Inspection Report

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

Oakwood Residential Home

192 West End Road, Bitterne, Southampton, SO18 6PN

Tel: 02380466143

Date of Inspections: 26 June 2014
25 June 2014
24 June 2014

Date of Publication: August 2014

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

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Cleanliness and infection control	✖ Action needed
Management of medicines	✖ Action needed
Safety and suitability of premises	✖ Action needed
Requirements relating to workers	✔ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	G & A Investments Projects Limited
Registered Manager	Mrs Karen Perrin
Overview of the service	Oakwood Residential Home is registered to provide accommodation for up to 28 people who require nursing or personal care. At the time of our visit 21 people were being accommodated. The home provides services to older people, including those living with dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Oakwood Residential Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Requirements relating to workers
- Staffing
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 June 2014, 25 June 2014 and 26 June 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 were accompanied by a specialist advisor.

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

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

What people told us and what we found

At a previous inspection on 11, 16 and 19 September 2013, we identified the provider was not meeting the requirements of nine regulations. We took enforcement action to prevent the provider admitting any new people to the home.

At the following inspection on 23 and January 2014, we identified the provider was not meeting the requirements of four regulations. We issued warning notices and told the provider to make improvements.

At this inspection, on 24, 25 and 26 June 2014, we found the provider had made improvements but was not meeting the requirements of the regulations.

We considered the evidence we had gathered under the outcomes we inspected. We spoke with nine people who used the service, five family members of people who we were unable to communicate with us due to their mental frailty, seven members of staff, the registered manager and a community healthcare professional. We also looked at 10 care plans and records relating to the management of the service.

We looked at outcomes relating to 11 regulations. We were accompanied by a specialist advisor, a pharmacy inspector and an expert by experience who had experience of people with dementia.

We used the information to answer the five questions we always ask;

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well-led?

This is a summary of what we found:

Is the service safe?

We found the service was not safe because people were not protected against the risks associated with medicines. Staff had received training in infection control and appropriate guidance was followed. However, not all people were cared for in a clean environment.

Some areas of the home were in need of decoration and laminate flooring in some communal areas was badly worn. There was a lack of handrails in some communal areas and access to the garden was not safe.

There were not enough qualified, skilled and experienced staff to meet people's needs. People told us this meant they were sometimes not able to go out on trips or did not always receive certain treatments as frequently as they required.

Arrangements to safeguard people's property were not effective and there were no arrangements in place to account for the use or disposal of alcohol brought in for people, to ensure it did not go missing. People were, therefore not protected from the risk of abuse.

The provider had a system in place to identify, assess and manage risks to people using the service. However, we found the risks associated with a person who smoked had not been assessed. This put them and others at risk.

Recruitment practices were safe, and pre-employment checks were conducted as required in most cases. There were arrangements in place to deal with foreseeable emergencies. Fire evacuation plans were in place and understood by staff.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The service had policies and procedures in place in relation to DoLS. One person was subject of a DoLS authorisation and we saw they were receiving appropriate monitoring and support.

Is the service effective?

The service was not effective as care plans had not been developed in relation to people's continence. People's hydration needs were not monitored effectively. It was, therefore, not possible for staff to easily identify whether people had received sufficient fluids each day.

Staff demonstrated a good understanding of people, including their likes and dislikes. However, we found staff were not aware of key information about the health of three people. Their lack of awareness meant they may not be able to provide safe and appropriate care to these people.

We saw nutrition plans had been completed for each person. These provided catering staff with information about people's dietary needs and preferences.

Is the service caring?

We found care staff were caring and showed compassion. 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 observed positive interactions between people and staff.

People told us they were able to make choices. For example, when they got up, how they spent their day and what activities they took part in. A choice of meals was available each day and people said they could request alternatives if they didn't like the menu of the day.

We noted the care plan for one person specified their preference for a male care worker. We found only female care staff were employed during the day which meant this preference could not be met.

People's privacy and dignity was promoted, but was not always respected. We observed staff sometimes knocked before entering people's bedrooms. However, on two occasions we found staff entered people's bedrooms without knocking.

Is the service responsive?

We found the service was not always responsive to people's needs. For example, the care plans for five people stated they lacked mental capacity to make decisions. However, there were no records to show how this related to specific decisions. In two cases we saw consent forms had been signed by relatives to give themselves, or other relatives, permission to access people's records. This did not comply with relevant legislation.

We found staff lacked knowledge of the Mental Capacity Act, 2005 (MCA) and how to make decisions in people's best interests. Most staff had not received training in MCA, although we saw this was planned.

People were given appropriate information and support regarding their care or treatment. We saw 'service user guides' had been prepared and were available in people's rooms.

The provider used survey questionnaires to seek people's views about the service. We looked at the results from the most recent survey, conducted in March 2014. We found

they had been analysed and action taken to address concerns. Minutes of residents' meetings showed they provided additional opportunities for people to express their views.

Is the service well-led?

We found not all aspects of the service were well-led. The provider had recently introduced a system of audits to monitor the quality of service provided. However, the system had not had time to become embedded in practice and was not yet working effectively. For example, records confirmed that care plans had been audited monthly, but it was not clear what issues these had identified or what changes had been made.

The provider had not completed an audit of infection control and had not identified the infection control concerns we found during the inspection. Medication audits had also not identified concerns we found during the inspection. Therefore, the audits were not robust.

The provider did not always take account of complaints and comments to improve the service. Family members told us verbal concerns were not always resolved effectively. We found there was no system in place to analyse complaints and identify learning from them.

Records showed most staff had not completed training in dementia or MCA. This meant they may not have the knowledge required to care for people with dementia appropriately.

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

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People expressed their views and were involved in making decisions about their care. People's privacy, dignity and independence was promoted but not always respected.

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

Reasons for our judgement

People expressed their views and were involved in making decisions about their care. We looked at care plans or parts of care plans for 10 of the 21 people living in the home. Each care plan contained information which showed the person, or their family members, had been involved in discussing their care and support needs. We spoke with nine people and five family members of people who were unable to communicate with us. One family member told us "I'm happy I'm involved in planning [my relative's] care". Where decisions had been made for people in relation to resuscitation, records confirmed they and/or their next of kin had been consulted.

People were given appropriate information and support regarding their care or treatment. We saw 'service user guides' had been prepared and were available in people's rooms. These provided information about the home, the staff, care planning and the 'key worker' system. Menus for the week were displayed on the notice board and there were clear signs to help people identify the day of the week.

People told us they were able to make choices. For example, when they got up and went to bed, how they spent their day and what activities they took part in. A choice of meals was available each day and people said they could request alternatives if they didn't like the menu of the day. Three people told us they preferred to spend time in their room and we saw staff accommodated this and took their meals to them. Care plans contained information about how people wished to be cared for, their food preferences and, in most cases, their personal histories. This provided staff with sufficient information to enable them to provide care and support that was appropriate to each person. We noted that the care plan for one person specified their preference for a male care worker. However, we found only female care staff were employed during the day which meant this preference could not always be met.

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 observed positive interactions between people and staff. At lunchtime we saw people were offered aprons to protect their clothing. Some people declined these and we saw their decisions were respected. We heard staff using people's preferred names. Where staff supported people to eat, they took their time and quietly encouraged people in a caring way, while ensuring they used their adapted cutlery in the best way possible. When one person became distressed, a staff member knelt down, reassured them and arranged for them to speak with a family member on the phone. Two people who gained comfort from carrying cuddly toys were supported to have these with them at all times. This showed compassion and understanding for people.

People's privacy, dignity and independence was promoted, but not always respected. Information was displayed prominently on walls and notice boards about how staff should support people with compassion and dignity. We saw people and their families had contributed to a 'dignity tree' in one of the communal areas to highlight the importance of being treated with respect. We observed people's doors were always closed when they were receiving personal care and staff sometimes knocked before entering people' bedrooms. However, on two occasions we found staff entered people's bedrooms without knocking when the people were having private discussions with us.

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Where people had the capacity to give consent, the provider acted in accordance with their wishes. However, clear procedures were not in place about decision making for people who were unable to give consent to receive care, treatment and support.

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

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We heard staff seeking permission from people before delivering care and support. They used phrases such as "Would you like me to…?" "Can I…?" and "What would you like to do now?" Where people were unable to communicate verbally, staff observed their body language and facial expressions to ensure they understood and agreed to a suggested course of action. When one person was asked where they would like to take their lunch, they pointed to an area of the dining room and were supported to sit there.

We spoke with staff about action they took when people declined to receive personal care. The described a number of ways in which they encouraged the person to consent, such as by "telling them how important it is"; "leaving them and trying again later" or "trying a different staff member". A senior staff member told us of one person who frequently declined to have baths, and said "they will only have a bath with [staff member], so we leave them until they are on duty and they are happy with that". Records of daily care confirmed this had occurred and provided examples of where other people's consent had been sought, declined and their decisions respected by staff.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. The care plans for five people stated they lacked mental capacity to make decisions. For example, one person's care plan stated their "capacity is impaired as they have dementia". However, there were no records of assessments that had been conducted to show how this related to specific decisions. This meant the provider was unable to demonstrate that the principles of the Mental Capacity Act, 2005 (MCA) and its code of practice had been followed.

In one case, staff and the care plan stated a person's relative had Power of Attorney to make decisions on their behalf. However, when we spoke with the relative they told us this was not the case. In two other cases we saw consent forms had been signed by relatives

to give themselves or other relatives permission to access people's records. There was no legal basis for this to be done in accordance with the Data Protection Act, 1998.

We found staff lacked knowledge of the MCA and how to make decisions in people's best interests. For example, decisions had been made that staff would manage people's medicines, but it was not clear how those decisions had been made. Most staff had not received training in MCA, although we saw this was planned. This would provide staff with the necessary knowledge to ensure decisions were made in people's best interests and in accordance with legislation.

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.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People's hydration needs were not managed effectively. Care plans had not been developed to manage people's continence effectively.

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 inspection on 23 and January 2014, we found people were not protected against the risks of receiving inappropriate or unsafe care. We issued a warning notice and told the provider to make improvements. At this inspection, on 24, 25 and 26 June 2014, we found the provider had made some improvements but was not meeting the requirements of this regulation.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at care plans and related records of care for 10 of the 21 people living at the home. We saw pre-admission assessments were completed and information from other agencies and healthcare professionals was taken into account when planning people's care. We found care plans were easy to navigate and followed a set format. Most people's needs had been identified and plans developed to show how staff should meet those needs.

In discussions with staff, it was clear they knew people well and understood how to meet most people's assessed needs. Each person was allocated a 'key worker'. Their role was to undertake monthly reviews of people's care and ensure up to date information was passed to other staff. Records confirmed staff had done this. We spoke with a community healthcare professional who told us they spent a day a month in the home and got "quite a few phone calls for advice". They told us staff monitored people's health appropriately and followed their advice.

The manager told us how they identified individual risks from each of the sections within the care plans. We saw risk assessments had been completed, together with measures required to manage each risk, which we found were being followed. For example, a person with swollen legs was sat with their legs elevated and people at risk of falling were using their walking frames appropriately.

We saw nutrition plans had been completed for each person. These provided

comprehensive information about people's dietary needs and preferences. Copies were available in the kitchen so catering staff could prepare suitable meals. At lunchtime, we saw meals were prepared and provided in accordance with the plans. One person, who was a very slow eater, did not receive appropriate support with their lunch and took an hour and half to eat it, by which time the food was cold. The manager showed us an invoice for a heat-retaining plate which had been ordered; this would help keep the person's food warm for longer.

People's hydration needs were not always monitored effectively. We saw people who had been identified as at risk of dehydration had fluid charts maintained so their intake could be monitored. A guide showing how much people should drink, based on their size, was available to staff. However, we saw fluid charts were not always completed accurately and daily totals were not recorded. It was, therefore, not possible for staff to easily identify whether people had received sufficient fluids each day. Where charts were not completed, or showed people had not received enough to drink, no action had been taken. This meant people were not protected from the risk of dehydration.

We found staff were not aware of key information about three people. For example, one person's diagnosis of a neurological condition was not known to staff. In another case a person had been recently fitted with a device to regulate their heart rate; however, there was no information about it in their care plan and, although staff were aware of it, they had differing views about the person's care and support needs. For a third person, we found there was conflicting information about an allergy to penicillin, which staff were unable to clarify. This meant staff may not have been able to provide safe and appropriate care to these people.

Information recorded in a file following visits by the community nurse was not always reflected in people's care plans. For example, assessments of the risk of people developing pressure injuries were recorded in the nurse's file but not in people's care plans. In some care plans, assessments of people's pressure area risk had also been completed by staff using an alternative tool to that used by the nurse, which used a different scale. Staff were not clear about how to interpret the assessments, so were not able to use the information to manage people's risks safely.

Care plans had not been developed in relation to people's continence. We saw a 'tick box' form had been used to record whether the person was singly or doubly incontinent and another form had been used to show the size of continence pads to be used. In addition, a 'toilet regime' form specified times when people's continence pads should be changed. The arrangements were not personalised to each individual and did not show how continence would be promoted.

We were shown a copy of the home's "Alcohol Policy" which stated the home would "neither encourage nor will it prevent" people's "moderate use of alcohol". It also stated the home would check with the person's doctor that alcohol would not affect medication they were prescribed before any alcohol was consumed. We found two people were regularly given alcohol and no checks had been made with their doctor to make sure it was safe. The policy had, therefore, not been followed and the provider was not able to assure themselves that people were receiving alcohol safely.

A range of activities was organised for people. The home had recently employed a new activities coordinator, who told us of plans to provide group activities, spend time with people on a one to one time basis and organise trips to local attractions. We observed people taking part in games and engaged in craft work. Staff had also developed a "wish

list" of activities people had requested. Some of these wishes had been met; for example, one person had had a trip to a cruise liner and another had attended a football match. Other wishes were planned in the future. Most people's welfare needs were therefore being met. However, one person, who spent most of their time in their room, told us they had requested a shelf of books to read. We had noted this at our inspection in January 2014, and found this request had not been actioned.

There were arrangements in place to deal with foreseeable emergencies. Fire evacuation plans were in place and understood by staff. We discussed with staff action they would take in the event of a fire alarm being activated. We found they had a clear understanding of the correct procedures to follow and how to safeguard people effectively. Personal evacuation plans had been developed for each person and were accessible in an emergency. "Hospital and ambulance files" had also been completed for people in the event that they were admitted to hospital. These provided key information about people's diagnosis, diet, medicines and allergies to help inform medical staff.

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 used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. Staff had received appropriate training in safeguarding vulnerable adults. However, arrangements to safeguard people's property were not effective

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

At our previous inspection on 23 and January 2014, we found people were not safeguarded against the risks of abuse. We issued a warning notice and told the provider to make improvements. At this inspection, on 24, 25 and 26 June 2014, we found the provider had made some improvements but was not meeting the requirements of this regulation.

We looked at the provider's policies relating to safeguarding and whistle blowing. We saw these had been recently updated and were appropriate for this type of service.

We spoke with four members of staff about safeguarding vulnerable adults. We found they had a clear understanding of what constituted abuse and were aware of people who were at risk of abuse. They knew how to report allegations of abuse, both internally and externally and had access to the contact details of the local safeguarding authority.

We viewed records of safeguarding training. These showed all staff had received training in safeguarding, either as part of their induction or by way of refresher training conducted annually. Consequently, staff had the knowledge required to identify and report abuse.

We also looked at risk assessments for people who were at risk of being involved in altercations with other people using the service. We saw some of these detailed specified actions required to reduce the risk. However, other risk assessments were not proportionate. For example, a risk assessment for a person at risk of becoming "aggressive" stated the "immediate action" was to "call 999 for ambulance or the police if someone has been hurt and inform the home manager and family". This would only be appropriate if someone had been seriously injured and required medical attention.

People who used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. We looked at

an authorisation for a deprivation of liberty safeguards (DoLS) in respect of one person. We saw this had been correctly authorised and the person was receiving appropriate monitoring and support. The manager was aware of recent changes in how the law should be applied in respect of DoLS and was working with the local authority to ensure they complied with legislation.

Arrangements to safeguard people's property were not effective. We spoke with three family members who told us clothing, bedding and towels bought for people frequently went missing. One family member told us that "despite having named clothing and bed linen" the person "often didn't have their own clothing in their cupboard or linen on the bed". Another family said, "If I wasn't here to constantly check, even more of [the person's] clothes would go missing than they do". We looked at the room used to iron and sort clothes after they had been washed. We saw this was not organised and, apart from some clothes that were hung on a rail, all other clothing was piled together and not separated according to the people who owned each item. We discussed this with the manager, who agreed the arrangements were not satisfactory and told us they would introduce a system using individual baskets for each person. This would allow the home to safeguard people's property more effectively.

Three people had alcohol brought into the home for them by family members. We found no records were kept when this was received or given to people. It was stored in a locked cabinet which senior staff could access when needed. We looked in the cabinet and saw it contained numerous bottles and cans. Three were labelled with the person's name, but the remaining 10 were not labelled. One bottle was of spirits, which the manager told us had been "taken off" one person as "they aren't allowed it". They said it would be returned to the family member who had brought it in when they next visited. However, there were no arrangements in place to enable the home to properly account for the use or disposal of alcohol and ensure it did not go missing. People were, therefore, not protected from the risk of abuse.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

Appropriate guidance was followed in relation to the use of personal protective equipment and the processing of soiled linen. However, not all people were cared for in a clean environment.

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

At our previous inspection on 23 and January 2014, we found people were not protected against the risk of infection. We issued a warning notice and told the provider to make improvements. At this inspection, on 24, 25 and 26 June 2014, we found the provider had made improvements but was not meeting the requirements of this regulation.

We found new arrangements to manage infection control risks had been put in place. For example, pedal operated bins for clinical waste had been installed in key places. Personal protective equipment (PPE), including disposable gloves and aprons, were available in appropriate places, including the laundry and bathrooms. We saw staff using PPE appropriately during our inspection. Liquid soap and disposable paper towels were available throughout the home and in people's bedrooms, together with notices about hand washing techniques. This meant staff had access to essential equipment to protect them and others from the risk of infection.

We looked at the provider's policy on infection control. We saw this was supported by a range of cleaning schedules which detailed how each area should be cleaned, the frequency of cleaning and who was responsible. We saw all areas of the home were included in the schedules. Check sheets confirmed that cleaning had been completed in line with the schedules.

Training records showed staff had completed training in infection control. We spoke with staff about the process used for handling soiled bed linen and found all were clear about how to manage this safely and in accordance with best practice guidance.

We also spoke with the member of staff responsible for operating the laundry. They demonstrated a good understanding of infection control and we saw there were clear procedures in place to prevent cross contamination. These were prominently displayed on a notice, so care staff could follow safe and effective procedures when operating the laundry out of hours.

Providers are required to have regard to the 'Code of Practice on the prevention and control of infections and related guidance'. The code requires infection control risk assessments to be completed. We found these had not been completed. Therefore, we could not be assured that all infection control risks had been identified and were being managed effectively.

Not all people were cared for in an environment that was clean and hygienic. The home employed two housekeeping staff to undertake most of the cleaning. In addition, care staff on nights performed cleaning of some communal areas and all care staff were expected to deal with spillages that occurred out of hours. The housekeepers had access to a carpet cleaner and we saw this being used to deep clean a bedroom carpet that had become soiled. We found most bedrooms and communal areas smelt clean and fresh. However, three bedrooms smelt strongly of urine and carpets on the landing and in four bedrooms were badly stained. Two pressure relieving cushions being used in the lounge were impregnated with dried urine. These put people at risk of infection. The manager told us carpets in bedrooms were due to be replaced with vinyl floor covering, but was unable to tell us when this would occur.

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. Homely remedies were managed safely.

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

At our previous inspection on 23 and January 2014, we found medicines were not managed safely. We issued a warning notice and told the provider to make improvements. Therefore, a pharmacist inspector looked at the use and management of medicines at this inspection. We found the provider had made some improvements but was not meeting the requirements of this regulation.

Medicines were not kept safely. Medicines were stored within a locked cupboard, trollies and a refrigerator within a locked room. Most keys were held by the senior care worker on duty; however the key to the cupboard where creams and ointments were stored, in a communal room, was not kept securely. Controlled Drugs (CD) storage was more secure than general medicines storage due to the increased risks. However, the CD safe was not compliant with the legislation. Therefore, we were not assured that access to medicines was restricted to appropriate staff.

Appropriate arrangements were not in place to store medicines within recommended temperature ranges. A dedicated medicines refrigerator was available with records of the current, minimum and maximum temperatures. These records showed the refrigerator had not remained within the recommended temperature range for medicine requiring refrigeration. On the day of our inspection a maximum temperature for the room available which indicated the room temperature had been above the maximum recommended temperature. Therefore, we were not assured that medicines were safe to administer to people.

Appropriate information was not recorded to assist the administration of medicines. During our visit we reviewed the Medicines Administration Records (MAR) for 21 people living in the home. The MARs contained consistent information concerning the allergies people had, including "No Known Drug Allergy". However discussions with the senior care worker identified that whilst recently reviewed, two documents did not reflect a person's current treatment plan. Topical Medicines Administration Records (TMARs) were used to record

the application of creams and ointments as part of personal care. A care worker told us how the creams and ointments were changed and the frequency of application adjusted to reflect the needs of people. They then showed us three examples of TMARs containing details of the product, where to apply and how often. However, neither the care records nor the MARs contained information on how people preferred to take their medicines. Therefore we were not assured that sufficient consistent information was recorded to ensure the correct administration of medicines to service users.

Appropriate arrangements were not in place for the recording of medicines administration. We reviewed the MARs for 21 people living in the home. From most of these records we could identify which medicines had been administered and when. However, for two medicines administered to one person the administration records had been duplicated, suggesting more medication had been administered that actually had been. When a variable dose was administered as tablets or capsules, we saw the exact quantity administered was recorded on the MAR. However the exact volume of variable dose liquids was not recorded. Therefore, we could not be assured from the records that medicines had been administered as prescribed.

Appropriate arrangements were not in place for monitoring the effectiveness of medicines. One person living in the home was prescribed a medicine that required monitoring to ensure their medicines were effective. Their monitoring records included on-going plans, test results and dates. However, the next test date was not recorded. Therefore, we were not assured from the records that future test dates had been scheduled to ensure the correct dose of the medicine would be administered.

Homely remedies were managed safely. The service held a small stock of homely remedies and documents approved by the person's GP. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds. Therefore we were assured that homely remedies were available for the benefit for people at the home.

Written procedures for the administration of medicines were available; however, they referred to documentation and staff groups not present at the service. Therefore we were not assured that the service's policies and procedures reflected the tasks undertaken by staff to look after people consistently within the home.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

Improvements had been made to the environment, including the bathing facilities. However, the provider had not taken steps to provide care in an environment that was suitably designed and adequately maintained.

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 a previous inspection on 11, 16 and 19 September 2013, we identified that people were not protected against the risks of unsafe or unsuitable premises. We took enforcement action to prevent the provider admitting any new people to the home. During this inspection, on 24, 25 and 26 June 2014, we found the provider had made improvements but was not meeting the requirements of this regulation.

We saw a new shower room had been created, the downstairs bathroom had been refurbished and a new bath hoist installed. Some of the communal areas of the home had been redecorated and new flooring had been laid in some corridors and bedrooms. These changes had made the bathing facilities more suitable for the 21 people living in the home.

The home was based on two floors with a stair lift connecting the two floors. Most bedrooms were en-suite and staff told us these were adequate to enable them to provide personal care to people. A communal lounge and a communal dining room were available for people to spend their time. These were appropriate for the number of people being accommodated.

Records showed fire safety equipment was maintained and tested regularly. A suitable and sufficient fire safety risk assessment had been completed. We found recommendations for improvements, made by the local fire service, had been completed. This meant fire safety arrangements were appropriate for this type of building.

We looked at arrangements for minor repairs and maintenance. The provider employed their own staff to maintain this and other homes in the group. We saw faults were recorded in a maintenance book and signed off when completed. No outstanding faults were awaiting repair at the time of our inspection, which showed the arrangements were satisfactory.

Some areas of the home were in need of decoration. For example, the paint was peeling

off the bannister rail and wallpaper or paintwork were damaged in some bedrooms. The laminate flooring in the main corridor, lounge and dining room were badly worn, with the top layer having worn away. This was particularly pronounced in the dining room where a door closure had made a deep gouge in the doorway. Carpets on the landing and in four bedrooms were dirty and three smelled of urine. The environment was not adequately maintained and did not promote people's wellbeing.

People living at the home were all elderly and many had been identified as having poor mobility. However, we saw handrails were only in place on the stairs and along one of the corridors in the home. We found there was a lack of handrails in other corridors and communal areas to provide support and promote people's independence.

Double doors provided access to a level garden via a shallow ramp. The garden was equipped with garden furniture and we saw people using this area on each day of our inspection. However, we found accessing the garden was not safe for people with limited mobility. The doors did not have retaining hooks and were seen to swing in the wind. This put people at risk of injury if they blew closed unexpectedly. Also, when leant on, the doors wobbled and did not provide people with adequate support. There was no handrail on the ramp which could only be accessed by stepping over a three inch high threshold. This presented a trip hazard and made navigation difficult for people with walking frames.

The garden was not secure. A gate provided access to a driveway, which led to a main road. The gate was secured with a bolt that could be opened from inside the garden. This meant people would be able to leave the home via the garden. Some people would be at risk if they left the home unattended, including one person who was subject to deprivation of liberty safeguards, who was not permitted to leave the home on their own.

Prior to this inspection, the provider sent us an environmental plan detailing improvements they planned to make. These included replacing carpets in bedrooms and redecorating all areas of the home. We asked the provider for a timescale of when they intended to complete these works, but this has not been provided. The provider had not taken steps to provide care in an environment that was suitably designed and adequately maintained.

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff. Appropriate checks were undertaken in most cases before staff began work.

Reasons for our judgement

At a previous inspection on 11, 16 and 19 September 2013, we identified effective recruitment processes were not always followed and necessary checks were not always completed. During this inspection, on 24, 25 and 26 June 2014, we found the provider had made improvements and was meeting the requirements of this regulation.

There were effective recruitment and selection processes in place. A senior member of staff described the processes used to recruit new staff. These included the completion of an application form, an interview and confirmation of training courses attended by applicants. Following recruitment, suitable induction arrangements were in place for new staff to shadow experienced staff until they were considered competent to work alone.

Appropriate checks were undertaken before most staff began work. We looked at the staff files for four members of staff recruited since our last inspection. We saw clear records of the recruitment process were maintained, together with a tracking sheet for each staff member, so the progress of their recruitment could be monitored. Records included application forms, evidence of identification and entitlement to work in the UK, references and Disclosure and Barring Service checks. These showed most staff were suitably vetted. However, the provider may find it useful to note that the reason why one person had left their previous employment, with a health care provider, had not been verified as required. This meant it was not possible to confirm that the person was suitable to work in the home.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs. Suitable staff training, appropriate to their roles, was planned to be delivered.

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

At a previous inspection on 11, 16 and 19 September 2013, we identified there were not enough qualified, skilled and experienced staff to meet people's needs. We took enforcement action to prevent the provider admitting any new people to the home. During this inspection, on 24, 25 and 26 June 2014, we found the provider was not meeting the requirements of this regulation.

We discussed staffing levels with the manager. We found they were initially unclear about the number of staff required on each shift and the process used to determine that number. They later clarified that there should be a senior member of staff plus three care staff on duty during day and late shifts, and a senior and one care staff member on nights. In addition, there was a cook during the week and cleaning staff daily.

We looked at the duty sheets for the three weeks before our inspection. We saw the required number of care staff were always achieved on nights. However, the required staffing levels had only been achieved on day and late shifts for seven of the 21 days we looked at. The manager told us the provider had given authority in the week prior to our inspection for agency staff to be used to cover any gaps. During the days of our inspection, we saw agency staff were being used for this purpose.

We spoke with nine people and five family members of people who were unable to communicate with us. They told us there were times when there were insufficient staff to meet people's needs. One person said this had meant they were sometimes not able to go out on trips and another person told us it meant they didn't always receive certain treatments as frequently as they required. Another person said of the staff, "Sometimes they're a bit short staffed, but it's OK". A family member told us that people "sometimes have to wait for staff". They added, "There used to be good staff visibility as staff did the records in the lounge, but they seem to spend more time in the office now". Another family member said, "Staffing is always a problem, staff often ring in sick. I've seen people not being attended to; they promise to be back to see to people in a moment and never come back". They provided an example of when their relative had "an accident" as there weren't

enough staff to take them to the toilet.

Staff members told us they felt shifts were not always appropriately staffed. One staff member said, "Sometimes we are short and it takes longer to see to people". A community healthcare professional told us "Staffing was a big problem a few weeks ago and a couple of days they were very short staffed". The manager told us they had recruited four additional staff since our last inspection and were waiting for another member of staff to start soon. They told us this would make staffing levels more consistent.

We looked at records of staff training. We saw the provider supported staff to receive appropriate training in subjects they considered 'mandatory'. These included safeguarding vulnerable adults, infection control, fire awareness and manual handling. We saw all care staff were up to date with their training in these subjects. The provider was in the process of supporting staff to receive additional training, which we saw had been booked. This included equality and diversity, dementia and the Mental Capacity Act. Records showed most staff had not completed training in these subjects. This meant they may not have the knowledge and skills required to care for people with dementia. Once this additional training is complete, people will be supported by staff who have received suitable training.

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.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

We have judged that this has a 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

At a previous inspection on 11, 16 and 19 September 2013, we identified there was no effective system in place to regularly assess and monitor the quality of service that people received. Also, the system used to identify, assess and manage risks to the health, safety and welfare of people using the service was not effective. We took enforcement action to prevent the provider admitting any new people to the home. During this inspection, on 24, 25 and 26 June 2014, we found improvements had been made, but the provider was not meeting the requirements of this regulation.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We looked at minutes of residents' meetings which showed they provided opportunities for people to express their views and influence the way the home was run. For example, we saw activities and changes to the layout of the garden had been discussed at their last meeting; we found the requested changes had been implemented.

The home operated a "key worker" system, where people were allocated a staff member to act as a point of contact for the person and their relatives. Records showed key workers spent time with people every month to discuss their care and support needs. We saw 'discussion sheets' had been completed showing what had been discussed. Relatives of two people told us they had been involved in this process.

The provider also used survey questionnaires to assess people's satisfaction with the service. We looked at the results from the most recent survey, conducted in March 2014. We saw responses had been received from people using the service and family members. These showed 61% of respondents were satisfied or very satisfied with the quality of service, 26% were dissatisfied and 13% did not know whether or not they were satisfied. The results had been analysed and action taken to address concerns raised by the survey.

Minutes of staff meetings showed staff were also able to express their views about the way the service was run. At the most recent meeting, we saw staff had discussed the appointing of a new activities coordinator and had identified ways they could work with the coordinator for the benefit of people using the service.

The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. In addition to people's individual risk assessments, we saw assessments had been made of other risks, such as from the environment. These included the kitchen and the laundry room. We saw action had been taken where risks were identified; for example a lock had been placed on the kitchen door to prevent people accessing it. We saw the lock being used during our inspection. However, we found the risks associated with a person who smoked and kept cigarettes and a lighter in their room had not been assessed. This put them and others at risk.

Records of accidents and incidents were kept in the form of a log, so management could track incidents such as falls. We saw appropriate action was taken following falls; for example, one person had their medication reviewed and another person had been referred to a specialist for advice. Records included a monthly and yearly audit so any repeated themes could be identified.

The provider had recently introduced a system of audits to monitor the quality of service provided. These included audits of the kitchen, cleaning, staffing, care plans and medication. However, the system had not had time to become embedded in practice and was not yet working effectively.

For example, records confirmed that care plans had been audited monthly, but it was not clear what issues these had identified or what changes had been recommended or made as a result. An audit of infection control had been completed by an external professional in May 2014 and we saw recommendations had been actioned. However, the provider had not completed their own audit of infection control and had not identified the infection control concerns we found during the inspection, relating to unclean carpets and cushions.

We looked at two audits of medication, completed since January 2014. These had identified areas for improvement; however, changes that may have been undertaken had not been documented. Neither of these audits had identified the concerns we identified during our inspection, such as medicines not being kept securely or at safe temperatures. Therefore the audits were not robust.

The provider did not always take account of complaints and comments to improve the service. We saw records showing written complaints were recorded, investigated and resolved in a timely way. Most people we spoke with told us they were aware of how to complain but had not had cause to. However, one family member told us verbal concerns were not always resolved effectively. They said, "there's no continuity of tracking concerns; the next person on doesn't know about concerns raised the previous day". Another family member told us they "felt ignored" as complaints they had made about a person's clothing going missing repeatedly had not been addressed. We found there was no system in place to analyse complaints and identify learning from them. We discussed this with the manager who told us they would implement such a system.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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

At a previous inspection on 11, 16 and 19 September 2013, we found records for personalised care, treatment and support were not always accurate and fit for purpose. Not all records were stored in a secure and accessible way that allowed them to be located promptly. We took enforcement action to prevent the provider admitting any new people to the home. During this inspection, on 24, 25 and 26 June 2014, we found improvements had been made, but the provider was not meeting the requirements of this regulation.

We found care plans had been completed for each person and followed a clear format. However, care plans for three people did not include key information. For example, one person's diagnosis of a neurological condition was shown in letters from a healthcare professional in a file in the manager's office, but this was not recorded in their care plan. In another case a person had been recently fitted with a device to regulate their heart rate; however, there was no information about it in their care plan. For a third person, there was conflicting information in their care records about an allergy to penicillin. This meant people were at risk of unsafe or inappropriate care and treatment.

Body maps were used to record marks or sores on people's skin. These were dated and described the type of mark found. However, the outcome or progress of the treatment for such sores was not always recorded within the care plans. For example, one record for a person found with a sore three weeks before our inspection stated, "Wash, dry, apply cream. Reported to senior". A review was completed by a senior staff member on the same day which stated, "To keep monitoring skin and sign off any issues outstanding". There were no records to show whether monitoring had been undertaken or if the sore had healed. This meant records were not used effectively to protect people from the risks of inappropriate care.

Records of people's weights were recorded on a white board in the 'nurses' office'. These were coded with colours to show whether the person had gained or lost weight. However, we saw the colour coding used was not always accurate. For example where one person

had lost weight it had been coded to show they had gained weight; where another person had gained weight, it had been coded to show they had lost weight. In the case of a third person, the weight recorded was not accurate.

We noted that entries in care plan records were recorded in time periods, such as between 8:00 a.m. and 2:00 p.m. but the specific time of an event or treatment within each time period was not shown. For example one person felt unwell and a GP was called. The person's care records stated "At end of shift GP had not arrived, passed over to senior on nightshift". The person was subsequently admitted to hospital and underwent surgery. The time the GP was called and the delay in them being seen and admitted to hospital were not documented, so it was not possible for the provider or other professionals to confirm that action had been taken in a timely manner. When they returned from hospital, the time and date of their return were also not recorded.

Three people were provided with alcohol by family members, which staff told us they controlled and administered each evening. However, there were no records of when and to whom alcohol was given. For another person, this, and the lack of accurate times in care records, meant it was not possible to determine whether their behaviour, which challenged others, was linked to their consumption of alcohol.

We looked at records of people's food and fluid intake. We saw people's food intake was recorded in all cases. However, we saw some fluid charts were not completed accurately and fluid intakes were not totalled. It was, therefore, not possible for staff to readily identify whether people had received sufficient fluids and appropriate care. Staff told us they jotted down what people had drunk in a personal notebook, before transferring the information to care records later in the shift. This posed a risk the information may not have been transcribed accurately or in a timely way.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. These were housed in the manager's office which was kept locked when not in use. All records we requested during the inspection were produced promptly. We spoke with a community healthcare professional who told us the service had "changed dramatically" since January 2014 and that records were "more organised".

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 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The registered person did not have suitable arrangements in place to ensure the dignity, privacy and independence of service users. Regulation 17(1)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users. Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

persons who require nursing or personal care	**Care and welfare of people who use services**
	How the regulation was not being met: There were inadequate steps taken to ensure people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. The planning and delivery of care did not always meet people's individual needs. Regulation 9 (1) (a) & (b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
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: The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse. Regulation 11(1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: The registered person had failed to ensure that service users and others were protected against the risk of infection by the maintenance of appropriate standards of cleanliness and hygiene. Regulation 12 (1) & (2)(c) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010**

nursing or personal care	**Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for recording, handling, safe keeping, dispensing and safe administration of medicines. Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person had not ensured that service users were protected against the risks associated with unsafe or unsuitable premises. Regulation 15(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying on the regulated activity. Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
Regulated activity	Regulation
Accommodation for	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

persons who require nursing or personal care	**Assessing and monitoring the quality of service provision**
	How the regulation was not being met: People were not protected against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to regularly asses and monitor the quality of services provided. The provider did not have regard to complaints and comments made by service users. Regulation 10 (1)(a) and 10(2)(b) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from the lack of proper information about them by means of the maintenance of accurate records. Regulation 20 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 21 August 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.

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