Inspection Report

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

Westgate House Care Centre

Tower Road, Ware, SG12 7LP

Tel: 01920426100

Date of Inspections: 12 June 2014
11 June 2014

Date of Publication: July 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✖ Action needed
Requirements relating to workers	✓ Met this standard
Records	✖ Enforcement action taken

Details about this location

Registered Provider	Westgate Healthcare Limited
Registered Manager	Mrs Shiji Mathew
Overview of the service	Westgate Care Centre is a purpose built care home providing nursing or personal care to older people. The home has a purpose built unit for people living with dementia and also provides rehabilitation care. The home is registered to provide care for up to 109 older people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Westgate House Care Centre had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Requirements relating to workers
- Records

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 11 June 2014 and 12 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services. We talked with commissioners of services.

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

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

What people told us and what we found

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 June 2014 and 12 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services. We talked with commissioners of services.

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What people told us and what we found

At our inspection on 03 and 04 March 2014 we found that the service was required to make improvements in relation to treating people with dignity and respect, their consent arrangements, the care and welfare of people who used the service, recruitment methods and the accuracy of people's records. The provider submitted an action plan on 17 April 2014 which told us they would be compliant with the regulations by 15 May 2014.

We inspected Westgate House Care Centre on 11 and 12 June 2014 and found the provider had made some of the improvements, we had requested by 15 May 2014. At this inspection we were supported by three inspectors and one expert by experience. We looked at 12 people's care records. We also spoke to the provider, manager, the unit managers for the three floors of the home, and 15 members of care staff on duty. We have served warning notices on the provider and manager requiring them to be compliant with the Health and Social Care Act 2008 by 18 July 2014. We will follow up this warning notice to ensure compliance has been reached.

We set out to answer five questions. These were whether the service is 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.

Is the service safe?

We found that care was not consistently planned and delivered in a way that was intended to ensure people's safety and welfare.

We found on two floors that pressure mattress settings were consistent with the weights of people who used the service. However on one floor we found that all pressure settings were set to firm, regardless of the weight of people.

Is the service effective?

We saw that most of the risk assessments and support plans had been reviewed and updated following our last inspection. We looked at the care notes for people whose plans we had viewed and saw that in most cases care was recorded as being delivered in accordance with the plans. However these had not been completed for all people who used the service.
Overall people's daily care records were up to date and reflected the care provided to people. However we found examples where the care plan had not been followed, reviewed or updated.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. Where applications had needed to be submitted at our previous inspection, proper policies and procedures had been followed. Relevant staff had been trained to understand when an application should be made, and how to submit one.

Is the service caring?

We observed staff interaction with people who used the service and noted that interactions were positive. Staff were attentive and kind and appeared to know the people well. However we also found that for two people who used the service, staff were unaware of their particular needs. These two people presented with particularly high and complex

needs.

During our previous inspection we found that all the bedroom doors for people were left open, this did not promote people's dignity and privacy. At this inspection we found that staff had reviewed this with people and their relatives and people's doors were only open where they had requested this.

We found that staff were in the process of reviewing all people's care records and were involving people who used the service and their relatives. This meant that they were able to seek the views of those people who best understood the needs of the person.

Is the service responsive?

The views of people who used the service were sought, encouraged and recorded in their care plan. However these views and preferences were not always carried out. We noted that preferences in relation to activities and bathing had not been provided for example.

The service listened to people's experiences, concerns and complaints to improve the quality of care they received. We saw that recently the manager and staff had held meetings with residents and relatives to seek their views and opinions. However it was too early to determine how the manager had reviewed the responses and learned lessons from these views.

Is the service well led?

The service did not always promote a positive management culture that was positive, and open. We were provided with one record which we determined had been doctored during our inspection to provide us with a false impression of recruitment procedures. We confirmed the false entry made on the record with staff working on duty who had made the entry.

We found that recruitment processes for employing new care staff had been reviewed. We saw from records we looked at that staff employed at Westgate House Care Centre had been thoroughly vetted to ensure they were of good character and experienced to work with vulnerable adults.

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 11 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 Westgate House Care Centre 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 ✖ Action needed

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 respected.

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

Reasons for our judgement

During our previous inspection on 03 and 04 March 2014 we found that all the doors to resident's bedrooms were open. Discussion had not been held with people who used the service, and having doors open was the usual practise. This did not promote people's dignity and privacy. We asked the provider to inform us how they were going to take action, and inspected Westgate House Care Centre on 11 and 12 June 2014 to ensure this had been implemented.

We found that staff had discussed with each person, or their relatives where appropriate the option to have their door left open. We noted that where a door was to be left open, staff had explained that a person may be at risk of having their privacy or dignity exposed at times. This meant that staff had ensured they had sought the views of people who used the service and their relatives to maintain people's dignity and privacy.

People told us they were involved in the planning of their care needs. Relatives told us they felt involved and staff regularly kept them up to date with any issues. Staff we spoke with told us that they placed the needs of the person at the centre of the care they provided. One staff member told us, "[It] can be difficult when the family wants one thing and residents wants another, at the end of the day the resident comes first."

Throughout our inspections between 11 June and 12 June 2014 everyone we observed in the home looked clean and tidy. People were dressed appropriately and we noted that staff had taken time to ensure people were well groomed.

We observed through our inspection that clear explanations were given to people before assistance was provided. Staff noticed when people needed the toilet and stopped what they were doing and assisted them. We observed this whilst one person was being assisted to eat and the staff member noticed that they were fidgeting and asked them in a

very dignified manner. They then proceeded to support the person's need and assisted them to their room. We saw one person who used the service sat in a lounge in a wheelchair wearing a soiled T-shirt. However we noted when we returned to the lounge that staff had assisted him to change and he was dressed appropriately.
This meant that the dignity, privacy and independence of people was maintained and they were encouraged to make, or participate in making, decisions relating to their care or treatment.

We observed that a visiting General Practitioner (GP) was seen in the communal lounge on Poppy unit undertaking a patient consultation. They said loudly to the resident who was hard of hearing, "I'm going to get the nurses to do a poo test for you". We asked the GP if it was their normal practice to undertake consultations in communal areas. They said that it was not, but that the service user concerned didn't wish to move to their own room and it was their choice. However, when we spoke with staff they told us that this was the normal practice for this GP. We noted that staff on duty did not intervene or challenge the conduct of the GP. This meant that the staff on duty did not take steps to ensure that people's dignity was promoted.

Care plans we looked at were not always written in a person centred and dignified manner. For example we noted that some care plans addressed people's 'problems'. One record we looked at noted a person's 'problem' for their social care plan was that they had, 'difficulty in participating due to reduced mobility'. We felt that the use of the word problem was not a suitable phrase to use when describing a person's individual care needs.

We saw from people's personal preferences and choices documented in their care records that these were not always provided to people. For example, one person stated that they liked to be outside and had an interest in gardening. The home had recently had a refurbishment of the garden area, which included flower beds and seating. We saw from this person's daily records that they had not been offered the opportunity to spend time in the garden or outside in the fresh air. Through our inspection of two days we noted that people from the upper two floors were not taken into the garden area, however we noted other examples where people had stated their hobby was gardening, plants or being outdoors. We also observed one person at breakfast time be provided with marmalade on toast. They said to the carer that the marmalade had been spread to thickly for their personal taste. The carer removed the toast, and prepared a new slice. However, this particular person was mobile, and capable of preparing their own breakfast once the components were given to them. One person who used the service told us, "With regard to activities I was only told about bingo." This meant that people's individuality and preferences had not been considered when providing activities and the home had done little to support and enable people's independence.

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

When we inspected Westgate House Care Centre on 03 and 04 March 2014 we found that the legal requirements of the Mental Capacity Act 2005 had not been followed. The records we looked at for people who were living with either dementia or some form of cognitive impairment showed that people's capacity to provide consent had not been assessed thoroughly. In some circumstances, where bed rails had been used, this meant people may have been unlawfully restricted to their beds without alternative less restrictive options being considered. During this inspection, staff were unable to demonstrate to us their awareness of matters relating to consent and the Mental Capacity act 2005. We asked the provider make to improvements and they submitted an action plan to us to inform us how and when this would be achieved.

When we inspected Westgate Care Centre on 11 and 12 June 2014, we looked at 12 people care records and spoke with eighteen people who used the service. We spoke with 15 members of care staff and senior management at Westgate Care Centre. The inspection team consisted of a team of three inspectors who were supported by an expert by experience.

We found that since our last inspection staff had assessed people's mental capacity in line with the requirements of the Mental Capacity Act 2005. Where people were using bed rails, staff had considered alternative options such as using low profile nursing beds and crash mats. This was to ensure the least restrictive options had been considered. Where appropriate, staff had also sought the views of people's relatives, and the views of healthcare professionals. Where the use of bed rails was the only available option to ensure people's safety, the manager had submitted in excess of forty deprivation of liberty application to the local authority. This was to ensure a person was not being unlawfully restrained.

In the twelve care records we looked at we saw that the appropriate assessments had been documented and were kept under regular review. We also saw evidence of people's relatives being involved in the assessment and signatures in the care records demonstrated this. This meant that where the person using the service lacked capacity, best interest meetings were held with people who knew and understood them.

Our inspection on 03 and 04 March 2014 found that where staff had received training in relation to consent, they were unable to satisfactorily demonstrate this awareness to us through discussion. However, during this inspection we spoke with three members of staff specifically in relation to consent. All staff were able to provide us with a satisfactory overview of how consent is obtained, documented and reviewed, and the manner in which consent is obtained.

We also found during our inspection on 03 and 04 March 2014 that the home did not provide access to an advocacy service for people. This meant that people who used the service that required the advice and support of an advocate may not be able to receive this. We found during our inspection on 11 and 12 June 2014 that people were provided with the details of a local advocacy service, and this had been discussed at recent resident and relative meetings. This meant that people who used the service had access to an advocate to assist them in understanding their options and enable them to make an informed decision.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care 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 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

When we inspected Westgate House Care Centre on 03 and 04 March 2014 we found that risk assessment had been carried out but in some cases care plans had not been created. We also found that where a care plan had been developed, care had not been delivered in line with this.

When we inspected on 11 and 12 June 2014, we found that the provider had made some improvements.
People who used the service were overall positive about the care they received at Westgate House. One person who used the service told us, "I think they have been fantastic here. It's not home of course but I've asked to move here permanently now so it must be okay." We spoke with people's relatives who were also positive about the home. During our inspection we observed that staff appeared to know people well, there was a friendly, sociable atmosphere and the home appeared relaxed and calm.

We looked at 12 people's care records and saw that overall people's daily care records were complete with no gaps. However we found that people's food and fluid charts were not always accurate and have reported this elsewhere in this report.

We saw from care records we looked at that the manager was in the process of inviting people's families to review the care records with the staff and the person who used the service. We observed one person who was being admitted to Westgate House Care Centre, and noted that their views were extensively sought by the nurse when developing the initial care plans.

We saw from the care records we looked at that people did not receive a bath as their preferred option. On one floor staff told us that they did not have the necessary equipment to hoist people into the bath safely. They told us that the manager was ordering the required hoist and sling to enable them to provide baths to people in the future. They also told us, "we need equipment to bathe people, the hoist in insufficient to get people in the bath. This meant people did not receive care according to their wishes. For example, one

person had indicated in their care record they wished to be bathed. However, records showed they had only received a bed bath, and not an alternative shower. When we spoke with staff they told us that ten people on that particular floor required bathing, however they were unable to provide this. Staff went on to say that each person had a day of the week for a shower. Unless of course they asked for an additional shower which staff assured us they would assist with. When we asked if one person had received their bed bath or shower, staff told us this had been missed for that week. They told us they were scheduling the person for later that day.

Multidisciplinary team meetings took place once a week to review people's care needs on the integrated care unit. This included the views of social workers, GP, occupational therapists, physiotherapists, the clinical manager and the unit manager. We spoke with one visiting professional who told us for that unit, "Yes they follow care plans and people's weights are stable. The staff seem to be giving supplements to people appropriately" However, one person was on a restricted fluid diet. We looked at the care records and noted the dietician had requested the person consumed only 1500 millilitres per day of fluid. The instruction documented in the corresponding care record noted that, Please limit [Residents] fluid intake to a maximum of 1500mls per day." We saw from daily fluid records that the amount of fluid provided fluctuated. For example, the day prior to our inspection the person was given 1250ml. Prior to this they were provided 2000ml, and prior to this 2400ml. Where a care plan was in place for this particular need staff were not aware, and were therefore not providing care as needed.

We became aware of one person who used the service who had been identified as a person who became depressed and had previously made suicide attempts. When we looked at the care records for this person we noted there had been no care plan developed. We spoke with three carers who were unaware of this particular need. This meant the needs and welfare of this person were placed at risk. This was because staff were not aware of this person's individual needs, and how to both identify and respond if their mood fluctuated. We spoke with the person who used the service who told us, I don't like it here. I am lonely. Nobody speaks to me. They play bingo I like that."

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by suitably experienced staff.

Reasons for our judgement

We saw from three staff records we looked at that a copy of the staff member's application, curriculum vitae and interview record had been maintained for all of them. We saw from the interview record that each particular role included specific scenarios to evaluate a potential employee's knowledge. Where nurses had been employed, we saw the provider had checked with the relevant professional body to ensure they were registered.

We noted that where a person had been recruited from overseas, a copy of the visa entitlement was kept in their file. Each recruitment record we looked contained proof of identity in the form of a passport and utility bills to ensure people were entitled to work. We also found that for each of the people employed, the provider had sought a Disclosure and Barring Service check to ensure potential employees were fit to work with vulnerable people. We noted these checks had been reviewed by the manager, and none of the employees had commenced work prior to these checks being completed.

Each record we looked at had at least two accompanying professional references, which had been reviewed by the home manager. Each person's employment history had been satisfactorily explained and there were no unexplained gaps in their employment. This meant that appropriate checks were undertaken before staff began work.

We looked at the induction process undertaken by staff. Staff we spoke with told us that they had shadowed a senior staff member during their first week. They told us this allowed them to orientate themselves with the home, review policies, and get to know people who used the service. Staff also completed the skills for care induction booklet which followed the national standards for caring.

The clinical manager told us that they were assessing three nurses from overseas to be able to administer medication safely, and we confirmed this during our inspection.

However the provider may find it useful to note that for one staff member who had been recently employed we were unable to find evidence of an assessment of their moving and handling skills. We asked the manager how they ensured staff were competent to perform their role, in this example, specifically with regard to safe moving and handling. When we asked to see a copy of their induction records to demonstrate they had been formally

assessed we were shown a copy of an entry made on the day of our inspection in response to our request that related to eight days previous to our visit. We have reported on this elsewhere in this report.

Records

✖ Enforcement action taken

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 because accurate and appropriate records were not maintained.

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 we inspected Westgate House Care Centre on 03 and 04 March 2014 we found that people's personal confidential records were not stored securely. We also found that people's care records were not accurate and had not been reviewed as necessary.

When we inspected Westgate Care Centre on 11 and 12 June 2014 we found that some improvements had been made.

We noted that key pad locks had been attached to all the nurse's stations to ensure people's records were stored securely. We observed throughout the two day inspection that the doors to the nurse stations on all floors were kept shut and locked. This meant that confidential care documentation relating to people who used the service was maintained securely.

However we noted during our inspection of 03 and 04 March 2014 that one person's care had been reviewed by a dietician. This information had not been updated in the person's care record. When we inspected on 11 and 12 June 2014 we found a contradiction in the dietician instructions recorded in the care plan in regard to amount of fluid to flush when using the percutaneous endoscopic gastrostomy (PEG). This is a method that used where patients cannot maintain adequate fluid or nutrition with oral intake. The Dietician reviewed the person and requested a reduction of the peg flush pre and post feed and with medicines. Peg feed care plan states 60mls. Care plans written and reviewed after the dieticians review on two occasions had not identified and implemented the instructions. However daily care records we looked at demonstrated the person was given the correct pre and post flush. This meant that where the care records were inaccurate, there was a risk that the person may have been given the incorrect amount of flush. The purpose of flushing the peg is to ensure it does not become blocked, and contribute to the daily fluid consumption for the person. Where this person was on a restricted fluid intake, there was a risk they may consume more fluid that was recommended by a health professional.

One person admitted the previous evening had not had an assessment of their needs by Westgate House Care Centre prior to their admission. They told us that nobody had undertaken an assessment of their needs at the time of their admission and they had not been visited in hospital by any representative of Westgate Healthcare in order to assess their needs. They had a fractured leg, but no individual moving and handling assessment had been documented to ensure staff were able to provide appropriate support.

We found that peoples risk assessments had been updated however these continued to retain conflicting information such as their care needs and people's personal preferences. For example, the home had reviewed people's personal preferences in response to our March inspection. We noted that a new sheet had been developed to record people's choices around daily activities such as choice of meal, activity, time they like to get up and go to bed. We noted that in this sheet, one person had said they liked to get up at 8am. However throughout the care records we noted consistently that an old entry referred to the person getting up at 7am. This meant that due to inaccurate records people's personal preferences and choices may not be met.

We checked the pressure mattress settings throughout the home. We saw on two of the floors that pressure settings had been set correctly according to the person's weight. On the integrated care unit for example we found people on correctly set mattresses which were checked twice daily. However, when we looked at the pressure settings for the second floor we found that all had been set to firm. The daily audit sheet had recorded that pressure mattresses and overlays were to be set to firm, and nurses had checked to say these were correct. We asked why staff had disregarded people's weights when applying the firmness of the mattress. The nurse told us that they were instructed to set the mattresses to a firm setting by the tissue viability nurse from the local authority, however was unable to show us evidence to prove this claim. We were able to establish however that where a risk of skin breakdown was present due to ineffective auditing and reviewing of the mattress settings, no person had suffered a breakdown of their skin integrity. This did mean however that due to the inaccurate records, those people who were at high risk of skin breakdown, may have rapidly developed pressure sores.

Risk assessments were not always accurate or in place for people where staff had identified a care need. For example we identified one person who used the service who had been in Westgate House Care Centre for over a week. We discovered this person presented a risk of self-harm or suicide. When we looked for a care plan and risk assessment to manage this we were unable to find one. We spoke with the nurse about this, who confirmed one had not been developed. We later saw an assessment that had been developed. We noted this assessment contained scant information about the signs and triggers for the person, how staff were to manage these, and medicines the person was prescribed. We spoke with the provider and showed them a copy of the risk assessment. They confirmed the content was not sufficient to both identify and manage the risk to the person.

We saw from cleaning records we looked at that daily task allocation schedules not been signed as completed as far back as April 2014. This included but not limited to items to be cleaned such as hoists, over chair tables, dining tables, kitchenettes, cushions, and rails in corridors. During the second day of our inspection we noted the manager had taken action to remedy this.

Fluid charts did not always total the amount of fluid consumed and output. For example one person's record indicated they had urinated, instead of recording an amount, staff had

recorded 'Wet Pad'. This made it difficult to review any persons hydration levels. This meant where people's fluid was being monitored for the purposes of tissue viability for example, staff could not be confident an accurate record of fluid had been maintained.

We reviewed staffing records for three new members of staff. We asked the manager how they ensured people had been assessed as competent to provide core personal care to people. For example, one member of staff employed as a carer had been employed from a different home. They had historically attended moving and handling training with the previous home. As part of their induction at Westgate House Care Centre we asked if new care staff were assessed by senior staff to ensure they were competent. The manager told us they were, and that the nurse on each unit carried this out. We asked to see evidence of this assessment and the manager went to the unit to collect this. After a lengthy period of time, the manager produced a supervision record that had been dated 04 June 2014. This recorded that the nurse had observed the staff member providing moving and handling and was competent. We challenged the authenticity of this document, and spoke with the nurse who had completed it. They told us, "I am sorry, I wrote it today because [manager] told me to backdate it." We spoke with the provider about our concerns of how this record was compiled. This meant that we were unable to see evidence of staff assessments because the manner in which the record had been maintained suggested it had been doctored.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Regulation 17 The registered person must, so far as reasonably practicable did not make suitable arrangements to ensure the dignity, privacy and independence of service users was maintained. Also the registered person had not always provided appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9 (1) (a) and 2 (i) (ii) The registered person had not taken appropriate steps to ensure that each person who used the service was protected against the risks of receiving inappropriate or unsafe care that met their

This section is primarily information for the provider

injury	needs and ensured their safety.

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 11 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 18 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 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
Diagnostic and screening procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** Regulation 20 1(a) (b) (i) (ii) The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment because an accurate record had not been maintained. In addition the registered person had not maintained other records as are appropriate in relation to persons employed for the purposes of the carrying on and management of the regulated activity.

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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