Inspection Report

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

Parklands

Highfield New Road, Crook, DL15 8LN

Tel: 01388762925

Date of Inspection: 02 April 2014

Date of Publication: June 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✖	Action needed
Care and welfare of people who use services	✖	Enforcement action taken
Safeguarding people who use services from abuse	✖	Action needed
Management of medicines	✖	Action needed
Requirements relating to workers	✖	Action needed
Staffing	✖	Action needed
Supporting workers	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Enforcement action taken

Details about this location

Registered Provider	T Chopra
Registered Manager	Mrs Jean Towland
Overview of the service	Parklands care home is a converted Victorian mansion set in its own grounds. It provides up to 36 places for older people and older people with dementia care needs. There is an additional extension which is connected to the original part of the building by a bridge where people who require nursing care live.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care 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

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 2 April 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

During our inspection we asked the provider, staff and people who used the service specific questions; is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our observations during the inspection, speaking with people using the service, and the staff supporting them and from looking at records.

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

Is the service safe?

People we spoke with told us they were happy living at the home, however we were unable to obtain the views of many people who used the service due to their health care needs.

Some of the staff working in the home were unaware of their responsibilities in relation to reporting incidents at the home and were not aware of how to report safeguarding concerns.

We saw the accident and incident book which related to people who received nursing care did not contain information about all the accidents and incidents that had occurred.

The provider had a recruitment policy in place and this was reviewed annually but we saw this was not being followed so was not safe.

The registered manager provided us with staff rotas. The staffing levels for people who required nursing care did not reflect the individual needs of those being cared for and did not allow for unforeseen circumstances.

Is the service effective?

People's care needs were assessed before going to live at the home. Where people needed help with their personal care needs, we saw they were involved with the planning of their care and the level of assistance the wanted.

Where people required nursing care their pre-admission assessments were not always carried out by a trained nurse. This meant the provider and registered manager could not be sure they were able to provide the correct level of care.

Is the service caring?

People who received help with personal care were treated kindly and with respect. People were happy with the care staff and we saw people's preferences being taken into account in ways like what they wanted to do during the day, what they wanted to eat and also if they wanted to spend time with visitors in private.

People who required nursing care were looked after by care staff that had not been appropriately trained for the role they were carrying out meaning they were unable to give the correct level of care and support to people who needed it.

Is the service responsive?

People who lived in the home were encouraged to participate in a variety of activities. Unfortunately those who required nursing care had very little stimulation and there were no cognitive activities for them to engage in.

Is the service well lead?

The home worked with other professionals like dentists, chiropodists and GPs to ensure people's wider health needs were met.
We asked the provider and manager to show us the operational systems in place to ensure people received care which was safe and appropriate. Both the Provider and manager told us they had no such system and this was something which required attention. Failing to have an operational system meant that people were at risk of receiving care which was not appropriate or safe.

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

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Parklands to protect the health, safety and welfare of people using this service.

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.

There was not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who use the service in relation to the care and treatment provided for them.

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 care records of twelve people and found systems in place to obtain consent from people in regards to their care and treatment were inadequate. For example, individuals and/or their representatives had not always signed consent to their care in most of the care plans we looked at. We spoke with the provider who told us they would improve this by ensuring that where people were not able to sign their care plans they would speak with the person's relatives or advocate.

We looked at the arrangements that were in place to manage people's end of life care and found that provisions did not meet the requirements of the law and good practice. For example where people did not have the ability to express their wishes in relation to end of life care there was no evidence that an appropriate assessment had taken place. There was no record to show that they were unable to make a decision and that a decision had been made in their best interests.

Most of the care records we looked at had written on them "Do Not Resuscitate". These had not been reviewed to ensure that they remained appropriate to the person's condition.

We looked at the systems in place to ensure that decisions were made in accordance with the person's expressed wishes or where people did not have the capacity to make their own decisions that this was done in the person's best interests. There was no evidence in people's records of a formal discussion showing that decisions had been made appropriately and in accordance with the law.

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

The provider had not taken proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Before people went to live in the home we saw assessments were carried out to establish people's needs and ensure the home was able to provide the appropriate level of care. We looked at the care records of six people who received personal care and six who required nursing care. We saw where people required personal care, assessments were carried out and a care plan was discussed and drawn up according to the requirements of the individual.

Care plans were written in a comprehensive and person centred way with details of the type of care required and how this was to be provided. In addition we saw risks were identified and risk assessments were carried out to identify ways in which the risks could be minimised.

People who required nursing care also had assessments and care plans to identify the type of care they required. We saw pre-assessments were carried out by the registered manager of the home prior to admission but due to the lack of skills and experience of the manager in relation to people who required nursing care this meant that detailed and robust assessments had not been carried out. For example we observed people with complex and challenging needs and these factors had not been considered as part of the pre-admission assessment to ensure the service was able to provide safe and suitable care.

Some of the people who required nursing care had been discharged from hospital with treatment orders however the staff at the home did not understand what the treatment orders meant and what their obligations were in terms of providing safe, effective and suitable care.

The care plans for people who required nursing care contained information about their medical diagnosis and physical health care needs. However where people's needs had

been identified the service did not always follow the instructions of health professionals. For example due to the nature of one person's condition they were identified as requiring three carers to look after them. Although this was recorded on the care plan there was not enough staff to ensure they received the correct level of care.

We saw that people receiving nursing care at the home had complex needs and their needs assessments and risk assessments failed to identify the challenging behaviour that some people presented. People receiving nursing care had no plans in place to manage complex and challenging behaviour and staff were unclear on strategies and interventions they could use to ensure people received safe and effective care. For example we observed one person with cognitive impairments attempting to urinate in the corridors of the home, it was brought to the attention of staff by inspectors but staff failed to intervene and support the person to use more appropriate toileting facilities. We were told by staff that this behaviour was common and a contributing reason for the odorous smell on the nursing unit. This meant people were not being treated with dignity and they failed to have their needs met also.

We saw the care plan for one of the people receiving nursing care gave details about problems they had communicating. Due to these difficulties the care plan stated the person had a communications passport. This was a way to communicate where the person had difficulties in using speech. We spoke with staff that worked with this person and asked them if we could see the passport. None of the staff we spoke with were aware of the communications passport or any other alternative methods that should be used to support the person to communicate effectively.

We saw the care plans for people who used the service gave details of appointments people had with doctors, dentists, chiropodists and other professionals. This helped to ensure people's wider health needs were identified and treated. We saw people who received personal care had their care plans updated following these visits and if changes to care were required these were noted and staff were made aware.

People who received nursing care also had records kept in relation to the professionals they saw, however on the day of our inspection we saw a visit by a speech therapist took place. We saw that due to care plans not being updated the nurse was unable to identify why the therapist was there and what support the person required. This meant the person was placed at risk of not receiving the care they required.

We saw the home had an activities co-ordinator employed to entertain the people who lived there but no time was spent with the people who required nursing care. We saw these people were not encouraged to participate in activities and the service failed to acknowledge National Institute of Clinical Excellence Guidance (NICE) by ensuring there was a cognitive stimulation programme for people with cognitive impairments.

We saw people's care plans contained information in relation to nutrition. This gave information on how meals should be prepared and details of people's food preferences. In addition there were details about people's dietary needs and if they required fortified drinks or meals. The provider should note that on the day of our inspection we saw people who required assistance with meals were not always given individual attention.

One of the people who required nursing care was observed to be wandering the unit with a staff member following attempting to feed them with food from a bowl and the use of a spoon. No assessment had been carried to consider if this was appropriate and what other alternatives could be used to ensure the person received adequate nutrition.

It was also identified that another person who required care had recently been seen by a dietician who had updated their records to say the person could eat tea spoons of solid food but the care staff were unaware of the advice from the visiting professional, and clinical care plans relating to the nutritional needs had not been updated.

We saw people who used the service were regularly weighed and their weights recorded in their care plans. The provider may like to note that due to the timing of meals this may impact on people's weight. For example we saw people being given a roast dinner with dessert and found that three hours after finishing the meal they were offered scampi and chips with a further dessert.

We spoke with the manager and provider who acknowledged our concerns during the visit and told us they would make improvements by employing an appropriate person with relevant skills and proven competencies to support required improvements.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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 records of staff who worked in the home. We saw certificates showing care staff who worked with people requiring personal care had been given training in safeguarding. This training included how to recognise abuse and how to report a safeguarding incident.

We spoke with staff and asked them about the training they had received. Staff were able to give examples of the different types of abuse and were clear about the action they would take if they witnessed anyone in their care being abused.

We looked at a diary which was located in one of the homes spare bedrooms. We saw the book contained information on events that happened in the home. One of the events that had been recorded was a physical disagreement between people who used the service. The information recorded was very brief and did not include details such as the date and time of the event.

We spoke with the nurse in charge and found they were aware of the event but were not able to inform us of the date and time it had occurred.

On the day of our inspection the nurse in charge was a member of staff who did not regularly work in the home. We spoke with the nurse about safeguarding and asked her about the recent event that had been recorded. The nurse told us that after a discussion with the person's relative they had informed the local authority safeguarding team. We asked about the safeguarding training she had received. We were told that she had not had any safeguarding training and was not aware of how the home reported safeguarding concerns.

We asked the home manager if police checks had been carried out for the staff employed in the home. Disclosure and Barring Service (DBS) checks are carried out to ensure people applying for jobs are of good character and haven't previously been prevented from

working with vulnerable people. We were told checks were carried out on all staff who were employed to work at the home.

We looked at staff records to check this information and found permanent members of staff had the appropriate checks and risk assessments had been carried out where required however the employer did not make arrangements to ensure those employed by the nursing agency had also been subject to these checks. This meant the employer could not be sure people were being cared for by people of good character.

As part of their requirements to the Care Quality Commission (CQC) providers and their registered managers should notify CQC of any events that occur in the home which cause certain injuries and also any incidents of abuse. For this reason we looked at the accident /incident book for the home.

We saw two books were held, one for people who required personal care and the other for people with nursing care requirements. The book for people who required help with personal care was completed appropriately however, the book for people who received nursing care had not been completed and we were able to identify incidents where this book had not been filled in.

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

We looked at the systems for the management of medicines at the service and looked at five people's records where they did not require nursing care. The service used a monitored dosage system from a pharmacy and there were records to demonstrate that these were checked when the service received the medicines, and any discrepancies addressed promptly.

We looked at the medication records and found that where people had allergies to certain medicines this was recorded clearly on the person's records. We also found where people were prescribed "as and when required" medicines there was a clear protocol in place to ensure staff were aware of the circumstances the medicines should be administered.

We found the service carried out daily temperature checks of both the medication storage room and the fridge where medication was kept. Where temperatures were too low or too high action was taken to rectify the matter immediately. This meant the risk of people receiving medication which was unsafe to use had been minimised.

Medicines were safely administered. We checked the medicines stock for five people and looked at their Medication Administration Records (MAR) and found that medicines were signed for by staff to reflect the prescriber's instructions. This meant people received their medicines appropriately.

The service carried out regular daily and monthly checks to ensure that medicines had been administered properly and also to ensure that any errors or discrepancies could be addressed promptly. This meant the risk of people receiving inappropriate care and treatment was reduced.

We also found that each senior care worker had received competency assessments to ensure that staff were suitably skilled to administer medication.

We looked at the medicine administration records and medicine supplies for 3 people

living in the home that required nursing care.

We saw that no assessments of competency had been carried out on nursing staff within the last 12 months to confirm that medicines were being handled safely.

Appropriate arrangements were not in place for the recording of medicines. For many medicines there was no record made of the medication carried forward from the previous month, or received into the home. This meant that we could not reconcile the remaining stock with the administration records to confirm that these medicines had been given correctly.

Medicines were not kept safely, we looked in a locked room that was described to us as a "treatment room" and found a stock of medicines no longer in use stored in cupboards, on the floor in carrier bags and lying over work surfaces, but there was no documentation recording the details of these medicines.

We spoke to the provider and senior people in charge who were unable to explain to us why the "treatment room" was in an unacceptable state or why the medication had not been audited.

We looked at some of the medications in the room and found the date of first opening for medicines with a short life (once opened) was not always recorded. This meant there was a risk that medicines may have been continued to be used when they were no longer effective, or safe to use.

We were unable to locate any up to date documentation in relation to the disposal of medicines. We were told that there was no current system in place for the recording of medication when it arrived into the home or when it was disposed of.

We were told that there was no system in place for the auditing of medication where people required nursing care. We saw that room temperature and fridge temperatures were not recorded daily and the nurse in charge told us they had no knowledge or awareness of the provider's policies in relation to safe handling and keeping of medication.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

People were not always cared for, or supported by, suitably qualified, skilled and experienced staff.

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 recruitment and selection procedures and how these were carried out. Every one wishing to work at the home (with the exception of agency staff) was required to complete an application form.

We saw the provider had a recruitment procedure in place which was reviewed annually however, we found the procedures laid out in the policy were not always adhered to. We saw references were usually sought from two people but this was not always the practice followed.

We looked at the staff files of four permanent staff and found that some had gaps in the employment. We also saw the details in relation to one person's employment did not match the information provided in one of the references obtained. There was no evidence that these inconsistencies had been noticed or questioned.

We saw people were subject to Disclosure and Barring Service (DBS) checks. These checks were carried out to ensure people who were employed by the service were of good character and had not previously been prevented from working with vulnerable people.

Agency staff who worked in the home had not been asked for evidence that DBS checks had been carried out and when we asked the provider the reason for this we identified their lack of understanding about their duties in relation to staff requirements and told us they had no need to check their DBS checks as the Care Quality Commission regulates the agency from whom he receives staff. We explained to the provider that in this instance the agency that provides staff is not required to register with the Care Quality Commission and therefore we do not carry out inspections in relation to that employment agency.

We saw the provider carried out checks to confirm people's identity and to confirm they were able to work in the United Kingdom. The files of permanent staff had appropriate identity checks and also evidence of the right to work, however no such checks were carried out on agency staff. The provider might like to note that where people have

produced a passport as evidence of their identity the photo page was not always the one copied and held on file.

The people who required nursing care had complex needs and often challenging behaviour. For this reason the staff required to work with them needed to have specialised skills. We saw the provider used a lot of staff from a nursing agency but did not check their skills or knowledge were appropriate to the tasks they were required to undertake.

We asked the provider how he chose the people he wanted from the agency and he told us he didn't choose them, they were sent. We also asked the provider for the personal profiles or CVs for the agency staff he used but he informed us he did not request these.

We spoke with the nurse in charge on the day of our inspection. She told us she was a bank nurse (not regularly at the service) and was working a twelve hour shift. We were told she received a hand over in the morning when she arrived on duty but when we asked her about her induction she told us she hadn't had one.

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 asked about the number of staff working in the home on each shift and looked at care plans to find out how much assistance people who were being cared for needed. We found where people required personal care there were sufficient staff on duty to support people with their everyday care needs.

Where people required nursing care we found there were not always enough staff to ensure they were appropriately cared for. We were told by the registered manager that there was usually one nurse and three care staff caring for these people but when we looked at the care plans we found one person was unable to move from bed and needed to be moved every two hours. This meant she required assistance from two people.

There were a further five people on the upper floor of the building, all with complex needs and some with challenging behaviour. Three care staff worked with them on day shift and two on night shift as well as one nurse on each shift. One of the people on this floor required the assistance of three members of staff meaning at night there were no staff available to deal with the other people who required care.

In addition the nurse on duty was required to dispense medication and change dressings as well as performing other clinical duties. This meant the nurse was often on a different floor or in another area of the home and was not always readily available for emergencies.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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

Staff working at the home should receive regular supervisions and one to one meetings with their manager. We found staff who worked with people requiring personal care were given more supervisions than staff who worked with people who required nursing care.

We spoke with the registered manager and asked her about staff supervisions for people who worked with those requiring nursing care. The manager told us none of the nurses who worked at the home had received any supervision. We were told this was either because they had not been there long enough or because they were agency staff. We asked the manager about one nurse who has been employed at the home for at least six months. The manager told us there had been no formal meeting with this nurse but that they should have had at least two by now.

We asked the manager about her personal development plan and her personal supervisions or one to one meetings. The manager was not aware of what a personal development plan was and told us she did not receive supervisions or appraisals.

We asked to see the training matrix for the home but we did not receive this. The manager did provide us with a lever arch file which contained staff certificates for training but there was no order to it which meant the service was not able to satisfy itself in relation to training completed and training required.

Staff who worked with people who required nursing care were provided with de-escalation training however due to the complex needs and challenging behaviour this was not sufficient to ensure the safety of staff and people who used the service.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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 not meeting this standard.

The provider did not protect people who use the service, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We spoke with the Provider and manager during our visit and looked at the information available to us such as audits of the physical environment and health and safety audits of equipment but these were not effective as they consisted of tick box answers and did not provide information regarding action that had been taken or actions required.

We found there was not an effective system in place for monitoring the service to ensure people received safe and effective care. The provider told us they did not have a system in place to monitor the quality of the service and this was an area that required attention.

We found neither the provider or registered manager have been able to demonstrate the knowledge or skills necessary to ensure people who require nursing care, receive care which is safe and effective.

Furthermore it was evident that the service has been unable to effectively utilise the expertise and skills of external agencies such as community nurses and social work teams by developing knowledge and skills in managing complex and challenging behaviours.

Neither the provider nor the registered manager had professional development plans and when we spoke with them about this they did not have clear interpretations of what a professional development plan was. Although we recognise that the provider and manager had received some training, neither of them held professional qualifications relating nursing or managing complex behaviours.

Given the complex nature of the people who live at the service and require nursing care we would expect the management team to hold some specialist qualifications, recognise their lack of skills and experience and access professional advisors where required.

Whilst the provider and manager were committed and wanted to support the individuals

who resided within their service, we found they did not always have the required skills and training to care for people in the service who required nursing care. It was also evident that neither of them fully understood the implications of providing a service for people with complex needs. For example they were not very clear about what support, clinical supervision and training staff working in the service required.

We have observed good practices for example the service had improved its meal time experience for people who do not require nursing care. We have also observed first hand inappropriate management of challenging behaviours for example staff observing people who have complex needs urinate around the unit without providing any appropriate intervention.

We have seen very little evidence of any real understanding of the contributing factors and triggers underlying the challenges that people who require nursing care can present due to the services lack of analysing of incidents and monitoring of people's behaviour. For example we saw accidents and incidents involving people who required personal care were fully recorded with all relevant details and families were informed of these.

We looked at the book for people who required nursing care and found there were no entries in the book despite having received notifications from the registered manager. We asked the registered manager, provider and nurse in charge why there were no entries but none of them could provide an answer to this.

Intervention was limited to some simple and often stigmatising preventative strategies such as the use of locks on doors to prevent damaging personal property, or holding by their hands to prevent touching or hitting. We have seen an absence of skills to manage complex behaviours.

We met with the Provider during our visit and expressed our serious concerns relating to the management and leadership of the service and also the service's ability to improve without expert help. The Provider acknowledged our concerns and told us they would take immediate steps to remedy our concerns.

We received information from the provider on 3 April 2014 telling us they had engaged a consultant to make the necessary improvements.

The provider told us they are in the process of recruiting a skilled manager in nursing care and they will continue to utilise the experience and skills of their consultant and will improve the quality of service for people.

We told the provider we will continue to monitor the service to ensure improvements are continued and sustained.

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 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: There was not suitable arrangements in place for obtaining, and acting in accordance with, the consent of people who use the service in relation to the care and treatment provided for them. Regulation 18
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Regulation 11 (a) and (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**

This section is primarily information for the provider

Treatment of disease, disorder or injury	**How the regulation was not being met:** People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation13
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers** **How the regulation was not being met:** People were not always cared for, or supported by, suitably qualified, skilled and experienced staff. Regulation 21 (a) (b) and (C)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** There were not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers** **How the regulation was not being met:** People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 1 (a) and (b) (2) and (3)

This section is primarily information for the provider

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

The provider's report should be sent to us by 01 July 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 07 July 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
Treatment of disease, disorder or injury	**How the regulation was not being met:** The provider had not taken proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (a) and (b)

We have served a warning notice to be met by 07 July 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
Treatment of disease, disorder or injury	**How the regulation was not being met:** The provider did not protect people who use the service, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems. Regulation 10 (a) (b) 2 (a) (b) (c) (d) and (e).

This section is primarily information for the provider

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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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