Inspection Report

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

RNIB Wavertree House

Somerhill Road, Hove, BN3 1RN

Tel: 01273262200

Date of Inspections: 21 July 2014
18 July 2014

Date of Publication: August 2014

We inspected the following standards as part of a routine inspection. 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	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Royal National Institute of Blind People
Registered Manager	Miss Diane Trill
Overview of the service	RNIB Wavertree House provides residential and personal care for up to 36 older people. The home is specifically designed to cater for the needs of people with varying degrees of visual impairment. There are particular adjustments in place in the home to meet the needs of people with a visual impairment.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 18 July 2014 and 21 July 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 and talked with commissioners of services.

What people told us and what we found

Our inspection team was made up of one adult social care inspector. We answered our five questions: Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

We spoke with six people who used the service. We also spoke with the registered manager, deputy manager, three care workers, care supervisor, activities coordinator and laundry worker.

Below is a summary of what we found. The summary describes what people who used the service and the staff told us, what we observed and the records we looked at. If you want to see the evidence supporting our summary please read the full report.

Is it safe?
Systems were in place to make sure that all staff learnt from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations. Feedback was sought from people which helped the home develop and learn.

The service was clean and tidy. We found that shortfalls highlighted at the last inspection of the service had been addressed and people were safeguarded from the risk of cross infection.

People spoke positively about the cleanliness of the home. We saw that dedicated housekeepers were employed. The home had a quality assurance framework in place to monitor standards of cleanliness and infection control.

The premises were safe and well maintained. We saw that staff had regularly tested safety equipment such as fire alarms. Floors and carpets were in good condition, which minimised the risk of people tripping.

Call bells allowed for people to summon assistance. People we spoke with commented that their call bell were answered promptly by care workers.

Is it effective?
People had their care needs assessed and staff understood what people's care needs were.

Before someone moved into the home, a pre-admission assessment took place. This allowed for the home to meet with the person and ensure they can safely meet their care needs.

People received appropriate support from healthcare professionals when required. Examples seen, included referrals to other professionals such as GPs, speech and language therapists (SALT) and the district nurses.

Care plans were not always correct and fit for purpose. The home did not consistently review care plans on a monthly basis. This meant that information for not available to care workers to provide the care required. We have asked the service to take action.

Care plans did not always demonstrate that the person was involved in their care plan and agreed with the content. We have asked the service to take action.

Is it caring?
People we spoke with commented that they were treated and privacy and respect. One person told us, "They always knock before they come into my room."

Care workers we spoke with demonstrated a sound understanding of the principles of privacy and dignity.

The service employed dedicated activity coordinators who organised daily events. We saw that people were encouraged to participate but could also request activities to engage with.

People were wearing hearing aids, glasses and footwear of their choice. We saw that people had their hair neatly done and people were dressed in accordance to their individual preference and lifestyle choice.

Is it responsive?
There was a complaints policy and procedure in place if people or their representatives were unhappy, which was monitored by the provider.

People we spoke with felt confident in approaching members of management with any concerns.

Where people's health had deteriorated, we saw that the home took appropriate action. We saw that the home worked closely with district nurses, GPs and other healthcare professionals.

Resident and staff meetings were held to explore how positive changes could be made.

Is it Well-led?
A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service and shares the legal

responsibility for meeting the requirements of the law with the provider.

The home had a quality assurance system, records seen by us showed that identified shortfalls were addressed promptly. As a result the quality of the service was continually improving.

Staff had the necessary knowledge, skills and experience to meet the needs of people at all times.

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 22 August 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

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.

Reasons for our judgement

We found that independence and individuality were promoted within the service

We spoke with six people who used the service. People we spoke with spoke positively about the home. They all told us that the standard of care received from care workers was excellent. One person told us, "They are lovely." Another person told us, "You are never lonely here."

Care workers demonstrated a clear understanding of the needs of each person. One care worker told us, "We received sight loss training during our induction which gave us an understanding of what it may be like. We recognise each person's individual need and the level of sight impairment they may be experiencing." Another care worker told us, "When I sit down with anyone, whether it's at the dining room or in their room. I introduce myself and say my name, so they recognise who I am."

During the inspection, we observed staff interaction with people. We saw that when staff walked past people, they said hello and who they were. When talking with people, we saw that staff sat down with the person and spoke with compassion and respect. During the day, we observed that one person was visibly upset. A care worker was seen comforting the person and spending the time with them to help ascertain the reason and provided reassurance. This demonstrated that people received care and support that was respectful and kind.

The home had policies giving guidance to care workers on privacy, dignity and people's rights. We saw that privacy, dignity and people's rights were covered during staff's induction. The home had a clear value statement which documented, "The older people's services places the rights of the residents at the forefront of our philosophy of support. We seek to advance these rights in all aspects of the environment and the services we provide and to encourage our residents to exercise their rights to the full."

Care workers we spoke with had a clear understanding of dignity and respect. One care

worker told us, "It's about always telling them what we are doing. Introduce ourselves, gain their consent to provide personal care and always explain what is happening." Another care worker told us, "I always knock on their door before entering and announce my name. When assisting with washing, I make sure their top half is covered and vice versus." A care supervisor told us, "Due to hearing impairment, some people don't hear if we knock but I still knock, go in and introduce myself. When giving personal care, making sure the door is closed and curtains are closed." This demonstrated that care workers understood the importance of respecting privacy and dignity.

People we spoke with confirmed that their privacy and dignity was respected. One person told us, "They always knock before they come into my room." Another person told us, "They always respect my privacy." Another person told us, "We can do what we chose and that it respected." This demonstrated that the service empowered to people to make daily choices and privacy and dignity was respected.

In the rooms that we viewed, we saw that each person had their own belongings and decorative effects to make them feel at home. We saw that people could bring items of importance such as pictures and ornaments and these were clearly displayed within their room. One person showed us with pride the furniture they had brought with them and recent items they had purchased. This demonstrated that the service promoted individuality and took into account people's personal preference.

One person walked around the home with us. They pointed out with pride the changes within the home and informed us what they enjoyed about the home and their favourite parts. We saw that the home had a court yard where people could enjoy the sunshine. A summer house had been built which was used regularly. On the day of the inspection, we saw that people enjoyed sitting in the summer house and accessing the garden.

People's diversity, human rights and religious and spiritual needs were respected. We saw that people's faith and spiritual beliefs were clearly recorded and taken into account when delivering care. The home supported people to attend their local church and local ministers, reverends and priests attended the home. We saw that people's preference for male or female care workers was respected and upheld. One person told us, "I once had a male care worker ask if it was ok to shower me. I said no and ever since I've always had female care workers." This demonstrated that the service took into account people's personal preference, diversity and likes and dislikes when delivering care and treatment.

During the inspection, we observed the lunchtime meal being served and people being supported to eat and drink in their own rooms. The provider may find it useful that we observed one care worker supporting someone with their lunch. They did not inform the person what they had for lunch. Whilst supporting with lunch, they did not explain to the person what they had on their fork or whether they had finished their mouthful.

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Before someone moved into the home, a pre-admission assessment took place. The registered manager told us, "Either myself or the deputy manager will meet with the person and their family. We discuss their care needs and what support they need. We look at all areas of their health and wellbeing. We need to make sure we can safely meet their needs." We saw that before someone moved into the home, they could come and visit. One person told us, "I came to have a look round and really liked it." This meant that the service was confident in meeting the care needs of people before they joined the service.

The home provided specific support and treatment for people experiencing partial sight loss, the blind and/or hearing loss. We looked at 12 care plans. We found that care plans provided a detailed medical history and level of sensory impairment for the person which included relevant information on the level of visual and hearing loss. We saw that care plans included information on the person's preferences for lighting and communication aids required. For example, one person had a communication difficulty. We saw that they had requested for care workers to speak clearly and to demonstrate patience. This meant that the service was taking into account the environmental and emotional needs of people.

Care plans contained information on the person's health care needs, medication and psychological needs. They included plans for personal care, oral hygiene, appetite traits and nutrition, continence, mobility, financial management, health appointments and social community. End of life wishes were recorded and each person had a palliative care plan. This documented what they would like to happen in the event their health had deteriorated. For example, one person expressed their wish to remain at RNIB Wavertree House. This demonstrated that the service was providing safe and appropriate support through co-ordinated assessment, planning and delivery.

Information and guidance was clearly documented about the person's level of mobility and orientation. Care plans the person's ability to mobilise and the factors which impacted

upon their level of mobility. For example, one person could mobilise with the aid of a walking stick in their room but due to their vision loss required escorting around the home by a member of staff. This meant that care and treatment was planned in a way that was intended to ensure people's safety, rights and welfare.

We saw that people who used the service were registered with GPs and had access to other healthcare professionals, including chiropodists, district nurses, speech and language therapists and dieticians. Each care plan included multi-disciplinary notes from the visiting healthcare professional. We saw that where people's health had deteriorated, the home worked in partnership with external healthcare professionals. For example, one person was declining food and fluids. We saw that the home contacted their GP asking for a dietician referral. One care worker told us, "We have good relations with nurses, physiotherapists and speech and language therapists." Another care worker told us, "We work closely with the district nurses and refer on when necessary." This showed that people's physical health needs were monitored and appropriate referrals made to health professionals.

Where the home had identified concerns with nutritional intake, we saw that the food and fluid charts were kept. We reviewed a sample of these. We found them to be completed on a daily basis recording the nutritional and fluid intake the person had received. People were offered daily choices on what they would like to eat but could also make requests. We saw that where people had dietary requirements, the home worked in partnership with them. We saw that the home devised a weekly menu based on their nutritional needs which was provided to them. This demonstrated that the service was aware of the nutritional needs of people.

We found that people who used the service were offered a wide range of activities which they enjoyed. The service employed two activity coordinators. During the course of the inspection, we observed an exercise class and a quiz. We saw that an activities timetable was displayed. Activities included shopping trips, art and crafts, quizzes, speakers and news stories. The activities coordinator told us, "We are always trying to encourage people to give us ideas about activities and what they would like to do. We recently had holiday week. This was a week, where we tried to create the feeling of going away. We had several outings which included trips to Arundel and shopping." People who used the service spoke positively of the activities. One person told us, "I want to keep my mind active. I enjoy the quizzes." Another person told, "I can no longer go shopping by myself as I can't see what I'm buying. I like that they take us shopping." This showed that there were opportunities for meaningful activity and social engagement for people who used the service.

During the inspection we found that people looked content in the present of care workers. People were dressed in accordance to their individual choice. We saw that people were wearing hearing aids, glasses and footwear of their choice. We saw that ladies were supported with make-up and jewellery and men were supported with shaving. The registered manager told us, "We have a hair dresser and chiropodist who visit the home regularly." On the day of the inspection, we saw that people were having their hair done and were seen to enjoy the experience.

We spoke with six people who used the service. One person told us, "I like that there is always someone available." Another person told us, "We can treat it like our own home. It is ideal for people like me. They treat me very well." A third person told us, "I like this special kind of sweet which normal shops don't sell. The other day, a care worker popped

a packet of sweets in my lap. It was so kind of them."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Deprivation of Liberty Safeguards and Mental Capacity Act 2005. On the day of the inspection, we were informed that no one who used the service was under a Deprivation of Liberty Safeguard (DoLS). We saw that people could freely come and go from the home. The registered manager told us, "The front door is locked at 21.00pm. During the day, people can freely access the community and we promote this."

We saw that people enjoyed going out for walks or accessing the local community with a volunteer. Staff training records confirmed that care workers received training on MCA and DoLS upon induction to the home. The provider may wish to note that we could not see that their training had been updated since start of employment.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment. People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

At the last inspection in February 2014, we found RNIB Wavertree House non-compliant with cleanliness infection control. This was because the service did not have an infection control lead and infection control audits had not been completed to identify any possible risks with infection control.

Following our inspection, the provider sent us an action plan outlining the steps they intended to take to rectify the issues identified. The action plan identified how the service would make improvements in infection control. Actions included the appointment of an infection control lead, audits to be completed and for policies and procedures to be updated. We found that compliance had been achieved.

In 2010 the Government issued advice to all providers of health and social care entitled, 'The Code of Practice on the Prevention and Control of Infections and Related Guidance' (CoP). This gave all providers a framework for managing the control and prevention of infection in the provision of health and social care services. Providers must follow the guidance or have equivalent or better systems in place.

The CoP (framework for compliance) documented that an individual was designated lead in this area and was directly accountable to the service. At the last inspection in February 2014, we found that the home did not have a designated lead that was responsible for infection control within the service. We saw that the registered manager had now been appointed and was working to improve the standards of cleanliness and infection control.

We found that RNIB Wavertree House had an 'Infection Control Policy'. We reviewed this policy and found it included information on the CoP, hand hygiene, protective personal equipment (clothes and aprons), and disposal of waste and body spillage. Policies and procedures referenced legislation which governed infection control in care homes, this included information on the 'Health and Safety at Work Act 1974 and the 'Control of Substances Hazardous to Health Regulations 2002'.

At the last inspection in February 2014, we found that the home had not undertaken quality assurance audits on infection control. Criterion one of the CoP documents that all social

care organisations need a quality assurance framework to monitor the standards of cleanliness and infection control and to identify any shortfalls in practice or where procedures had not been followed. Since the last inspection, we saw evidence that RNIB Wavertree House now undertook quality assurance audits. We saw that an audit toolkit and framework had been implemented. We saw that an infection control audit had been completed in June 2014. Action points had been identified. The result of the audit recorded that the home had scored 89% compliance with infection control. This meant that cleanliness and infection control was governed by an assurance framework and the service had mechanisms to monitor, review and assess standards of cleanliness and infection control.

On the day of the inspection, we viewed the whole service including communal areas and people's bedrooms. We found the home to be clean and tidy. The service employed three dedicated housekeepers who worked five days a week. We were informed that one housekeeper was unable to work currently but would be returning to work shortly. The provider may find it useful to note that care workers felt only two housekeepers was not sufficient for such a large home. We were informed that they felt an interim housekeeper should have been appointed.

We saw that the kitchen's level of cleanliness was well maintained. The kitchen staff we spoke with demonstrated a sound knowledge of practices associated with good food hygiene. Regular records for checking fridge/freezer temperatures and cooked food temperatures were maintained.

We saw there was a system that ensured appropriate equipment was used for specific tasks, such as the use of colour coded mops for different areas of the building. We found arrangements in place for the safe handling and processing of laundry. The home employed a laundry worker. They demonstrated sound knowledge of the laundry process, such sluice wash for soiled clothing. We saw that each person's laundry was washed separately and everyone had a set laundry day. This demonstrated the provider had ensured that people who used the service and persons employed were protected from acquiring a health care associated infection.

All care workers we spoke with were able to tell us how to use personal protective clothing (gloves, aprons) and that there were plentiful supplies. We saw personal protective clothing being used appropriately. We saw hand sanitizers and appropriate hand-washing facilities were available and were regularly used. This demonstrated that care workers understood and applied procedures relating to infection control.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who used the service were protected against the risks of unsafe premises.

Reasons for our judgement

When we arrived at the service, we were shown around the building by the deputy manager. RNIB Wavertree House was purpose built and offered wide corridors, doorways and large bathrooms. This enabled people with mobility aids to move around the home easily and safely and provided room for care workers to support them if needed.

We saw that areas within the home were clearly labelled such as the lounge and dining room. For people who understood braille, we saw that braille was on the signs to help orientate people. People we spoke with commented that they found the home easy to navigate. The registered manager told us, "People living here are supported by the RNIB welfare officer. They come and visit people to make sure they have the equipment to promote their quality of life."

Maintenance reporting procedures were efficient. We saw that there was a system for care workers and staff to report defects and items that required repair. The registered manager told us, "We are visited twice a week from the maintenance team who assist with any repairs and maintenance issues."

We saw that the environment was monitored and risk assessments were completed. In January 2014, a risk assessment was completed which looked at the access to the home, cleaning of the home and its electrical safety. We saw that an action plan was implemented. Actions included the safe disposal of any electrical items that may have presented a risk. This demonstrated that the home had a quality assurance framework to monitor and review the maintenance of the building.

The service had a fire test every week. We looked at the fire log which confirmed that at every fire test, all fire alarms were working and all fire doors closed appropriately. Each person had a personal emergency evacuation plan (PEEP) on their file. This showed each person's ability to evacuate the building in the event of an emergency.

We looked at records of safety certificates for the service. We found that current gas safety and electrical test certificates were in place. Other records showed that the water was tested for bacteria. Temperature of the water was tested monthly. Records documented that the lift was last serviced in July 2014. This helped to ensure that the service remained

safe to be used.

On the day of the inspection we checked a sample of the call bells. We found all the call bells to be within working order. All had batteries in and were placed next to the person. The deputy manager told us, "People living here always tell us if their call bell is not working. We are due to get a new call bell system but currently if any batteries are low, they can be replaced." People we spoke with commented that their call bell works and care workers respond promptly. This demonstrated that people who used the service could summon assistance when required.

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

The home had systems in place to improve and develop the standard of care people received and experienced.

We saw that staff and 'resident' meetings were held on a regular basis. The purpose of these meetings was to provide an open forum for any concerns and issues to be addressed. We saw that the last resident meeting was held in June 2014. The deputy manager told us, "We aim to have resident meetings every month. The next one is on the 27 July 2014." We reviewed the minutes from these meetings and found that that people had made suggestions on how the service could be improved. We saw that a common theme was the improvement of the meals offered. The offer of different activities and outings was also explored. One person told us, "Oh yes, we have resident meetings. We can make suggestions and I do feel listened to." Care workers we spoke with confirmed that staff meetings were held regularly. We saw that the last staff meeting was in May 2014. This meant that the service had systems in place to involve people who used the service and staff on the running of the service.

Accidents and incidents were recorded which allowed for any trends or patterns to be identified. We viewed a sample of these records. Incidents and accidents were reported to the provider's quality assurance team who monitored these and provided support and guidance to the registered manager of the home.

We saw evidence of a complaints policy and that complaints had been handled appropriately and resolved. During the inspection, we saw that the complaints policy was displayed throughout the home. People we spoke with commented that they would feel happy raising any concerns or worries.

Discussions with people found that they felt safe and well cared for. One person told us, "They listen to us." Another person told us. "I feel involved." A third person told us, "I feel involved in the running of the home. If I've got a suggestion, they do listen."

The registered manager told us that care workers should receive supervision every six

weeks. Supervision is a formal meeting where training needs, objectives and progress for the year were discussed. The provider may wish to note that care workers were not receiving supervision every six weeks. We saw that some care workers had not received supervision since February 2014.

Care workers we spoke with commented that they felt supported by their care supervisor and could raise any concerns. The provider may find it useful to note that care workers commented on the staffing levels at weekends. Care workers felt that with only three members of staff, they were rushed and did not have time to spend with people.

The home had received regular quality assurance visits from a representative of the provider. We saw that regular audits were completed which looked at areas such as care records, medication, infection control. Where any issues had been identified the registered manager had an action plan to follow to address these. This showed us that the service had a quality assurance framework in place which monitored, reviewed and evaluated the delivery of care, treatment and support.

Representatives from RNIB visited the home on a regular basis. They had looked at how the service had met the essential standards of quality and safety. This detailed what providers should do to comply with the Health and Social Care Act 2008. Where any issues had been identified the registered manager had an action plan to follow to address these.

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.

The service had not taken steps to ensure that people were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not always 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

We looked at 12 care plans. A care plan is something that describes in an easy accessible way the services and support being provided, and should be put together and agreed with the person through the process of care planning and review. We saw that when someone moved into the home, their care plan was signed. We found that following a review of the care plan they were not signed by the person to acknowledge their consent as to whether they agreed with their care plan. We could not find any supporting documentation to confirm that people agreed with their care plan and any subsequent changes following a review. Care planning should be based on the needs of the person, their wishes and preferences on the care they receive and need. This meant that there was no evidence to demonstrate people's involvement in the review process or whether they consented to their care plan review.

The registered manager told us that care plans should be reviewed monthly. We identified that a majority of care plans that had not been updated monthly. For example, one care plan had not been reviewed since February 2014. This meant that any changes in care needs or risk were not recorded and available for care staff as a source of guidance.

Where care plans had been reviewed, we found that not all information had been updated. For example, one care plan documented that the person's health had significantly deteriorated. We found that their care plan still documented that they were independently mobile when their mobility and deteriorated. A risk assessment for pressure damage (skin damage) had not been updated to reflect they were receiving all of their care in bed and were at greater risk of pressure damage. This demonstrated that care plans were not always accurate and fit for purpose.

We spoke with six people. One person told us, "I know my care plan. They read it to me, to make sure I'm happy with it." The majority of people we spoke with were unclear about their care plan but were happy with the care they received.

We found that recruitment practices were safe and the relevant checks had been completed before care workers worked unsupervised at the home. We looked at four staff files which confirmed that staff had completed an application form, references were obtained, forms of identification were present and a disclosure and barring check had taken place. This showed us that the service had checked that people had no record of misconduct or crimes that could affect their suitability to work with vulnerable adults.

We looked at the home's policies and procedures and saw that the majority had been updated regularly. The manager showed us a wide range of policies and procedures which addressed aspects of the service. Some of the policies focussed on fire and evacuation, management of service user's money, health and safety, complaints and whistleblowing. We noted that all policies were clear and included guidelines and procedures for the staff to follow.

Records were kept securely and could be located promptly when needed. People's care plans were kept in the office. They were easily accessible to staff when needed, but were difficult for unauthorised people to obtain.

The home kept records of electrical testing, fire tests, legionella testing and water safety. This meant that the provider kept fit and accurate records in relation to the maintenance and suitability of the premises.

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 activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Regulation 20 (1) (a) The provider had not taken steps to ensure that people were protected from the risks of unsafe or inappropriate care and treatment because not all care records were accurate and fit for purpose.

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 22 August 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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