Inspection Report

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

Princess Lodge Limited

11 High Street, Princes End, Tipton, DY4 9HU

Tel: 01215571176

Date of Inspections: 08 July 2014
30 June 2014

Date of Publication: August 2014

We inspected the following standards as part of a routine inspection. 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	✖ Action needed
Requirements relating to workers	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Princess Lodge Limited
Registered Managers	Mr Frank Brown Mrs Jayne Elizabeth Whitehouse
Overview of the service	Princess Lodge is registered to provide accommodation and nursing care to a maximum of 36 people. People living there have a range of conditions related to old age which may include dementia.
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

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

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 30 June 2014 and 8 July 2014, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care 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 were accompanied by a pharmacist. We talked with commissioners of services.

What people told us and what we found

The names Mr Frank Brown and Mrs Jayne Elizabeth Whitehouse appear in this report. However, those people were not in post and were not managing the regulatory activities at this location at the time of our inspection. Their names appear because they were still identified as registered managers on our database at the time of our inspection.

Our inspection of October 2013 and our pharmacy inspection of January 2014 highlighted some serious non-compliance. As a result we issued two warning notices to the provider and also set compliance actions for improvements to be made. After we issued the second warning notice we determined some improvement but identified that further improvement was needed in relation to care and welfare. During this, our most recent inspection, we again found non-compliance relating to the same areas we had previously.

Our inspection was carried out over two days. An inspector conducted the first inspection day and our pharmacy inspector inspected the medicine management systems on a second day. No-one knew we would be going to the home on either day as our inspection days were unannounced.

During our inspection days 25 people lived at the home. During our inspection days we spoke with eight people who lived there, three relatives, seven members of staff and the manager. Several people who lived there were unable to tell us about their care and support experiences so we spent time observing how staff interacted with people and looked at the daily routines.

The summary is based on our observations during the inspection, discussions with people who used the service, the staff supporting them, and by looking at records. If you wish to see the evidence supporting our summary please read the full report.

We considered all the evidence we had gathered under the outcomes we inspected. We used the information to answer the five questions we always ask;

Is the service safe?

Systems to protect vulnerable people from the risk of abuse were not followed so had not ensured people's wellbeing and safety.

Staff we spoke with had a basic knowledge of Deprivation of Liberty Safeguard (DoLS) processes. DoLS is a legal framework that may need to be applied to people in care settings who lack capacity and may need to be deprived of their liberty in their own best interests to protect them from harm and/or injury. However, we found that an application or advice that should have been sought for one person was not.

Recent recruitment practice did not comply with the law. It was not safe or effective and placed the vulnerable people who lived there at risk of harm from potentially unsuitable staff being in contact with them.

People were not protected against the risks associated with medicines because staff were not following arrangements in place to manage medicines safely.

Is the service effective?

People we spoke with gave us mixed views about the standard of care and support they received. One person said, "They look after me well, I do not know about the other people". Another person said, "It could be a lot better here. I do not think it is that good".

We found that staffing numbers were in need of a review as they did not demonstrate that they could effectively meet people's needs and preferences. A number of people and staff we spoke with highlighted that additional staff were needed. People told us that at times, they had to wait for support and assistance.

The provider had taken note of previous concerns raised by us, the Care Quality Commission, the local authority and Clinical Commissioning Group (CCG) at the end of 2013 and had made some improvements. However, insufficient action had been taken to ensure that those improvements were sustained. This inspection identified similar issues to those we had identified in 2013. This did not give assurance that the service provided was effective.

Is the service caring?

Overall, we found that care and support was provided with kindness and compassion. People told us that they could make some choices about how they wanted to be supported. All people we spoke with were complimentary the staff and described them as, "Kind" and "Caring". One person told us, "Staff are kind and friendly". A relative told us, "The staff themselves are caring".

We spent some time observing interactions between staff and the people who used the service. We saw that most staff showed patience when supporting people. However, we observed durations when there was no engagement or interaction from staff. People were asleep in their chairs, or looked unhappy. We saw that their faces had a blank expression and some people were restless.

Is the service responsive?

We found that basic systems were in place to give people and their relatives the

opportunity to raise any issues. However, the issues about the lack of staff and activity provision had not been adequately addressed. This showed that the provider had systems in place listen to the views of the people who lived there but did not always take action to address them adequately.

We found that for one person nursing staff had not assessed a person's sore arm when the care alerted them to this. This meant that the person was at risk of continuing unnecessary discomfort.

Is the service well led?

At the time of our inspection, although a manager was in post, they had not formally registered with us as is required by law. The registered provider gave us assurance that they would ensure that the manager applied for registration as a matter of priority.

We found that the manager was responsible for this and another home. Evidence presented to us by documents and verbally from staff indicated that there was not adequate manager input. Inadequate manager input and the findings from our inspection did not give confidence that the home was well led.

We identified from observations and care plans that some staff did not follow instructions. During our inspection we identified some issues that should have been reported to social services as people were not being safeguarded as they should have been. This had a negative impact on people's health and wellbeing and did not demonstrate a well led service.

Staffing was not always organised to ensure people's needs were met and support was not always available for activities. A number of people told us that they had to wait for staff assistance.

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 19 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 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.

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

We have judged that this has a 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

At our previous two inspections of October 2013 and February 2014 we found that the provider was not meeting the law regarding this care and welfare. For example, we identified that care plans did not include all known needs and risks and that personal care was not always provided to meet people's personal preferences and wishes.

People and relatives we spoke with had mixed views about the care provided at this home. Whilst the majority of people were happy with the care provided a small number were not. One person who lived there said, "I feel they look after me". Another person said, "It could be a lot better. There are not enough staff to look after people properly". One relative said, "It is alright. I have not really got any concerns". Another relative told us that at times they did not think that staff were attentive enough to their family member's health condition, which they told us, could be unstable at times.

We saw that people were dressed in individual styles of clothes. People told us that a hairdresser visited the home once a week and people were pleased about that. One person said, "The hairdresser is nice. They do my hair how I like it to be done". Records we looked at and people we spoke with confirmed that people selected what clothes they wanted to wear each day. One person said, "I always choose the clothes I want to wear each day. The staff help me. They know that I like to look nice". This showed that staff knew that it was important to people that they looked their best and meant that ensured that their self- esteem was promoted.

We identified that some people needed to be moved by staff using a hoist. We saw that staff hoisted people appropriately by ensuring that the people were given an explanation of what they were going to do. Staff told us they had received moving and handling and hoist training and records we saw confirmed this. This showed that systems were in place to

promote safety and prevent accidents.

When staff did engage with people we observed that they communicated positively with them in a kind and caring manner. One person said, "The staff are nice. They are kind to me. One staff brings me some sweets".

Although one person told us that more frequent chiropody was needed, in general we found that routine health checks were carried out. For example, the optician visited frequently. One person told us, "I think that we could do with the chiropodist more often but I have my eyes tested and have had new glasses". One person was attending a hospital out-patients appointment on the day of our inspection. They said, "A staff member is coming with me. I am glad about that". This showed that that the provider had systems in place to appropriately support people to access health care services.

We looked at five people's care records and overall, we found that people's needs were assessed. However, we found that the instructions in care plans were not always followed, or they were not up to date. For example, one person's care plan stated that they needed to consume a certain amount of fluid each day. We asked staff to show us the person's fluid intake chart to see if they were taking the amount required. Staff told us that they did not record the person's fluid intake. Without recording the amount of fluid the person had taken there was no evidence to confirm that the person had taken the required amount of fluid. This meant that either staff were not following instructions or the care plan was not up to date and current. After breakfast we saw that at least four people had been taken into the small lounge and left in their wheelchairs for over three quarters of an hour. The people looked uncomfortable. We looked at care plans for two of the people which highlighted that they were at risk of skin damage. The care plans instructed that staff should ensure that the people be seated on special cushions to prevent skin damage. We looked at the people sitting in the wheelchairs and found that they were not sitting on the special cushions. We asked a staff member about this who told us, "People should be moved to easy chairs after meals so that they can sit on the special cushions. This has not happened". This meant that the care plans in place were not being followed which placed people at risk of ill health and discomfort.

Records we looked at highlighted that on two different days a staff member had reported to nursing staff that the person had a 'Gash' on their arm and discomfort. There was no documentary evidence to confirm that the nursing staff had assessed the person's arm. This was confirmed by the clinical lead for the home who told us that they did not know anything about it. This meant that the person's discomfort continued as nursing staff had not been responsive to their potential medical need.

All of the people we spoke with including staff, relatives, and the people who lived there, told us that there were not enough staff to meet people's individual needs or to keep them safe. One person said, "I have to tell you that we have to wait to go to the toilet for a long time early mornings". Another person concurred with that. A relative told us, "We have raised the issue of staffing levels as they are not safe". This meant that the provider had not ensured that staffing was adequate to meet people's basic personal care needs.

A relative told us, "My family member was not well when we visited last week. It took us ages to find a staff member. I do not know what would have happened if we had not visited and found them to be unwell. Staff not being available in the lounge to supervise is a frequent occurrence". This meant that the provider had not taken adequate steps to ensure that staffing was adequate to meet people's safety needs.

The majority of staff we spoke with also told us that there were not enough staff. They gave us examples of the impact this had on the people who lived there which included, people having to wait to go to the toilet, rigid daily routines and a lack of personalised care. Relatives raised the issue of staffing levels in a recent meeting held on 11 June 2014. This showed that there were on-going concerns regarding staffing levels. The general manager told us that staffing levels were adequate. However, people and relatives were adamant that they were not.

Our observations showed that the care provided was 'task orientated' rather than person centred. A staff member agreed with the findings from our observations. They said, "I did some observations myself last week. The care is very task orientated. It is not personalised to meet people's preferences". Task orientated care is where priority is given to the task for example, getting people out of bed, washed, dressed and giving them food and drink. This type of care is not based around the individual needs of people and can lead to them feeling frustrated and unhappy.

Although we saw notices on the walls informing people of external performers coming to the home, we found that day to day activity provision was inadequate. People we spoke with told us that in their view there was not enough to do. One person said, "Same every day. It gets a bit tedious, not much to occupy us". A relative said, "We have raised the lack of activities. They did listen at the time and things improved but have slipped back again". We observed that several people had high dependency needs, and could not walk independently and had no verbal communication skills, spent most of the day sat in chairs asleep in the lounge. Most people were largely left to themselves with little or no staff interaction except on occasions when they were prompted to wake up for a drink or food. This showed that people were not provided with enough activities to keep them stimulated to maintain their welfare and well-being.

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.

The provider had not responded appropriately to any allegation of abuse. People who use the service were not protected against the risk of unlawful or excessive control because the provider had not made suitable arrangements.

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

All of the staff we spoke with told us what they would do if they were concerned about any behaviour of their peers or people's relatives. All staff we spoke with confirmed that they had received training in safeguarding vulnerable adults which was confirmed by records that we saw. However, we found that one situation of neglect and two acts of omission had not been reported as they should to the local authority safeguarding team. We identified that it was senior members of staff who were responsible for the non-reporting of those incidents. This highlighted that arrangements in place to ensure that people were protected from the risk of harm were not followed. This meant that people could not be assured that they would be protected from the risk of harm or abuse. Following our inspection we alerted the local authority safeguarding and contract monitoring teams to those incidents so that they could investigate them and take action.

Staff we spoke with had a basic knowledge of Deprivation of Liberty Safeguard (DoLS) processes. We were told by the general manager that all staff had received DoLS training however, this was not evidenced on the staff training matrix. We found that advice had been sought from the local authority DoLS team regarding one aspect of a person's care. However, neither an application nor advice had been sought for a different issue when it should have been. We observed during the afternoon a person trying to get out of their easy chair. They clearly did not want to sit in the chair. A staff member stood by them and kept asking them to sit down. We determined from their body language and verbal communications that the person was agitated and frustrated by this experience. This did not give assurance that staff were adhering to the legal DoLS framework to address the person's risks and choices.

Whilst people have capacity they can choose to set up a Lasting Power of Attorney (LPA). A LPA gives a delegated person the authority to make decisions on their behalf. We looked at five sets of care records which included consent to use bed rails. These had been signed by relatives. With the exception of one person there was no evidence available to determine that a LPA was in place. This meant that decisions were being

made by family members who had not been formally authorised to.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

Our inspection of 9 January 2014 raised concerns about the recording, administration, and disposal, safe keeping and monitoring of medicines which might have resulted in people not being fully protected against the risks associated with medicines. Following our January 2014 inspection the registered provider told us that they would take action to make improvements. However, during this our most recent inspection, we found that this action was not effective as concerns about medicine management systems remained.

Medicines were kept safely. We found the provider ensured that medicines were now being stored at the correct temperature. The storing of medicines at the correct temperature meant that they would be effective in treating the conditions they had been prescribed for.

Appropriate arrangements were not in place in relation to the recording of medicines. During the inspection we looked at seven medicines administration records. This was so that we could check if these records could show us whether people were receiving their medicines as prescribed by their doctor. We found that the provider had a procedure to record the receipt of medicines on to the medicines administration records. However, we found that the staff were not always recording the receipt of the medicines received and therefore we were unable to carry out an audit to see if the medicines had been administered as prescribed. Where the receipt of medicines had been carried out we found that there were some discrepancies between the quantity found and the quantity calculated from the medicine administration records. These discrepancies could indicate that some people were not receiving their medicines as they had been prescribed. We also found that staff had used medicines that had been carried over from the previous 28 day administration cycle but had not accounted for these in the current records. All of these issues meant that the provider was not able to evidence that the people who lived at the home were receiving their medicines as prescribed. Poor record keeping of medicines could affect the health and welfare of the people who lived there.

Appropriate arrangements were not in place in relation to obtaining medicines. We found

that three people had not had their analgesic tablets for a period of between four and 14 days. Although we saw that the provider had a procedure in place to identify the shortage of these medicines and take steps to rectify the situation. However, staff had not followed this procedure. This meant that these people did not receive the treatments that had been prescribed for them by their doctor and this placed their health and welfare at risk.

Medicines were not disposed of appropriately. We found that where people had refused to take their medicines the staff were making a record of this on the administration records. The staff were also indicating whether the medicines had been disposed of. Where the staff had indicated on the administration record that the medicines had been disposed of we examined the disposal records to see if these medicines could be accounted for. The records that we looked at did not confirm that these medicines had been disposed of. We therefore found that the provider did not have a system in place to ensure that the disposal of medicines was accurately recorded and therefore there were medicines that could not be accounted for.

Medicines were not administered safely. We found that there was no written information about how to specifically administer medicines through a Percutaneous Endoscopic Gastrostomy (PEG) tube. A PEG tube is inserted by surgical procedure in a hospital setting for people who are unable to take nutrition fluid or medicines by mouth. When medicines are being administered through this tube we would expect the provider to have a written procedure in place. This procedure should describe how to prepare each medicine before it is flushed down the tube and how much fluid should be used to prevent the tube from becoming blocked after the administration of each medicine. The provider was therefore unable to demonstrate that medicines given in this way was being carried out safely by the staff.

We identified a particular concern about a person who had been prescribed an inhaler to treat their breathing difficulties. Our audit of their inhalers and the records we looked at highlighted that this person had not been receiving the prescribed dose of their inhaled medicine. This particular inhaler had a dose counter which tells the user how many doses have been used/are left in the inhaler. We looked at the dose counters on the inhalers found that 30 doses had been administered. We looked at the medicine administration records which showed that the staff had administered 144 doses to this person. The manager was unable to explain this anomaly. The manager assured us that a thorough investigation would take place to establish what had happened.

Requirements relating to workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Appropriate checks were not undertaken before staff began work.

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 saw documents to confirm that induction programmes were available. A new staff member described their induction programme to us. This included looking at policies and care plans to prepare them for their role. They told us that they had also shadowed experienced staff before they worked alone. This showed that processes were in place for new staff so that they were given some knowledge of what would be expected of them when they started working with the people who lived at the home.

We looked at the recruitment records for two staff members who had been employed in a six week period prior to our inspection. These showed that before they had started to work at the location they completed an application form, attended an interview and proof of their identity was obtained to ensure they were suitable to work with the people who lived at the home.

Prior to the employment of staff providers must undertake a Disclosure and Barring Service (DBS) check to ensure that staff are not barred from working with vulnerable adults because of a criminal record or an incidence of abuse. DBS guidance states that in exceptional circumstances providers can employ staff prior to their full DBS being received providing a satisfactory DBS 'Adult First' check is obtained. For one staff member the DBS Adult First check highlighted that they should not be employed until the full DBS had been received. However, we found that the manager had allowed them to start work even though the full DBS had not been received. For another new staff member, we found that they had given names for two references to be obtained from their last but one previous employer. The provider had received references from those people. However, the person had not given a name for the provider to contact to give a reference from their most recent care provider employer. A clear reference from the most recent employer would give the people who lived at the home assurance that the person's conduct had been satisfactory. When we asked the general manager about this, they told us that policy states that a reference should be requested from the last employer and they did not know why this had not happened. This showed that recruitment of those staff did not comply with the law. They were not safe or effective, and placed the vulnerable people who lived there at risk of harm from potentially unsuitable staff being in contact with them.

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 enough 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

The majority of people and relatives we spoke with were positive about staff attitude and conduct. People described the staff as being, "pleasant" and "Friendly". A relative told us, "The staff themselves are good, kind and helpful".

Some of the people who lived at the home had a diagnosis of dementia. Some people displayed behaviours that challenged. At least 12 people required two staff to safely move them and some people had physical health needs.

All of the people we spoke with including, relatives and the people who lived there, told us that there were not enough staff to meet people's individual needs or to keep them safe. A relative told us that in their view at times staffing levels compromised the safety of the people who lived there. The majority of staff we spoke with also told us that there were not enough staff. This showed that there were on-going concerns regarding staffing levels. Overall, the evidence we gathered during our inspection showed that the current staffing levels did not meet people's individual or safety needs. We have detailed the impact of this in the Care and Welfare section of this report.

We asked the general manager if they had a formal system in place to assess the number of staff needed on duty at any time. The general manager told us that a staffing calculating tool was in use and showed this to us. However, they were not able to provide us with evidence of how dependency levels were scored to enable them to input the information into the staffing calculating tool. They confirmed that an overall dependency score was not available for each person. This meant that they would not be able to effectively determine how many staff were required at any given time.

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

When we asked people about their views of the service provided we had mixed responses. Comments included, "I like it here". One person said, "There could be improvements in staffing levels". A relative said, "I think the home is OK". Another relative told us, "Improvements are needed".

A relative told us that meetings were held. We saw minutes of a meeting held for people who lived there and their relatives. The last meeting was held on 11 June 2014. We saw that a comments box was available in the front reception area. This showed that there were some systems in place to enable the people and their relatives to comment on how the service should be run. However, the issues about the lack of staff and activity provision had not been adequately addressed. This showed that the provider had systems in place listen to the views of the people who lived there but did not always take action to address them adequately.

The manager was not registered with us. It is a requirement of the law that the home has a manager who is registered with us. This meant that the provider had not complied with a condition of their registration.

We found that the manager was responsible for this and another home. Both homes provided nursing care to people with complex and high dependency needs. Although we asked the general manager and other senior staff they were unable to provide us with an account of the precise number of days/hours the manager spent at this home. The duty rota highlighted that they worked 40 hours a week. However, the rota did not confirm how many hours they worked each day at this home. We saw the sections on the rota where specific hours to be worked each day should be entered was blank. Our inspection findings of non-compliance with the law, for example, unsafe recruitment and safeguarding processes, and our discussions with staff, highlighted that the situation of the manager covering two homes, although a deputy manager was in post, was not adequate to demonstrate that the service was well led or safe.

We asked for specific information during our inspection relating to how the service provision was assessed and monitored. We found that some care records and other audits had been undertaken. We were told however, by the clinical lead that other audits were not being undertaken regularly due to the time allocated to updating the care files.

We saw that information regarding complaints processes was displayed in the home and available in a 'service user guide' document that was available in each bedroom. We looked at the complaints file and saw that three complaints had been made since our last inspection. However, for two of the three complaints the section on the form that confirmed that the complainant had received feedback and was satisfied was not completed. The general manager told us that the form should be fully completed but had not been. This showed that complaints processes had not been followed.

We found that the provider did not have a robust audit system in place to ensure that the people who lived at the home were receiving their medicines as they had been prescribed. As a consequence the discrepancies seen during the inspection had not been identified by the staff. The lack of a robust audit system was failing to protect people against the risks associated with the unsafe use and management of medicines.

We determined during our inspection that there had been concerns relating to the care and welfare of people. The provider had not forwarded a statutory notification regarding an allegation of abuse or omission of care to us the Care Quality Commission (CQC) as required by law, or the local authority safeguarding team as they should. This did not demonstrate that the service was responsive, well led, or could give assurance that people would be safe. The lack of reporting incidents to us was highlighted in also our October 2013 report. This showed that lessons had not been learnt and the lack of action in reporting had been repeated. This did not demonstrate a well led or effective service.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 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) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of - (b) the planning and delivery of care and, where appropriate, treatment in such a way (I) to meet the service users individual needs and (ii) ensure the welfare and safety of the service user.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Regulation 11(1)(b)(2). The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of; responding appropriately to any allegation of abuse. Where any form of control is used the registered person must have suitable arrangements in place to protect service users against the risk of such control.

This section is primarily information for the provider

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Regulation 13 People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: Regulation 21 (a)(1)(b). The registered person must operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character. The registered person must ensure that the information specified in Schedule 3 is available in respect of each person employed.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: Regulation 22. In order to safeguard the health, safety and welfare of people, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified,

This section is primarily information for the provider

	skilled and experienced staff employed for the purposes of carrying on the regulated activity.
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Regulation 10(1)(a)(b). The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems.

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 19 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.

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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk