of changes or for training. For example training in relation to appropriate documentation.

We saw that questionnaires had been sent to people living at the Bungalows. We saw that these had been done in May 2014. Further questionnaires had recently been sent out to people, and the manager was awaiting the return of these. A full report and action plan would then be devised and actions taken. We saw that these included the option of requesting a one to one meeting with management if the person wished to discuss any issues in confidence.

We saw that a medication audit had been completed. A number of other systems of auditing were in place, these included health and safety, a summary of incidents and a daily checklist. The daily checklist was completed by the trained nurse each day to ensure that people had received appropriate care, documentation had been completed and appointments attended if appropriate.

We looked at accidents and incident reports. We saw that these had not always been completed when incidents had taken place. We found that information had been

documented in statements or in people's daily care records. The provider may find it useful to note that this meant that the summary of incidents completed had not been accurate, as not all incidents had been correctly documented.

The maintenance employee was on holiday at the time of the inspection so we were unable to access some of the documentation in relation to maintenance checks and servicing. However, we saw that equipment had up to date stickers with dates in place to show that regular checks had taken place. This included portable appliance testing which had taken place throughout the home. Staff spoken with told us that they reported any maintenance issues in the maintenance book and on the computer. Most issues were rectified immediately as the maintenance employee was 'on site' most days. For more serious issues we saw that the service had contact numbers for outside agencies to respond to issues if they arose.

We spoke with the deputy manager who told us that audits had not taken place to monitor infection control. However, care staff had recently taken on 'link' roles. This included infection control and a number of other areas within the service. This had recently commenced so we were unable to see any evidence of how this would look in practice.

People we spoke with told us they were aware of how to make a complaint. At the time of the inspection there were no current complaints on going at the Bungalows.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not been maintained.

We have judged that this has a minor 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

People's personal records including care plans were not accurate. Care plans seen had been reviewed monthly. We saw that reviews had been recorded as 'no change'. However, this did not reflect changes to people's care and treatment. We saw that one person's covert medication care plan had not been updated to include changes. Another person's care plan did not include any care plan or risk assessment in relation to alcohol, although instructions in relation to this were seen in the staff communication book. This meant that care records did not contain up to date relevant information to inform staff how to provide care safely and appropriately.

People with specific medical needs did not have up to date information in the care records. For example, catheter care and catheter changes had not been documented in a consistent manner. Although information was seen in people's files this had not been consistently updated and care documented appropriately.

We found mistakes and poor documentation which identified staff had not followed policies and procedures. This included medication, reporting of accidents and incidents and documenting when people were in pain or unwell. This meant that people were not protected against the risks of unsafe or inappropriate care and treatment as accurate records had not been maintained.

We saw in care plans that new style 'pen pictures' were in the process of being implemented. However, these were not in place for all people living the bungalows. This meant that records were not up to date, and did not reflect people's current needs. This meant that the provider had not ensured that service users were protected against the risks of unsafe or inappropriate care, as there was a lack of proper information about people living in the service.

We looked at accident and incident forms. We saw that not all incidents had been recorded on incident forms in accordance with the organisations policy and procedure. We saw hand written notes which had been written by staff. However, it was unclear from

records seen what actions had been taken to address issues raised. This meant that there was no accurate and appropriate information in relation to the care and treatment people had received.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: (1) The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate,treatment in such a way as to—

This section is primarily information for the provider

	(i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user,
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The provider had not taken steps to ensure that service users were protected from the risks associated with the unsafe use and management of medicines.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**

This section is primarily information for the provider

care Diagnostic and screening procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** The registered person had failed to protect service users from the risks of unsafe or inappropriate care, because accurate and appropriate records were not maintained. Regulation 20(1)(a)

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 27 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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