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

The Old Deanery Care Home

Deanery Hill, Bocking, Braintree, CM7 5SR
Tel: 01376328600

Date of Inspections: 17 July 2014
09 July 2014
08 July 2014
Date of Publication: September 2014

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

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<td><strong>Registered Provider</strong></td>
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<tr>
<td><strong>Registered Managers</strong></td>
<td>Ms Juliet Hornabrook</td>
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<td>Ms Fiona Christina Smith</td>
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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 8 July 2014, 9 July 2014 and 17 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 carers and / or family members, talked with staff and reviewed information given to us by the provider. We talked with other authorities and were accompanied by a specialist advisor.

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

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

What people told us and what we found

We visited the home on 8, 9 and 17 July 2014. We spoke with 32 staff, the registered manager, five relatives and thirteen people using the service. We looked at the care plans of 16 people using the service and also looked at other records relating to the running of the service.

The inspection team who carried out this inspection consisted of four inspectors, three specialist advisors who specialised in differing areas of care delivery and an expert by experience. An expert-by-experience has personal experience of using or caring for someone who uses this type of care service.

Due to the complex needs of some people living at The Old Deanery Care Home they were unable to talk with us. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed two mealtimes and spent time in a communal lounge.

During the inspection, the team worked together to answer five key questions; is the service safe, effective, caring, responsive and well-led?

Below is a summary of what we found. The summary describes what we observed, the
If you want to see the evidence that supports our summary please read the full report.

Is it safe?

The service was not consistently operating in a way that ensured people were safe. Some people told us they felt safe and secure and we found staff had knowledge of when and how they should report any concerns about the safety of people using the service. However, we found that some concerns, had not been investigated by the manager. This meant action had not been taken to investigate some incidents and determine if referrals to the local authority for consideration under their safeguarding vulnerable adult's procedures were needed.

We found that recruitment procedures in the home were rigorous and thorough to ensure staff were safe to work with vulnerable adults. However when arranging staffing, the management team did not always ensure there was a suitable skill mix in relation to competencies, knowledge, qualifications and experience.

We saw that where people had been assessed as being at risk from acquiring infections or were at risk of falling, the assessments did not give staff information on how they could support people and minimise these risks.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. We found that although some staff had a lack of knowledge of DoLS, the registered manager had a good understanding and there were people with a DoLS authorisation in place in line with current policy. However, we found the Mental Capacity Act 2005 (MCA) was not being adhered to. This meant people were not always being supported with decisions made in their best interest.

Is the service effective?

The service was not consistently effective. Communication between staff was inadequate at times and led to delays in people receiving appropriate healthcare support from external professionals such as a GP.

We found that although staff were given training, they were not always putting this training into practice to ensure people were cared for safely.

Is the service caring?

The service was not consistently caring. We saw that some staff showed patience and gave encouragement when supporting people. We received some positive comments from people who were more independent. One person said, "Very pleasant here. I am glad I moved here." Another person said, "It is a friendly place. It is pleasant." Three other people told us they were very happy in the home with one saying, "I wouldn't have anything to complain about."

However, the needs of people who lived with a dementia related illness were not consistently understood or met in a caring way, by staff that supported them. We observed some people receiving care and support from staff who had little understanding of how to care for people with dementia. We saw this led to people with a dementia related illness records we looked at and what people using the service, their relatives and the staff told us.
not being supported to have choices, not always being treated with dignity and being placed at risk, for example burning themselves on hot food.

Staff had a good understanding of how they should support people with their privacy and dignity and we observed examples of staff respecting this. However we also saw examples of when people and their belongings were not treated with dignity. We heard staff refer to people as room numbers and tasks rather than by their name. This meant people were not always treated as individuals.

We saw inconsistencies in care plans in relation to people's likes, dislikes and information about the person's life history. This meant staff did not have the information they needed to make sure people were cared for in a way which they preferred.

Is the service responsive?

The service was not consistently responsive. We found that people who had a high level of need were not always being given the same choices as people who were more independent. People who were more independent told us they were happy with the level of care they received however our observations of people who needed more support from staff were not as positive.

We found that when people made complaints these were not always responded to and resolved appropriately or to the satisfaction of those that had raised them.

Is the service well led?

The service was not consistently well led. We found concerns in relation to the care and support people using the service were receiving. Throughout our inspection it was clear there was a lack of leadership of staff and systems were not robust enough to ensure people received a service that provided consistent good quality care. Other than the matron and the registered manager's reviews there was no system for the provider to check that those reviews were effective in identifying issues and/or improving the quality of the service.

We found that the service was not learning from experience because there was a lack of oversight when analysing or evaluating events to establish cause; identify any trends or themes and continually review practice. Whilst in some cases investigations were being, or had been, undertaken in relation to the conduct of some staff, there was no system in place to develop solutions and risk reduction actions to protect people and ensure future lapses were minimised.

The service did not have effective systems to assure the quality of the service they provided. The way the service was run had been regularly reviewed but action had not always been taken to improve the service or put right any shortfalls found. Information from the analysis of accidents and incidents had not been effective in identifying changes and improvements to minimise the risk of them happening again.

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 07 October 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 taken enforcement action against The Old Deanery Care Home 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

Respecting and involving people who use services  

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 not meeting this standard.

People's privacy, dignity and independence were not always respected and people's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

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 spoke with staff in relation to privacy and dignity and they had a good understanding in relation to how they would support people with this. Staff were able to give us examples of people who had a preference about the gender of the staff member who cared for them and we saw this carried through in practice on one occasion.

However, we visited one person's bedroom and saw a set of dentures on a dusty chest of drawers. There were cobwebs at the windows and the room was not well cleaned. Some of their belongings were on the floor. In their en-suite was a toothbrush with hard congealed toothpaste on it. This showed that staff were not actively respecting this person's belongings or personal space. We showed this to the registered manager of the service who agreed this was not the standard of care expected.

We saw that one person who used the service was sitting in a wheelchair which had another person's name, of the opposite gender, on the label. The staff told us they did not recognise the name of the person and they no longer lived at the home. This was undignified for this person.

We looked at the care records of one person who displayed behaviour which staff may find difficult to manage. A behaviour check record sheet was in place to record any episodes of 'challenging behaviour.' This did not have the person's name or any other identifying details. This document was used by staff to record difficult interactions with the person. The document contained many examples of 'labelling' which means a label was used a as the main way to describe or relate to the person. Within the document the person was labelled as, "Nasty", "Nice", "Aggressive", "Cooperative", "Polite", "Resisting." This meant staff were referring to this person in an undignified way and showed a lack of
understanding about the person's needs and the effect on their behaviour.

People using the service with a higher level of need did not always get the same choices as other people. We saw people in two dining areas who had a positive dining experience in relation to choice and being supported to maintain their independence. However people who were seated in a third dining area were not supported to have the same level of choice and support to be independent. The two front dining rooms were luxurious, with crisp white table clothes and serviettes. People dining in these areas were offered a choice of wines with their meal. They were also given tureens of vegetables and supported to help themselves to this. However people in the third dining area, which in contrast to the other dining rooms was quite bare, did not have tablecloths and had paper napkins. These people were not offered any wine and were not provided with tureens of vegetables; instead staff served their meals on a plate. The provider told us that tablecloths for this dining area were being ordered. However this meant not everyone using the service had the same choice or support to be independent.

People were given the opportunity to provide feedback about the meals provided every day on forms completed by staff and at resident forum meetings held every month and attended by the chef or another member of kitchen staff. We looked at a random selection of daily feedback sheets completed in June and July 2014. We saw that most of the feedback recorded was positive with entries such as; 'Everyone really enjoyed lunch', 'Enjoyed very much; beef really tender' and 'Very nice, lovely apple and custard.' However, there was no evidence in the sample records that people, who used the Garden Dining Room, where people needed to support with their meal, had been asked to provide feedback. This meant people who needed a higher level of support were not given the same opportunity to make comments or choices about the food.

We saw some examples of when staff did not show care and compassion to people using the service. For example, we saw that during one mealtime staff assisted people to eat mainly in silence and there was very little interaction or encouragement either to eat or make it a social and stimulating experience. We observed a person who gripped hold of an apron and two staff tried to tug the apron from the person's tight grip. We intervened and staff members agreed it was not essential to remove the item from the person at that time.

The activities coordinators and some staff showed compassion and kindness to people who used the service. They comforted and reassured people and showed commitment. Whilst there was a varied choice of activities which people enjoyed we observed that some were too complex for people living with dementia. They were provided with information at a rate too fast for people to keep up with and understand. This meant people were not always supported to engage in activities tailored to their individual need.

Three people told us they were concerned about communication with some staff in the service. This was related to staff whose first language was not English. A relative said, "If I can't understand then how are people with dementia supposed to?" One person using the service told us that sometimes if they asked for drinks the [staff whose first language was not English] didn't understand and they didn't get their drink.

We found that some of the environment, which people who had a dementia related illness used, was bare and lacked any stimulation and signage to support them to orientate themselves. Having signs in place could support people to navigate around the service.

We saw inconsistencies in care plans in relation to people's likes, dislikes and information
about the person's life history. In some care plans this information was detailed in a
document which was designed to give a full picture of people's life history and what was
important to them. We found this document was blank for two people whose records we
looked at. The registered manager told us that arrangements were in place for relatives to
have input into completing this form. However there were no arrangements in place for
people who did not have a next of kin or were not able to complete the form themselves. It
is important to gather such information to help staff develop relationships and
understanding.

We saw evidence in some care plans that people using the service and/or their relatives
had been involved in their own plan. However we saw that some people and/or their
relatives had not been involved in their care plan although we were told that the service did
offer this to all people.
Consent to care and treatment  

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.

Before people received any care or treatment they were not always asked for their consent and the provider did not always act in accordance with their wishes.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. Regulation 18

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 16 care plans and found there were inconsistencies in the way in which the Mental Capacity Act 2005 (MCA) had been applied. This is an act introduced to protect people who lack capacity to make certain decisions because of illness or disability.

We spoke to three staff members about the MCA and found that all three had a very limited understanding of this legislation and were not always sure how to apply this appropriately to the people that they cared for.

When reviewing the care plans we found that there was some confusion about how the service ensured people were protected when it was necessary to make decisions in their best interests. For example, when we looked at a person’s care records we could not find any documentation to confirm whether or not a mental capacity assessment had been carried out and staff could not confirm this either. Further records indicated this person had the capacity to make some decisions, for example, whether to have a key to their room and what social life they would like. However their relatives had signed other documentation such as the end of life plan. Because of the lack of assessment available it was not clear how each decision had been made in the person’s best interests.

Records showed that another person had not consented to a medical test on one occasion. However staff had carried on and undertaken the test without first using a MCA assessment to assess if this would be in the person’s best interest. This person was also resistive to personal care on occasion and there had not been a best interest assessment completed to inform staff of what they should do if the person resisted care.

We saw an assessment in one person’s care plan on which staff had documented the person did not have any impairment in relation to their ability to make decisions. Yet further on within the record staff had recorded that the person lacked the capacity to make
specific decisions. It was not clear from this whether the person had the capacity to make decisions or which decisions they may need support with. This meant staff did not have the information they needed to ensure the person was supported to be as independent as possible in making their own decisions.

We were told by the matron that one person had a skin condition and to prevent the person from making this worse, staff were putting on an 'anti-nail biting' application and gloves. A MCA assessment had not been carried out to determine if the person had the capacity to understand the reasons for this technique and to determine if it was in their best interest. This meant a restrictive procedure was being undertaken without the person's consent.

We saw a person's care records that where it had been deemed appropriate for the person to have bed rails in place, there was a two stage MCA assessment in place to show this decision was made in each person's best interests.

We looked at whether the service was applying the Deprivation of Liberty safeguards (DoLS) appropriately. We found there were people with a DoLS authorisation in place. The registered manager knew about a recent court ruling in relation to this and said they had retrospectively submitted 20 forms to comply with this requirement. This meant the registered manager knew her responsibilities in relation to this Act.

We spoke with four staff and one agency staff about their understanding of their responsibilities under DoLS. Three staff had a clear understanding of DoLS and what it meant to people using the service. The agency worker we spoke with did not have the same level of understanding. The fourth member of staff we spoke with told us they had heard of it but was not sure what it meant in relation to people using the service. This meant not all staff had a good knowledge of their responsibilities in relation to the Act and may not know how to support people who were subject to a DoLS.

We had been formally notified that one person using the service had a DoLS authorisation in place. This was because it had been deemed necessary in the best interests of the person to restrict their liberty in certain circumstances because they lacked capacity to make some decisions for themselves.

We saw that where people had made a decision in relation to DNAR the forms were appropriately completed and kept in people's care records. Where people did not have the capacity to make the decision relatives, the person's GP had been involved in the decision making. This meant that decisions in relation to care received in such an event were taken into consideration.
Care and welfare of people who use services

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a 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

When looking at the outcomes for people in this area we considered the action plan the provider had sent us after our last inspection in February 2014. In addition we reviewed all the information held about the service. This included information shared with us from a variety of sources including commissioners of care, relatives and staff. We found improvements had been made to moving and handling practice. The provider had purchased individual slings for people who needed assistance to transfer from their chair or bed. These were available to staff and were detailed in a moving and handling care plan in each person's care records. This meant this improvement had been made and staff had appropriate equipment in place to assist people to transfer safely.

We saw that in some cases staff practice in ensuring that people received the right care at the right time was good. This included seeking professional advice from GPs and others when needed. We spoke with two practice managers and a representative from the district nurse team who confirmed this and shared that they felt they worked well with the service. However we found the services ability to meet people's needs was inconsistent and also varied depending on the complexity of their health care needs. When people had a specific health condition there was not always a plan in place to inform staff how to monitor and changes or deterioration. For example, one person had been taking antibiotics for a urinary tract infection (UTI) and records showed that they started to feel very unwell after this. Staff had recorded varying symptoms which should have alerted them that the antibiotics were not working. However the person's GP was not contacted for six days. Once they got advice, the GP changed the antibiotics and the person began to feel well again. This meant the person had not received the healthcare they needed in a timely manner.

We looked at one person's care records which showed that they had previously suffered a gastrointestinal bleed following a gastric ulcer. However, the records did not contain any further information about whether the risk of reoccurrence had been assessed nor was
there guidance about how to monitor or review the condition.

We identified that care plans still did not always contain all the relevant information in relation to assessing and delivering safe and appropriate care to people using the service. For example we looked at the records for one person who was receiving 'end of life care' due to a significant deterioration in their health. Their care plan had not been updated in a timely manner to reflect this and so staff did not have the information they needed to inform them what support was needed in a consistent way. We addressed this on the day of our visit and the Registered Manager put in place systems to assess the person for pain and introduced a plan with information for staff. This meant this person could receive the support needed to ensure they were as comfortable and as pain free as possible.

We found a lack of effective assessment and planning in place for some people at risk of developing a pressure ulcer. For example, one person had been assessed as being at ‘mild risk’ of developing a pressure ulcer. However we found they had developed pressure ulcers on both of their heels. This had not triggered a reassessment of the risk and a plan had not been implemented to inform staff how to manage this.

We saw that where people had a high risk of falling, there was not always a plan in place informing staff how they could prevent or limit the risk. For example, records showed that one person had fallen 41 times in the last six months but there was not a plan in place informing staff how to minimise the risk of further falls. The senior management team felt this was related to a specific situation and the person was not at risk of injury. However they could not show how the service was proactively addressing this for the person to improve their care and help inform staff how they might manage it more effectively.

People were not always supported to wear their hearing aids. It was recorded in one person’s care plan that they needed to wear two hearing aids. We found the person was not wearing their aids during our visit and staff told us the person could not hear well. Neither of the staff we spoke with could remember the person ever wearing hearing aids. A second person was found without their hearing aids in and could not communicate with us. We asked staff to put the aids in, which they did but they failed to notice the aids were not working or switched on and therefore the person could not hear. We asked staff to change the batteries and once this was done the person was able to communicate with us and their relatives. We read a complaint made to the service about the negative effect of the loss of a hearing aid. They said that it had an ‘isolating’ effect on their relative and left them unable to communicate effectively. Although systems were in place for staff to check people’s hearing aids, staff we spoke with unsure about the requirements and the need to check that the devices worked. This meant we were not assured that people’s basic needs were being met in order to allow them to participate effectively in everyday life.

We saw that some people had mobility needs which meant that they could not move around independently and required support from staff. We spoke with people in their rooms and observed that in some cases important items were not within their reach. For example, we saw that one person who was in bed, could not easily access a jug of water because it had been placed out of reach. We also saw that the call bell and pressure mat, used to alert staff if the person moved independently (to help avoid falls), was partially disconnected from a wall socket to the extent that it did not function. This person had been assessed as being at risk of falls. We plugged the call bell back in and it activated and a senior carer responded. They told us they didn’t know why the plug had not been inserted properly and said, “[It] shouldn’t be like that, no excuse.” They also agreed that the jug of water should not have been left out of reach but they then left the room without moving it.
We repositioned the water jug and glass so as to be within easy reach. We were concerned that without our intervention the person could not easily access a drink if thirsty or summon the assistance of staff.

We had concerns about how people were supported when they were at risk of acquiring infections, such as a urinary tract (UTI). For example one person had developed a UTI on three occasions. A 'short term care plan' had been put in place to inform staff how to support the person during the infection. However a long term plan had not been put in place to inform staff how to support this person to prevent them developing further UTIs and information about how to spot warning signs that there was a risk of another developing.

We identified concerns about how support was planned for people who exhibited challenging behaviour. For example, the records of one person showed that the person showed patterns of, 'agitated wandering' and being repeatedly taken back to their bedroom where they spend the majority of their time. A member of senior staff said the person asked continuously to go home. We saw there were no care plans in place to manage this level of distress and the senior staff confirmed there was not. We saw another person suffered with anxiety. However this was not mentioned or taken into account in the planning and delivery of their care. This meant staff did not have the information they needed to ensure this person was supported when they were agitated. This did not ensure that staff had the information to take a consistent approach. This could also contribute to their mood and increase their anxiety.

We found staff were sometimes focussed on tasks rather delivering care which was centred on the person. For example, during our SOFI observations on the morning of our first visit we observed that several people who arrived for their breakfast were very sleepy or asleep at the table. The staff also noted this and said they would take one person back to bed after their meal. Another person was taken to the breakfast table asleep in their wheelchair. The staff tried to rouse them several times but continued to try and assist the person to eat and drink regardless of them not being alert. This would indicate they were not ready to get up at that time and that staff were working in a task orientated way rather than assessing individual needs on the day. Some staff we spoke with confirmed they worked to a routine which was set out on a 'working structure' document used in the home.

The senior management team shared that they recognised that the service was not suitable for people with complex needs particularly as these needs were increasing as people's health deteriorated. They told us they would be working with people, their relatives and professionals to improve this situation. In addition they had considered and changed the way they assessed people for admission to the service.
Safeguarding people who use services from abuse  

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

Prior to our inspection visit, we were aware of continued work by other agencies responsible for investigating concerns around safeguarding and protecting people from abuse. We saw at this inspection that procedures and systems had been strengthened to encourage staff to report any concerns and be knowledgeable about their responsibilities for reporting and sharing concerns about those they cared for.

We received concerning information about the care and welfare of two people using the service, prior to and after our visits. One person who raised concerns told us they had already spoken with the management team but they felt nothing had been done. We gave the information about these two people to the Local Authority (who have responsibility for looking at these matters) for consideration under their safeguarding vulnerable adult's procedures. We will monitor and review the outcome of these referrals.

We spoke with nine members of staff about their knowledge of their role in relation to safeguarding people from abuse. Eight of them were able to tell us how they would respond to incidents or allegations of abuse and how they would report it. An agency worker needed more prompting as they had some gaps in their knowledge.

We saw that staff recorded on a 'body map' when people were found to have bruising or an injury. This is good practice and showed that staff understood the importance of making these records. However, we saw that some of these had not been followed up by the Registered Manager to assess whether an investigation was required or if they needed to share the information with the local authority for consideration under their safeguarding vulnerable adult's procedures.

For example one person had been noted as having bruising on 10 separate occasions and when we checked accident records none had been recorded for these occasions and so it was unclear how the bruising had been caused. On two occasions it was recorded that a minor injury had been sustained whilst staff were assisting with personal care and a
transfer in their wheelchair. There were no records to show this had been followed up to make sure the staff had used safe practice whilst assisting this person.

We had similar concerns about bruising recorded for a further four people using the service. Bruises in elderly people can frequently occur because their skin has become thinner with age. The tissues that support the underlying blood vessels have become more fragile. However, bruising sustained from an unknown cause should be monitored and further investigation undertaken where needed. We were concerned that the service was not being proactive in this area to ensure that people using the service were not at risk.

We found the management staff at night did not have a good enough understanding of how they should lead and direct staff to deliver safe and effective care. One of the night managers told us that they would not have known about unsafe practice when people were being given care and support in their bedrooms as they, "Can't see through closed doors." This did not show us that the provider had learnt from recent events to ensure that management staff knew how to monitor staff and identify poor practice or concerning behaviours.

We asked people using the service, who could communicate with us, if they felt safe in the service. Some people told us they felt safe. One person told us, "We do feel safe and generally they treat me with respect, it is their job." Another person said, "Generally they are respectful and treat me as an individual." A further person told us, "Yes I feel safe here and the general atmosphere and the carers and the nurses make me feel safe."

We saw that information and guidance about how to raise concerns externally regarding potential abuse and other safeguarding issues had been displayed in various locations throughout the home. This was a visual reminder for staff to report concerns and to give people using the service information on raising concerns.

Some people we spoke with raised some concerns and we passed these to the manager to investigate. One person told us they did not feel safe. They said, "I don't like their kind of treatment, I like to be independent. The way I am treated, recently but I do not want to say. There are many different ways to treat me." Another person told us about a recent incident where they had not liked the manner in which a member of staff had addressed them.
Requirements relating to workers

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

Met this standard

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at the recruitment records of three members of staff and we saw the required checks were undertaken before staff began work. Records showed that staff were being given an induction when they first started working in the service and the five staff we spoke with in relation to this confirmed the checks had taken place and that they had been given an induction. This meant there were systems in place to recruit staff that were safe to work with vulnerable adults.

We asked to see information that related to staff performance management. Records showed that in the last year 18 staff had been subject to disciplinary hearings. We found that eight of these had stemmed from staff using the whistle blowing procedure. There were 14 disciplinary matters that related to the care, welfare and treatment of people living at the service. Records showed that the service had taken appropriate action to protect people once matters had been brought to their attention. This meant that when poor practice was identified, action was taken to protect people using the service.
Staffing

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 major 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

The last time we visited the service we had concerns about the staffing levels. The provider sent us an action plan and we looked at whether the improvements had been made during this inspection.

During this inspection we had concerns about the effective delegation of work between staff and we found there were not always enough staff with the right knowledge and skills to meet the needs of people living in the service. There were times when people's needs were not responded to in a timely manner, further that the delegation of work was not effective to ensure that needs were being met. A combination of factors led to this and it was not clear how this was being effectively managed.

There was a high reliance on agency staff due to vacancies the Registered Manager was trying to recruit staff in to. They shared that they had an agreement with the main agency to try and ensure the same staff were sent whenever possible.

Some of the agency staff we spoke with were not always familiar with people's care and support needs or the risks that had been identified. Some told us they had either not been allowed to look at people's care plans or had not yet had the opportunity of doing so. For example one agency worker did not know that one of the people they were supporting was at the end of their life and had a specific care plan around this. This meant there was a risk the worker would deliver unsafe or inappropriate care to that person.

We asked a senior staff member how they were assured that the agency staff were appropriately trained and competent to undertake their roles at the service. They said the agency staff completed a questionnaire about the training they had received and the agency was contacted to verify this. The registered manager told us following the inspection that they kept this information. Whilst these are positive steps, senior staff should be aware of the skills and competencies of agency staff within the staff team to ensure they can meet the needs of people in their care.

People we spoke with raised some concerns about the agency staff. One person said, "At
night there are lots of agency staff. Another person said, "I have got nothing against the staff but are too many agency staff at night and this has been going on since February. Agency staff are not so good and you do not know who is coming." One person said, "Needs better staffing ratio so that staff do not feel so under pressure and could spend time talking to residents. That would have repercussions and have a knock on effect. Good quality permanent staff is needed."

A relative raised concerns about the high proportion of agency staff working in the home saying, "[There is an] awful lot of agency staff, particularly over the weekend, therefore nobody builds up a relationship with [my relative] who doesn't know who to approach."

We found there were not enough staff to provide timely support to people. We saw that during at breakfast and lunch time observations there was a lack of support provided because the staff were not organised efficiently to ensure people could eat their meals in a calm and managed way. It was not clear who was in charge or what the roles and responsibilities of staff were. We saw several examples of people not receiving the appropriate support and encouragement they needed to eat or drink. On another occasion we noted that a staff member was left alone in a dining room to manage the needs of all of the people and could not do this effectively. One person said, "I have not had my cup of tea yet" to which the member of staff said, "I am doing my best." One person commented "I get tired of the vegetables being put on the table and having to wait for my meal. I then have to wait for staff to help me serve my vegetables."

We were told by people using the service about delays in receiving assistance that had caused them discomfort. One person told us that recently they had been left on a commode by staff for 20 minutes despite attempts to alert staff via the call bell system that they had finished; this had caused the person some pain.

We were told by a person that they wished to have a shower daily but were only able to shower twice a week as staff were not available to support a daily shower.

We were told by a person who uses the service that when they had used their call bell to call staff had been told "I am on buzzer cancelling duties". This person said this had happened on a number of occasions. Staff told us that there was always a member of staff on 'call bell duty' and that they cancelled the bells and "triaged" who needed to be seen first. This meant there were not enough staff on duty at peak times to ensure people received care and support when they asked for it.

We were told by staff that early in the morning there were two people that require three staff members to support them. This change in dependency levels had not been translated to an increase in staffing levels therefore, in the early morning there is one less staff member to respond to people's needs.
Supporting workers

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 always 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

We looked at the training records for staff members, spoke to staff in relation to the training they had received and observed practice.

We spoke with seven staff in relation to training and they all told us they had been provided with training. Some of these staff members told us that the training was adequate however one member of staff said that they would benefit from more in depth training in the conditions that people have so they can better understand people's needs. Staff told us they had not received any guidance or training in some of the more basic care needs for people such as how to support them with their hearing aids.

We looked at the training records and we saw that 91% of staff had been supported to gain a recognised qualification in health and social care. We saw that some staff had completed training in moving and handling, infection control, DoLS and medication training. However, only 42% of staff had received any training in how to care for people who lived with a dementia related illness. We saw the manager had booked training for staff to attend throughout the year. We looked at the dementia training which had been delivered. We saw that 19 of the 45 staff had received this training. Five had not received any dementia training since 2010. We saw there was further dementia training booked in July 2014 but no staff had yet been invited to these sessions.

Our observations of staff supporting people living with a dementia related illness showed that some staff needed further training because they did not have an understanding about how they the condition affected people differently. For example, we saw several times during the inspection that different staff presented hot food or drinks to people with dementia giving them an instruction to leave it to cool down. Some people with dementia lose the ability to judge the temperature of food and this presents a risk of burns and would not be able to retain this warning to remain safe from scalds or burns.

Staff we spoke with told us they were receiving regular supervision to discuss their work. The records we reviewed confirmed that supervisions were taking place. Staff told us that
they felt supported by the management team, they told us, "Anything you ask for you get. Management is easy to talk to and they are supportive." A further member of staff told us they felt well supported and that the atmosphere and general circumstances had improved. They told us they were now kept up to date with plans and had clear objectives.

We looked at information provided to staff on induction. We saw that staff were given a summary of the needs of people they would be supporting. The summary did not include any reference to people's care records or information about their health needs or identified risks. We noted that although background information about people's character and personal circumstances were provided, important information about people's basic needs and vulnerabilities were not highlighted. For example, no mention was made of one person's significant risk of falling, another person's specific dietary and nutritional needs or another's communication needs. This meant a new member of staff may not have been provided with sufficient information to enable them to meet people's health and welfare needs.
Assessing and monitoring the quality of service provision

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 have an effective system to regularly assess and monitor the quality of service that people receive.

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

Overall we found that the systems in operation at the service were failing because they did not include effective assessment, monitoring and review of the quality of the service to address identified risks. We found that the leadership within the service did not have a good oversight of the way in which the home operates. This included the way staff were managed to deliver care and support effectively.

We found that some concerns had been identified during the auditing process but had not been addressed effectively to make the improvements required. We attended a 'relatives and residents' meeting where the Clinical Director advised people and their relatives that they had concerns in September 2013 and had been working to address them. We were concerned about the amount of time the service was taking to make improvements.

We found key people in the management team were not being monitored effectively by the provider, to ensure they were making the required improvements and were leading staff in good practice when delivering care and support. We observed that there was a lack of effective supervision and direction for staff, particularly at night. For example, there were a team of three leaders responsible for the safety of people using the service on the night we visited. All three found it hard to describe what dementia care was all about and even more difficult to explain their understanding of the MCA 2005, DoLS, capacity and best interest decisions.

It had been identified by the provider that there was a need to train staff in expected values and behaviours following a safeguarding incident within the home. We saw that there were plans in place for this training but only 43% of all staff had completed this. The Matron was carrying out some observational checks in this regard however we were concerned that there was such a delay in the plans being implemented to ensure staff knew what their employer expected in relation to values and behaviours.
The provider had confirmed in advance of our inspection that they had made the required improvements identified at our last inspection and had received support and input from multiple agencies and professionals. However we still observed examples of poor practice during our inspection visits. For example we observed a member of staff providing care that was not respectful of the person and did not take into account their needs or abilities. When we spoke to the staff member they were unaware that their actions amounted to poor practice. We intervened in this case and reported the staff's conduct to the manager who said they would address this in supervision. Other examples included the manner in which some staff spoke with and/or about people in their care. We saw that care staff provided task based care without always considering people's individual needs or choices.

We identified concerns at our last inspection with staff referring to people by their room number's rather than names. When we visited the service on 18 July 2014 we heard that the night staff routinely refer to people by their room number and a member of staff that we spoke to could not identify people if we used their names. We saw that none of the bedrooms had the person's name on the outside door and only a few had a picture of the person on them. We asked a member of the management team for the care plan of a person and they immediately asked for their room number. This practice displayed by one of the leaders within the organisation could promote a culture of institutionalisation and did not demonstrate knowledge of individuals that we would expect.

The service has a call bell system in place which monitors and logs when bells are not responded to by staff within a specific timescale, with call bells switching to 'emergency' if unanswered after six minutes. The Registered Manager used this to assess if staff were responding to people's needs. We saw as a result of the allegations that call bells were being pulled out, staff had been told to record in people's daily notes whether the call bell was in place and working. We saw that staff had recorded that in daily notes that call bells were plugged in and working on the days we visited. Despite this during our inspection, we found three people's call bells were not connected to the system. We visited one person in their bedroom on four occasions during our inspection. Records showed it was important for them to have access to the call bell for support from staff. Three times we found their call bell was not working and on the fourth occasion we found it was out of their reach. Although reasons were given for each situation it demonstrated that records were not accurate and that the system put in place to ensure call bells were working and could be used were not effective. During our night visit, we found a further four people in bed who did not have their call bell within reach. This meant that if they needed to summon staff during the night they would be unable to without moving independently or calling out.

We looked at the systems used to identify, analyse and review risks to the older people at living at the service. We found that the service had a falls strategy, written in 2012. It was updated in 2013 but the telephone number given for the local falls assessment team was out of date and there was no reference made within the policy to assessing the mental capacity of people at risk of falling. We found that the review and update of this document had not been effective. The service was aware of NICE guidelines such as 'Falls in older people' and Department of Health information on 'Independence, Choice, & Risk: A Guide to Best Practice in Supported Decision Making' but these guidelines had not been fully included in the strategy.

We saw evidence that falls were documented on an individual basis with further discussion taking place at a Health & Safety Meeting. Incidents of falls were aggregated and total figures were included in the Senior Management Report. However there was not a systematic approach to identifying trends and actively seeking to prevent re-occurrences
of falls. In addition, the service was collating the number of infections that were affecting people living at the service. In June 2014 there had been 22 infections reported. We found that statistics were collected and analysed but as with falls, there was no system focusing on prevention of infection.

We examined the accident and incident book at the service and found that there was not a systematic approach to audit accidents and check for trends. The Registered Manager told us that they had all of the information "in my head" and was therefore able to identify trends. We were concerned that without records in this regard with actions to ensure mitigated risk, the service was not ensuring people were protected from potential risk.

We asked for all information that demonstrated that the service listened to people and their representatives who used the service. We found that there had been a relatives meeting on 01 May 2014, 27 May 2014 and 01 July 2014. The next was planned for two months' time. There had also been resident forum meetings held with minutes kept on 07 May 2014, 10 June 2014 and 07 July 2014. The senior management team were aware of the need to keep people using the service, their family and others informed and up to date in respect of ongoing investigations being completed by other agencies. Most people were satisfied that those responsible for previous poor care were no longer working in the service and the majority of issues discussed at these meetings focussed on the experiences of daily living including laundry and food.

Many people were dissatisfied with the process of laundering and returning their clothes. The senior management team told us they had tried to address these concerns however people we spoke to felt this was still a problem area. For example we were told that people are still receiving other people’s clothes; that clothes are not ironed and a relative told us that they had had to resort to taking clothes away to launder at home to ensure this was done to an acceptable standard.

We found that whilst senior staff members were carrying out observations of practice with the view to ensure improvements this was not always effective. For example we saw that the Matron at the service had completed observations of mealtimes in two dining rooms in May 2014. The findings of the observation set out eight concerns directly effecting people using the service. The Matron told us they had feedback to the Registered Manager but they were unable to provide us with an action plan of what measures were being taken to address the concerns. During our inspection we identified similar concerns, six weeks following the matron’s report.

We looked at the log of complaints made to the provider regarding the service provided and how the service had responded and learnt from complaints. We found that in May 2014 the service had received five complaints. Each one had been logged, matters looked into and complainants had been responded to in writing. On one occasion a senior manager had met with complainants face to face to discuss concerns. Where this had happened we could not see any minutes of the meeting or of any agreements reached in that meeting. In one case where a person had made a lengthy complaint listing 15 different concerns we only saw a one page reply that did not address each matter raised. We were therefore not assured that all complaints were responded to in an effective manner.

Two relatives shared their concerns with us about the quality of the governance of the service and the ability of some staff to provide basic care for their relative and keep them safe. One said the management did not acknowledge concerns. They said, “Things aren’t getting better quickly enough.” Another said, “Promises are false, [we are] paying for top
notch care but not getting it. At meetings they tell us what are going to do to improve but apart from new staff not much else is evident."

We saw that in 2013 a quality assurance survey had been completed. This sought the views of people at the service, their relatives/advocates and feedback from professionals who visited. The overall finding was that 67% of people were happy with the service offered. However there was not an action plan in place of learning or development from these findings or to address the 33% that were not satisfied.
Records

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 20(1)(a) and (2)(a)

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 a range of care records relating to a number of people who lived at the service. We found that most were kept in poorly maintained folders which were disorganised and difficult to navigate. Records and information about people's needs were not always filed correctly and it was often difficult to establish exactly what needs had been identified, assessed and planned for. For a new member of staff it was not clear how they would know about or understand a person's needs quickly or easily.

We found conflicting information relating to people's needs and abilities in care plans. For example, one person had a plan in place for a 'safe environment' which stated the person mobilised using a wheelchair. However there was a further plan in place which held conflicting information about the person's mobility, ranging from walking with a walking aid to needing two staff and a hoist to transfer. We needed to speak with staff to ascertain what support the person needed. This meant the records were not fit for purpose as they did not provide information for staff on how this person mobilised.

We saw that record keeping demonstrating which staff had provided care to individuals and when this care had been given was not always completed in a way that demonstrated the care was being delivered as it should be. For example, we found that two people should have been repositioned every two hours. However there were frequent gaps of up to six hours and no records at all on some days. One of these people needed two staff to deliver the care but staff were sometimes only recording one name on the repositioning document. This meant the service could not always demonstrate through records that the care had been delivered in a safe way.

We saw that information needed to monitor people at risk of dehydration or malnutrition was recorded in a number of different places including people's care records, fluid and food intake charts held separately and in communication books. This meant that important details about the risks to people's health had been duplicated needlessly and it was not always clear where to find the most up to date information. This was also the case for the...
recording of falls, adverse incidents, accidents and injuries sustained. For example, details of a fall suffered by a person during the early hours on our first day of inspection was recorded in a staff communication book but not the accident records when we checked the following day.

We saw that one person had a nutritional screening tool in their care plan. However there was no name recorded on the assessment so it was unclear if it belonged to this person. There was also a MCA assessment in this person’s care plan, which had another person’s name on and so did not belong in that care plan.

We saw that some records were incomplete. For example the care plan of one person held a summary of the person’s needs but the information was incomplete. There was a care plan review document and some dates were missing and the preferences for the person had a space to record it had been discussed with the person’s next of kin but this was blank. This person had a continence assessment completed by staff and they had failed to record the person’s medical history, weight and results of a urine test carried out as part of the assessment.

Body maps were being used to record when people had sustained bruising and/or injury. There were prompts on these maps for staff to follow up the bruising/injury at various intervals. None of the body maps we saw had follow up information recorded. We spoke with a member of staff about one person’s body maps they told us that the records had not been completed properly which made it difficult to establish the cause of this person’s bruising.

We saw that staff recorded information in the communication books in a detailed and appropriate way but did not always transfer that information to care plans. For example, there was an entry in the communications book on 16 June 2014 which said that one person had punched a carer in the stomach. We checked the person’s records, including their behaviour management charts and there was no mention of this event having taken place or any actions taken as a result.

We saw there were inconsistencies in the weekly weight charts kept to assess weight loss. There were occasions where records would indicate a loss or a gain of in excess of 5kg in a week. A member of staff told us they had recognised this inconsistency on one occasion and told us they had re-weighed people as something was not right and some weights were, ”Way out.” We saw other occasions where the weights were inaccurate. This meant staff could not properly assess where people were becoming at risk in relation to nutrition. Following our inspection the registered manager told us that the scales were calibrated 6 monthly and an investigation had identified that each time different weighing equipment had been used for some people which meant the results were inconsistent.

We found the cupboard used to store people’s care records on the first floor had been left unlocked and insecure on a number of occasions during our inspection. This was despite a sign having been clearly displayed on the door instructing staff to keep the cupboard locked at all times when not in use. This meant that people’s confidential personal and medical information had not been adequately protected from unauthorised access.
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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Respecting and involving people who use services</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>People's privacy, dignity and independence were not always respected and people's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. Regulation 17 (1)(a)(b)</td>
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<th>Regulated activity</th>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Consent to care and treatment</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Before people received any care or treatment they were not always asked for their consent and the provider did not always act in accordance with their wishes.</td>
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<tr>
<td></td>
<td>Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements</td>
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<th>Regulated activity</th>
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<tr>
<td>Accommodation for</td>
<td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations</td>
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<td>Regulated activity</td>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Staffing</td>
<td></td>
</tr>
<tr>
<td>How the regulation was not being met:</td>
<td>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 (1)(a)</td>
</tr>
<tr>
<td>Regulated activity</td>
<td>Regulation</td>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td>Supporting workers</td>
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<tr>
<td>How the regulation was not being met:</td>
<td>People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Regulation 23(a)</td>
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<td>Regulated activity</td>
<td>Regulation</td>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td>Records</td>
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<tr>
<td>How the regulation was not being met:</td>
<td>People were not protected from the risks of unsafe or</td>
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inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 10 (1)(a)(b) (2)(a)(b)(i)(ii)(iii)(v)(c)(i)(e)

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 07 October 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.
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.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
<th>How the regulation was not being met</th>
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</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Care and treatment was not planned and delivered in a way that was intended to ensure people’s safety and welfare. Regulation 9(1) (a)(b),(i)(ii)</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Assessing and monitoring the quality of service provision</td>
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We have served a warning notice to be met by 07 October 2014

This action has been taken in relation to:

Regulated activity | Regulation or section of the Act | How the regulation was not being met |
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<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Care and treatment was not planned and delivered in a way that was intended to ensure people’s safety and welfare. Regulation 9(1) (a)(b),(i)(ii)</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
</tbody>
</table>

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.
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.
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:

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

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.