Inspection Report

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

Andrew Cohen House

River Brook Drive, Stirchley, Birmingham, B30 2SH

Tel: 01214585000

Date of Inspections: 30 July 2014
29 July 2014

Date of Publication: September 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

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

Details about this location

Registered Provider	Birmingham Jewish Community Care
Registered Manager	Miss Josephine Stinton
Overview of the service	Andrew Cohen House provides accommodation and nursing care for up to 59 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 in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 29 July 2014 and 30 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 were accompanied by a pharmacist and talked with other authorities.

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

The inspection team was made up of two inspectors, a pharmacy inspector and an expert by experience. There were 55 people using the service during our inspection. We spoke to fourteen people who lived at the home and with six relatives.

We set out to answer our five questions; Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. The summary is based on our observations during the inspection, discussions with people using the service, their relatives, the staff supporting them and looking at records. If you wish to see the evidence supporting our summary please read the full report.

Is the service safe?

We found there were not appropriate arrangements in place to ensure staff managed the risks associated with the use and management of medicines. We were informed by the manager and the director that all issues identified by the inspection would be investigated and action taken.

People were sometimes cared for by an insufficient number of staff. The staff turnover was also high. The service had some people who had dementia and so were at risk of

becoming disorientated by having an inconsistent staff team.

People told us they felt safe. One person told us, "I'm not frightened of anyone here." The staff we spoke had a basic understanding of safeguard procedures as they had not all received training in this. However, staff said that if they witnessed poor practice they would report their concerns.

The provider had notified the local authority as required of some incidents that had occurred in the home under safeguard procedures. However we had been made aware of other incidents that had not been reported. This places people at risk of allegations not being properly investigated.

There were no people having restrictions placed on them through the Deprivation of Liberty Safeguards (DOLS). These safeguards apply where it is thought that it is in someone's best interests to be placed in a care home but they lack the capacity to make a decision about what is being proposed for them. In these circumstances the provider must apply for authorisation to deprive the person of their liberty. We found that the manager was not aware of a recent Supreme Court ruling that impacts on the circumstances when an application should be made.

Risks to people's health, safety and welfare had not always been assessed and remedial action had therefore not been taken. We were not provided with evidence during our visit that the provider had taken full account of published guidance from the health and safety executive regarding risk of falls from windows or balconies in health and social care settings. Some action to reduce risk was taken during our visit.

Is the service effective?

People we spoke with indicated that they were generally happy living at the home. One person told us, ""I feel alright here, I don't see anything bad." Another person told us, "Its' nice here." The majority of relatives we spoke with were positive about the care provided at the home. One relative told us, "We are so grateful to this home for the high quality of care."

We checked people's care plans and found most of them to be detailed, relevant and up to date. However, in some instances we found that information to support staff in managing people's behaviour was not sufficient. This meant that some people were at risk of receiving inadequate or inappropriate care.

Is the service caring?

People were supported by kind and attentive staff. We saw that care staff showed patience and gave encouragement when supporting people. People were generally positive about the staff who supported them. One person told us, "The staff are all very nice and helpful." Another person told us, "We have very nice staff."

The home employed two activity co-ordinators. We found that people were given the opportunity to participate in a number of activities and organised events at the care home.

We spoke to staff who had recently started working in the home. Staff confirmed that they had an opportunity to complete 'shadow' shifts when they first started and had worked alongside experienced staff. Some staff who had worked at the home for some time told us that that they felt the training and support for new staff needed to be improved.

Is the service responsive?

During this inspection we identified a number of issues about which the provider took immediate action to rectify or improve the situation. At our last inspection in January 2014 we had identified that the home was not meeting the regulation in regards to the management of medication. At this inspection we found that this regulation was still not being met.

There was evidence that some learning from incidents took place and appropriate changes were implemented. We followed up on two incidents and found that actions had been put in place to help reduce the risk of future similar incidents occurring.

We found that records were kept of accidents, the number of falls and admissions to hospital. There was no central log of all incidents and medication errors. We were told that this information would usually be kept within people's individual records. This meant it would be difficult to track the number of incidents occurring and actions taken in response. It also did not enable the provider to complete a full analysis in order to identify any reoccurring patterns or trends.

People's views about the care they received were sought through meetings and questionnaires and relatives and visitors were asked to comment about the service. We saw that completed questionnaires showed that people using the service and relatives were mostly positive about the care they received and these results were available for people to view in the reception area. Where a minority of negative comments had been received there was no information included about the home's response. This meant that people may be unsure if their comments would be acted on.

Is the service well led?

The service has a quality assurance system, but this had not always ensured that areas that needed improvement had been identified and appropriate action taken.

Systems were in place to assess and monitor the quality of the care provided but some of the concerns we identified during our inspection had not been recognised by the provider.

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 17 September 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 Andrew Cohen House 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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and support was not always planned and delivered in a way that would ensure people's safety and welfare.

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

Reasons for our judgement

People we spoke with indicated that they were generally happy living at the home. One person told us, ""I feel alright here, I don't see anything bad." Another person told us, "Its' nice here." The majority of relatives we spoke with were positive about the care provided at the home. One relative told us, "We are so grateful to this home for the high quality of care."

We observed how people were supported by care staff throughout the day. We saw and heard mainly positive interactions between staff and people who lived at the home. People appeared relaxed and comfortable with the staff who were supporting them. Throughout the day people sitting in the lounges were offered regular drinks, and we saw people being offered biscuits as snacks. We also observed that people who were in their bedroom had access to a drink.

Most of the people we spoke to said that they were well cared for but some people were concerned about the lack of care staff to support them.

We found that most people were offered or received personal care every day. People told us they were happy they could have a bath or shower whenever they liked. One person told us, "I have a choice of when to get up and I have a shower every day," Another person told us they liked staff of the same gender to help them. We found this request was recorded in their care plan and was being accommodated.

We observed staff assisting people to move or transfer using equipment and saw they did this safely. One person told us that due to their mobility they needed to be hoisted and staff respected their need to wait for two staff to work together to protect them from harm.

We had been made aware prior to our visit that CCTV was in use in some communal areas of the home. In 2012, meetings had taken place with people and their relatives to discuss their use. Our visit found there were signs in place informing people of the cameras. A relative told us," I know CCTV cameras are about, I think it's a good thing. I've seen the sign on the door." One person told us that they have seen the sign displayed on the wall in reference to the CCTV but were not sure where they had been installed. The provider may find it useful to revisit consultations with people to ensure people have no concerns about the camera's impact on their privacy.

We looked at care records for five people who lived at the home. One person was new to the home and their needs had been assessed prior to their admission. People's care plans contained records showing that risks associated with their physical health had been assessed. This included the risk of people getting sore skin, not eating well, and helping to support people with their mobility. One person had sore skin and needed pressure relieving equipment and regular repositioning. We saw that the person had pressure relieving equipment and two staff spoken with were able to tell us about the pressure care the person was currently receiving. This meant that staff were aware of the specific pressure area care that people needed to meet their needs.

We found that people had been offered the opportunity to be weighed regularly. Measuring people's weight is a way of identifying possible changes in people's health or well-being. One person who was underweight had been assessed as needing food supplements and we saw that these were being given during our visit.

In some instances the care plans lacked sufficient detail about how people were to be cared for by staff. We were told that one person had some behaviours that are challenging and at such times they were encouraged by staff to go to their room. This information was not in their care plan and there was no information about how the person's behaviour should be managed. Another person's care plan recorded that they often became distressed when personal care was undertaken and this could result in them displaying behaviour that was difficult to manage. Their care plan recorded that at such times the use of minimal restraint had been agreed with other health care professionals and their relative. However the care plan needed to be more specific about when this should be used and for how long.

Some people at the home had been assessed as needing bed rails to prevent them falling out of bed. We found that two people's risk assessments identified there were risks with using the rails. The manager told us that the risks had been reduced as bumper covers had been fitted to the bed rails. The risk assessments had not been updated to reflect this but we observed that covers were fitted to the rails.

We found that a verbal handover system was in place at the beginning and end of each shift so that staff were made aware of any changes that may have affected the delivery of care. It was the provider's expectation that a written handover was maintained daily. We found these records were often incomplete.

We looked at the opportunities people had to undertake interesting activities each day. People had been consulted at residents meetings about possible activities. This meant people had an opportunity to make suggestions and contribute ideas to the activity programme. The home employed two activity co-ordinators. We found that people were given the opportunity to participate in a number of activities and organised events at the care home. During our visit we saw people engaged in one to one activities and also

enjoying a visiting entertainer. An art session was also planned the day of our visit with the assistance of a volunteer.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not 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 minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at the arrangements to safeguard people from abuse because we had received information of concern.

We spoke to several people who lived at Andrew Cohen House and they told us that they felt safe with the staff who cared for them. Comments included, "I'm not frightened of anyone here."

We saw evidence that people were reminded on how to raise a concern during resident's meetings which were called 'Quality Circle Meetings'. The provider may find it useful to note that there was no information on display to people or their relatives about where they could report allegations of abuse.

Relatives of people living at the care home did not raise any concerns about people's safety. One relative told us, "They do everything really well, we trust them implicitly."

We found that the provider had policies in relation to 'Safeguarding Vulnerable Adults' and protection of vulnerable adults'. These policies explained what abuse was and where care staff could report safeguarding concerns, should they arise.

We looked at training records and saw that most of the staff had received training in safeguarding vulnerable adults. Many of the new staff had not yet received this training and it was not included in the initial induction to the home. We were told that new staff were given a booklet that included the safeguarding procedures. The arrangements in place did not ensure that all staff would be aware of the signs of abuse and how to report them.

We spoke with several staff about their understanding of safeguarding and what they would do if they suspected or saw abuse was occurring. Staff were aware that this was something that must be reported and told us they would make the nurse in charge or

manager aware of any concerns.

The provider had notified the local authority as required of some incidents that had occurred in the home under safeguard procedures. However we had been made aware of other incidents that had not been reported as required. This included some recent medication errors that may have been considered as neglect. Whilst these had been investigated by a senior member of staff they had not been reported as a safeguarding issue. We discussed this with the manager who acknowledged that in retrospect the incidents should have been reported. Following our visit, the manager informed us she intended to attend refresher safeguarding training to help ensure similar errors did not occur in future.

There were no people having restrictions placed on them through the Deprivation of Liberty Safeguards (DOLS). These safeguards apply where it is thought that it is in someone's best interests to be placed in a care home but they lack the capacity to make a decision about what is being proposed for them. In these circumstances the provider must apply for authorisation to deprive the person of their liberty.

Discussions took place with the manager regarding the recent judgement on 19 March 2014 by the Supreme Court, and how this will impact on the provider's responsibility to ensure Deprivation of Liberty Safeguards (DOLS) are in place for people using the service. This judgement by the Supreme Court widened and clarified the definition of deprivation of liberty. It confirmed that anyone who required continuous supervision and would not be safe to leave the home independently would be deprived of their liberty, and safeguards must be put in place to protect their rights. The manager confirmed that they were not aware of this recent judgement. This meant that they had not reviewed if any DOLS applications may be required to ensure people were deprived of their liberty in the least restrictive way, and in accordance with the law. The manager agreed to review this and confirmed that they would make necessary applications where appropriate.

Following our visits we received a concern about the homes recruitment practices. We requested information from the provider about the procedures in place. DBS Adult First is a service provided by the Disclosure and Barring Service that can be used in cases where, exceptionally, and in accordance with the terms of Department of Health guidance, a person is permitted to start work with adults before a DBS Certificate has been obtained. Information indicated that the provider often, rather than exceptionally, employed staff on receipt of a 'DBS Adult First 'check. We also found that the provider did not have a policy in place regarding the renewal of DBS checks. Some staff had last had a check in 2003. Whilst it is not a legal requirement to renew these check providers need to assure themselves that the staff they employ are still suitable to work with vulnerable people. Following our inspection, we were informed by the provider that they intended to introduce a policy of renewing DBS checks every three years.

Management of medicines ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We looked at how medicines were managed for 18 people living in the home. We found that appropriate arrangements were not being undertaken to manage the risks associated with the unsafe use and management of medicines.

We were told that regular checks were made to ensure people were being given their prescribed medicines. We were shown copies of these medicine checks. However, when we looked at people's medicine administration records we found medicine errors or problems with people's medicines. This meant that although the service had a checking system in place these errors had not been identified and no action was being taken to learn and prevent the errors happening again. We could not be assured people were receiving their medicines as prescribed.

We found it was difficult to check that people had been given their prescribed medicines. The date and quantity of receipt of people's medicines was not documented for the current month. We also found that the balance remaining of some people's medicines from the previous month had not been carried forward onto their new medicine administration record. We looked at the medicine administration records for one person prescribed a medicine that needed to be carefully monitored in order to make sure that they were given a safe dose. We found that it was difficult to check the balance of this particular prescribed medicine. This made it difficult to know the total quantity available and therefore determine if the correct amount of medicine had been given.

Medicine administration records were not always accurately completed to document if people had been given their prescribed medicines. We noted that five people's medicine administration records had not been signed for the administration of a medicine or a reason documented to explain why the medicine had not been given. In particular one person did not have a medication administration record available for the current month. There were no records available to document if the person had been given their prescribed

medicine. This meant it was not always possible to determine if people had been given their prescribed medicines.

Appropriate arrangements were not in place to ensure that medicines were given according to the prescribers instructions. We found that medicines prescribed to be given on a particular day in the week were not always given on the correct day. Five people had not been given their prescribed medicine on the day it was due. In particular three people who were prescribed a skin patch medicine for pain relief had not had their skin patch applied on the correct days.

On the day of the inspection we had to alert nursing staff that two people had not had their pain relief skin patch applied and the medicine was now overdue. Immediate action was taken for the two people to have their prescribed pain relief. When we looked at previous medicine administration records we found that this medicine error had happened before for two people. Another person was prescribed a medicine to be given on the same day once a week. However we noted that the medicine had been signed as given on two days of the same week. This meant we could not be assured that people were being given their prescribed medicines as intended to treat diagnosed healthcare conditions. The service had failed to identify these medicine errors and therefore no action was being taken to prevent them happening again.

We looked for supporting information available for staff to safely administer medicines. Allergies to medicines were not always recorded onto people's medicine administration records. We noted that the care records for one person stated that they were allergic to 'penicillin' however the pharmacy printed medication administration record stated 'none known'. It is important that known medicine allergies are recorded on all medicine documents to highlight the risk of an allergic reaction. We further noted that when people were prescribed a medication containing skin patch to be applied on different parts of the body there were no records to show where they had been applied. This information would show where the last patch had been applied and therefore ensure that a new patch was applied to a different area of skin. The management team agreed to ask for supporting recording documents from the supplying pharmacy.

We also looked for supporting information for nursing staff to safely administer medicines to be given for anxiety or agitation 'when necessary' or 'as required'. We found that although there were some procedures available the information was not specific or detailed to the individual person. This is particularly important to provide guidance for members of staff who are not familiar with a person's individual behaviour and also when people are not able to communicate verbally.

Medicines were not always managed safely. We found that four people had the same medicine stored in two different locations in the medicine trolley. This meant that there was an increased risk of the same medicine being given twice.

Storage arrangements did not always ensure that medicines were stored according to the manufacturer's guidance. We found one person's prescribed medicine stored inside the medicine trolley despite a round blue sticker on the bottle stating 'Store in a refrigerator'. Nursing staff we spoke with did not know how long the medicine had been out of the refrigerator. This meant that the medicine may not be effective.

Arrangements were not in place to ensure that medicines with a short expiry were dated when they were opened. In particular we found that eye preparations such as eye drops

with a 28 day expiry on opening were not always dated when opened. We found one person's eye drops opened and in use in the medicine trolley which had not been dated when opened. This meant that there was an increased risk of contamination and the preparation may no longer be effective.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We looked at the staffing arrangements because we had received information of concern about staffing levels at the home.

We spoke with the manager about the numbers of staff that had been assessed as needed. We found that there had been no formal assessment of staffing needs based on people's dependency levels but we were told that as a minimum two nurses were needed during the day and at night time. We were told that a minimum of four care staff at night, 10 in the mornings and 8 in the afternoons were required. Activity workers, catering and domestic staff were in addition to care staff employed.

The staff rota showed that the number of staff on duty met the home's assessed minimum numbers of staff for the days of our visits. Over the two days of our visit we did not observe people having any long delays in receiving the support they needed from staff.

We looked at the staff rota's for July. These showed that the home's own minimum staffing levels were often not being met at night and sometimes were not met during the day. The rota showed that there had often been only one nurse on duty at night. The manager told us this was because the home was short of nursing staff and that an additional senior carer was being provided. There was no risk assessment available to show these interim measures provided safe staffing levels. We were informed that recruitment of additional nursing staff was underway and that agency staff had not been used due to the costs and disruption to people.

Systems were in place to ensure that all nurses remained registered with their professional body for the roles they were employed to undertake. We found there was a high level of staff turnover within the home, particularly nursing staff. Of the ten nurses currently employed only three had been employed for longer than five months. This meant that there was a risk of people being cared for by staff who were not fully aware of their needs.

We spoke with people who lived at the home but not everyone was able to comment about

the numbers of staff on duty. People were generally positive about the staff who supported them. One person told us, "The staff are all very nice and helpful." Another person told us, "We have very nice staff but they do need more staff."

We spoke with the relatives of six people who lived at the home. Relatives were complimentary about the staff but there were some mixed views on the staffing arrangements. One relative told us, "There's usually enough staff." Another relative told us, "I'm very concerned about the staffing levels, a lot of staff have left. It's worse at weekends."

We spoke with nursing and care staff about staffing arrangements in the home. The majority of staff told us that the home was currently understaffed. Two staff told us they felt unable to comment on staffing levels due to the short period of time they had been working there. Comments from staff included, "They've been recruiting people but we are short staffed" and "There's been a lot of people leave, we always seem to be short staffed, I don't want to be so busy that I can't spend any time with people and have a little chat. I only have time to talk to people when I'm doing personal care."

During our visit we spoke with the manager and the director of the home about our concerns regarding the staffing arrangements. We were informed that recruitment of new staff was underway so that there would be sufficient numbers of staff to support people. Following our visit we were informed that five new staff were due to commence work and that agency nurses had been booked so that two nurses would be on duty during the night.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We looked at the arrangements for supporting staff because we had received information of concern about staff support and training before our inspection.

During our visit to the home we found that staff had the opportunity to complete an annual survey that included asking their views regarding the training and support they received. We looked at the results for the last survey completed in December 2013 and these showed that the vast majority of staff felt supported and said that they received sufficient training. Since then there had been a high turnover of staff at the home and new surveys had been distributed to staff in July 2014. The results of the new survey were not yet available.

We spoke to staff who had recently started working in the home. Staff confirmed that they had an opportunity to complete 'shadow' shifts when they first started and had worked alongside experienced staff. One member of staff told us, "I like it here, I had good training when I started. There was lots of shadowing and formal training at first."

Some staff who had worked at the home for some time told us that that they felt the training and support for new staff needed to be improved. One member of staff told us, "Some of the new staff need more training, they have no experience. I think some of the residents suffer a little because of that." Records showed that staff completed an initial induction to the home. For one new staff we saw that their induction had covered 34 topics that had been signed as completed over one day. An induction was not completed that took into account the Skills for Care Common Induction Standards (CIS). It is an expectation that care staff would complete the CIS within 12 weeks of starting their job if they have previously not completed this. During our visit the manager showed us a new induction pack from a training provider and told us it was intended to use this for new care staff.

We looked at the records of supervision for several new staff and found that often they had not received formal supervision meetings within three months of commencing

employment. This meant that the provider had failed to identify what support staff needed in order to improve the quality of the care people received.

We found that a training matrix was available to show the mandatory training attended by staff. This showed there was a programme of relevant training for staff that included refresher training. This included the provider's mandatory training on a variety of topics including health and safety, manual handling, first aid, fire safety and dementia training. Staff were also encourage to achieve a qualification in care. One care staff told us, "They give you a lot of training, I've just done my NVQ 2."

We found that safeguard training was arranged on an annual basis. The home had many new staff and we found that several new staff had been at the home for over three months but had not yet had the opportunity to attend this training. Some people at the home sometimes became upset or distressed and this had the potential to result in behaviour that staff may find difficult to manage. We found that some staff had not yet received suitable training in managing behaviour that is challenging. During our visit the manager arranged for training to take place and provided us with evidence that training in these topics was now scheduled to take place in October 2014.

During our visit we looked at the arrangements for staff supervision and appraisal. One member of staff told us, "My supervision is daily chats and my manager and checks on my work, but not formal meetings, it's just day to day." Records showed that staff had an annual appraisal where their performance was discussed but that recorded supervision was not regular for all staff. We found that when supervision meetings took place these were often to cover a particular topic, for example bed rail safety or accident reporting. The records of these supervisions did not record that there was any over view of staff's current performance or training needs. There was also no indication that staff had an opportunity to raise any issues during these supervision sessions. The lack of opportunity for staff to reflect and de-brief meant an opportunity to evaluate and improve the quality of care offered was being missed.

Assessing and monitoring the quality of service provision ✖ Action needed

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 in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

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

The service had a quality assurance system in place, but this had not always ensured that areas that needed improvement had been identified and appropriate action taken. Systems were in place to assess and monitor the quality of the care provided but some of the concerns we identified during our inspection had not been recognised by the provider.

At our last inspection in January 2014 we had identified that the home was not meeting the regulation in regards to the management of medication. At this inspection we found that this regulation was still not being met. This meant that the systems in place had not ensured people received their medication safely and when they needed it.

People's views about the care they received were sought through quality circle meetings and questionnaires and relatives and visitors were asked to comment about the service. Relatives confirmed they received a survey twice a year. We saw that completed questionnaires showed that people using the service and relatives were mostly positive about the care they received and these results were available for people to view in the reception area. We observed that people's names were recorded in the reports and this has the potential for people to be reluctant to make any negative comments. Where some negative comments had been received there was no information included about the home's response. This meant that people may be unsure if their comments would be acted on.

During our visit we had the opportunity to attend a quality circle meeting that had been arranged. This was attended by 15 people and two relatives. We found the environment noisy but the quality assurance manager did make attempts for people to participate in the meeting. We looked at the minutes of previous meetings and saw that in a meeting in May a person had raised a concern about staff. We saw no evidence that this had been followed up but were told the person had been spoken with about their concerns.

There was evidence that some learning from incidents took place and appropriate changes

were implemented. We followed up on two incidents and found that actions had been put in place to help reduce the risk of future similar incidents occurring.

We found that records were kept of accidents, the number of falls and admissions to hospital. There was no central log of all incidents and medication errors. We were told that this information would usually be kept within people's individual records. This meant it would be difficult to track the number of incidents occurring and actions taken in response. It also did not enable the provider to complete a full analysis in order to identify any reoccurring patterns or trends.

Arrangements for assessing and monitoring of the premises were not effective. Bedroom checks were undertaken on a monthly basis and this included checks of bedrail safety, décor and the nurse call system. We noted there was not a written record of window restrictors being checks and was told this was also completed but the records were not available as the maintenance operative was on annual leave. During our visit we observed a bedroom door was open on the first floor of the home. The bedroom had full length opening glazed doors onto a small balcony area. These doors were open. We looked at an adjoining bedroom and found the same type of doors were fitted, these were shut but were unlocked. We were concerned these may pose a risk given that some of the people at the home have dementia or may at times become confused. We were not provided with any evidence during our visit that the provider had taken full account of published guidance from the health and safety executive regarding the risk of falls from windows or balconies in health and social care settings. When we brought this concern to the attention of the manager during our visit she took immediate action to make sure these doors were locked to protect people's immediate safety and informed us that a risk assessment would be completed. Following our inspection we were informed that it was intended to fit restrictors to the doors.

We found that weekly fire alarms tests were carried out which were appropriately recorded. Staff had been involved in fire drills to ensure they were confident with such processes. There were good infection control procedures in place at the home. A recent audit by an external infection prevention nurse in July 2014 had showed the home had achieved a score of 98%. This showed that procedures were in place to help prevent people becoming unwell from the spread of infection.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person did not take proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe by, the planning and delivery of care and where appropriate, treatment, in such a way as to meet the user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The registered person did not make suitable arrangements to ensure that service users are safeguarded against that risk of abuse by means of, taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and responding appropriately to any allegation of abuse. Regulation 11 (1) (a & b)

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had failed to ensure that, at all times, there were enough qualified, skilled and experienced staff to meet people's needs. Regulation 22
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The registered person did not have suitable arrangements in place to ensure staff received appropriate training and supervision. Regulation 23 (1)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person did not take proper steps to protect

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	people from the risks of unsafe or inappropriate care. They did not have an effective system to identify, assess and manage risks relating to people's health, welfare and safety. Regulation 10

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 17 September 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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 15 September 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines** **How the regulation was not being met:** The registered person was not protecting people against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping and safe administration of medicines. Regulation 13

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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