Inspection Report

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

Newlands Hall

High Street, Heckmondwike, WF16 0AL

Tel: 019244407247

Date of Inspection: 04 September 2014

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

Care and welfare of people who use services	✖	Enforcement action taken
Meeting nutritional needs	✖	Action needed
Safeguarding people who use services from abuse	✖	Enforcement action taken
Cleanliness and infection control	✖	Action needed
Management of medicines	✖	Action needed
Safety and suitability of premises	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Records	✖	Action needed

Details about this location

Registered Provider	Silverline Care Limited
Registered Manager	Mrs Helen Gill
Overview of the service	Newlands Hall is registered to provide accommodation for up to 37 people who require residential care. Nursing care is not provided.
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

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 September 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information sent to us by commissioners of services and talked with other authorities.

What people told us and what we found

Silverline Care Limited is registered as the provider for Newlands Hall. At the time of this inspection the day to day management responsibilities were discharged to Orchard Care Homes Limited through a Management Agreement. The inspection visit was carried out by two inspectors over one day. During the inspection, we spoke with the manager, a compliance officer from the management company, two senior care assistants, four care assistants, five people who lived at the home and four visitors who were relatives or friends. The inspectors also looked around the premises, observed staff interactions with people who lived at the home, and looked at records.

The person named as manager of the service in this report is no longer in post.

We considered all the evidence we had gathered under the outcomes we inspected.

We used the information to answer the five key 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. The summary describes what we observed, the records we looked at and what people using the service, their relatives and the staff told us.

If you want to see the evidence that supports our summary please read the full report.

Is the service safe?

People were cared for in an environment that was not clean and hygienic. We found

people may not be protected from the risk of infection because appropriate guidance had not been followed.

There were some issues relating to safety of the building. This included an open door to concrete steps leading to the laundry.
There were issues with how staff organised their time to meet the care needs of people living at the home.

One visitor who was a person's relative told us that people who lived at the home were not safe because staff were not always available in communal areas. The visitor said they had needed to intervene to support people when staff were not around.
Safeguarding referrals had not been made as needed.

We made a safeguarding referral in respect of one person whose healthcare needs were not being met and who was at risk of serious illness.

Records were not kept securely, were not well maintained and were not sufficient to support the delivery of care.

Is the service effective?

We looked at five people's care records and found them difficult to use. We could not easily find up to date information within the records to inform staff of the support people needed to meet their needs.

Menus showed the meals provided at the home offered people a healthy, nutritionally balanced diet but people had limited choice. We also saw there were some people living at the home who required assistance from staff to eat their meals and have an adequate fluid intake. Staff did not support people appropriately in this. This meant people were not protected from the risks of inadequate nutrition and dehydration.

We saw that some people did not have their health care needs met.

Is the service caring?

Two people who lived at the home told us that were good and they gave them help when they needed it. Two visitors told us they were generally happy with the care their relatives received.

Two of the visitors we spoke with told us they were concerned about their relative and other people who lived at the home.

The care assistants we spoke with told us they felt there were enough of them to meet people's needs.

When we looked around the home we saw some people's bedrooms were not clean or appropriately furbished.

Care staff did not always respond in a caring manner to people who lived at the home. For example, a person who asked for their walking frame was told they could have it when they had finished their lunch.

Is the service responsive?

Two of the visitors we spoke with told us that staff had not responded appropriately to concerns or queries they had raised.
Some people who lived at the home did not have their needs clearly identified within care records and we saw some people did not have their needs in relation to their healthcare met.

Is the service well-led?

There had been four different managers at the service within the previous seven months. The current manager had been in post for several weeks. The manager was not aware of the care needs of the people who lived at the home. For example, the manager told us none of the people living at the home were living with dementia. We found several people either had a diagnosis or were displaying symptoms of dementia.

The manager was not aware of their responsibilities regarding the people who lived in the flats situated in the grounds of the home.

Issues relating to quality had not been identified during auditing of the home by the company's senior personnel.

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 18 November 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: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Newlands Hall to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

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

During our inspection we observed care and looked at care records for five of the people who lived at the home.

We found care records were very difficult to follow and were unable to locate care plans for specific needs. For example, we wanted to see a care plan for one person's pressure area care but were unable to find it. We asked a senior care assistant and the company's project manager to find it but they were unable to do so. The project manager agreed that the care records were very disorganised and did not reflect people's current care needs.

We also saw examples of care plans not being followed. For example, we observed one person sitting at the dining table saying they couldn't find their walking frame. We saw the person get up and walk unsteadily to the toilet and back. No staff were in the room. When the staff member returned, the person said they wanted their walking frame as they had needed to go to the toilet and had to go without it. The care assistant told the inspector the person hadn't walked without their frame, we confirmed they had as we had seen this happen. The person asked again for their walking frame and the care assistant said they could have it back after their lunch. The inspector intervened and asked the care assistant to give the person their walking frame. When we looked at the person's care plan we saw the person was assessed as being at high risk of falls and needed their walking frame.

We had seen one person was in bed. The manager told us they had a chest infection. We asked if a care plan had been developed for this and the manager said it had. When we

looked at the care plan we saw it had been completed the day before our visit and only gave details of the antibiotic the person had been prescribed. No other details of the care and support the person needed had been documented. One daily evaluation had been made which said, "New, first day." No record had been made of the person's condition.

We saw this person had been admitted to hospital four days prior to our inspection. They had been discharged with a diagnosis of dehydration and urinary tract infection (UTI). We saw the care plan for the UTI only included details of the antibiotic prescribed and gave no details of the care and support needed. There were three daily evaluations which made no reference to the UTI. The care plan had been discontinued two days after it had been developed. This meant there were no directions available for staff to follow in how to care for this person.

When we looked at other care records for this person we saw they had received 50mls of fluid at tea time the previous day and no diet or fluids since. We also saw this person had not received their antibiotic as prescribed. We asked the manager to refer this to the person's GP.

We saw that some care documentation gave conflicting advice about people's care needs. One example was a person who needed their drinks thickening due to a swallowing risk. We found different advice regarding the amount of thickener to be used. We also saw that the speech and language therapist (SALT) had discontinued the use of thickener in July 2014. Care records said to follow the advice in the hand book from the SALT. We were unable to locate this handbook and staff said they didn't know where it was. This meant that staff were not following the advice of healthcare professionals and could be putting the person concerned at risk.

We spoke with two visiting relatives who both told us they were generally happy with the care their relative received. One relative said they thought more could be done to support their family member with orientation as they were living with dementia. They said the clocks were always wrong and there was nothing to orientate people to the day or month. The relative also said they thought things had improved slightly with the new manager, though the manager had not yet introduced themself to the relative.

Two other relatives we spoke were unhappy with the care at the home. They were particularly concerned about people's safety when staff were not around for long periods.

When we asked the manager if there were any people living at the home with a diagnosis or symptoms of dementia, they said there were not. When we looked at care records we found there were a number of people with a diagnosis of dementia. This meant that the manager was not aware of the care needs of people who lived at the home.

Some visiting relatives told us that the day before our inspection a number of exotic animals had been brought into the home for people to hold and look at. This included a snake, a large centipede and cockroaches. One relative told us some people had appeared distressed by these creatures. They said the creatures were just brought into the lounge areas without people being given the choice of seeing them.

We asked the manager if people had been asked about any fears or phobias they might have prior to these creatures being brought into the home. The manager said this had not been done.

We noticed there was a building to the rear of the property. The manager told us it was

private flats and that fourteen people lived in them. The manager said the people who lived there came to the home sometimes for activities. The manager also told us that the people living in the flats had call bells which sounded in the home and that staff would respond to these calls as needed. The manager said calls to the home were rare. We asked to see details of contractual agreement between the residents of the flats and the home. We have not been given this information and the manager was unsure of any agreement.

This situation could impact on the availability of staff in meeting the care needs of people living at the home.

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration.

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

People were not supported to be able to eat and drink sufficient amounts to meet their needs.

Prior to this inspection we had received concerns about people who lived at Newlands Hall not being supported to meet their nutritional and hydration needs.

During our inspection we looked at care records relating to food and fluid intake and observed meal times.

When we arrived at the home we saw a rack of trays in the corridor containing pre-prepared breakfasts. We asked how the cook knew what people wanted for their breakfast. They told us people were asked the previous evening and a list was given to kitchen staff. We asked to see this list. After waiting for a while we went to see if the list had been found. We saw a member of kitchen staff writing the list we had asked to see. This meant that people's choices had not been obtained as we had been told.

We looked at a sample of food and fluid intake charts for five people. We saw that two different charts were in use and the information recorded on them was conflicting. For example, one person's charts showed that on two consecutive days they had not been offered any drinks after 8pm and on one of the days the record showed the person had taken only 600mls of fluid with drinks recorded at 8am, 1pm, 5pm and 7pm.

Another person's chart contained only ticks in the fluid intake column at 11am and 12pm. Only one meal had been recorded on the chart.

We looked at the fluid intake chart for a person who had been admitted to hospital suffering from dehydration. We saw the chart from the day prior to their admission detailed only two drinks taken totalling 270mls. There was no record of any drinks offered after 5pm. We also looked at the fluid intake chart for this person the day after they were discharged from hospital. The chart showed an intake of only 200mls of fluid taken in only one drink throughout the day. There was no evidence of any auditing of intake charts.

We observed the lunchtime meal in two different dining rooms. We saw that people were assisted to the tables up to twenty five minutes before the first meal was served. We also saw that some people were served their meals long before others at the same table.

We saw that everybody was served the same meal of beef stew with pancakes and potatoes. One person expressed their surprise at this combination and another said, "I don't want a pancake with this." Meals were served plated up so nobody had choice of portion size or components of the meal. One person asked a member of staff to take some of their gravy off as they said they couldn't eat the meal with so much gravy. The staff member said they couldn't do that. The person said, "Well I don't want it then." The staff member took the meal away and replaced it with a meal of salmon and vegetables. The person appeared satisfied with this.

We asked the cook what the dessert option was for people with diabetes. The cook said they always got either yoghurt or fruit. No sugar free options were prepared.

We saw one person had been given their meal in their room. The person had not touched their meal for over twenty minutes. We went to see if the meal was still warm. The person said they didn't want it. We tested a small piece of the food and found it to be cold. We looked at this person's care plan for eating and found it said the person needed a lot of encouragement to eat their meals. They had been referred to the dietician due to losing weight. We saw they had lost 4.3 kg in five months. We asked a care assistant why this person had not been supported to eat their meal. The care assistant said they had been busy assisting another person.

We saw that some people were served drinks in baby's feeding cups. When we asked the manager about this they said people's relatives had brought them in. We asked the visiting relative of one person who had been given one of these cups and they said they had not brought it in. They said they were supplied by the home.

One visitor whose relative was using one of these cups told us their relative was often given the cup with the spout down. They were not able to put the spout in the drinking position themselves which meant they could not have their drink. They also told us their relative had been served hot chocolate with cream in one of these feeding cups. This was too thick to go through the spout so the person was unable to drink it.

Most of the people we spoke with told us they enjoyed the food at the home but one person said they would like more choice.

Safeguarding people who use services from abuse ✖ Enforcement action taken

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 not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

Reasons for our judgement

People who use the service were not protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Prior to our visit we received information of concern about the alleged bullying of a person who lived at the home by other people who lived at the home.

We looked at the care records for the person who had allegedly been bullied. We saw a care plan entitled 'Mental State' had been developed in November 2013 which said the person could be "aggressive at times" and instructed staff to use an ABC chart. This is an assessment tool used for assessing what might cause a person to display behaviours that challenge and what the consequences of that behaviour were. An evaluation of this care plan in August 2014 said, "Doesn't like one of the other clients, can get unsettled, staff to keep apart." There was no care plan available to show how to manage this person's behaviour or how staff were to protect this person from other people who lived at the home.

We spoke to care staff who told us there had been incidents involving this person when another person had shouted at them and told them to get out of the room. We asked the member of care staff what they would do when this happened. They said they would take the person away. We asked the staff member if they thought this was abuse and should be reported. The staff member said they didn't know. Another senior staff member said the person was "picked on" by another person who lived at the home. When we asked what they did about this the senior care assistant said, "We just monitor it, try to keep them apart."

We asked the manager how the ABC charts were used for documenting and assessing the

person's behaviour. The manager was unclear about this.

We asked a senior care assistant if they had received any safeguarding training. They said they didn't know what safeguarding meant. We asked if they had received training in abuse and they said they had not had any recently, maybe a few months ago but they were not sure.

We asked the senior care assistant about different types of abuse that might occur and they were able to list them. They said they would report any incidents to the manager.

We asked what they would do if they were in charge and the manager wasn't available. The senior care assistant said they didn't know. They said they were not aware of the safeguarding procedure and had not been taught about it. They said they thought it might be reportable but did not know who to.

We asked the senior care assistant if they knew about the Mental Capacity Act and in particular Deprivation of Liberty Safeguards. The person said they didn't know anything about that.

We asked the manager if any referrals had been made through safeguarding procedures in respect of the person who was 'picked on' by other people. The manager said they were unaware of the situation.

When we looked at incident reports we saw a record of the person having had a glass of orange juice thrown at them. There was no documentation to show this had been reported to safeguarding.

We asked the manager to make sure safeguarding referrals were made as appropriate.

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.

People were not cared for in a clean, hygienic 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

There were not effective systems in place to reduce the risk and spread of infection.

When we looked around the home, we found several examples of poor standards of cleaning and infection control. We found several chairs in lounges and bedrooms were stained and worn. We saw evidence of spillages down the walls in some bedrooms and some carpets were stained and very worn.

Some bedrooms had been recently refurbished and were clean and well presented. Others had worn carpets, dirty windows and fittings and were dusty in several areas.

We saw two chairs where the zip on the seat cushion had broken. The cushions had been covered with black bin liners which were torn and ill fitting. This meant these chairs could not be cleaned properly.

We found a strong unpleasant odour in two of the bedrooms we visited.

We saw that much of the crockery in use was damaged and stained. Damage to the glaze on the crockery and heavy staining on plastic cups meant they could not be cleaned properly.

The laundry room was not clean and the floor and walls were concrete with several damaged areas. This made cleaning of this area very difficult. We saw a jug used for putting laundry liquids into the machines was caked with dried on liquid and very dirty.

We did not see people who lived at the home were supported to wash their hands prior to meals or to the chocolate tasting event held during our visit.

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 had appropriate arrangements in place to manage medicines.

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

Medicines were not handled appropriately.

During our visit to the service we examined the systems for the receipt, storage, administration and recording of medicines.

A senior care assistant told us that when medicines are delivered to the home on a monthly basis they are stored in an empty bedroom until they can be put in the medicine trolleys. We looked in the bedroom and saw there were no lockable storage facilities in which to store medicines.

We saw a large bucket in the bedroom which contained a large number of bags from the pharmacy. The bags had been screwed up as if ready to be thrown away. When we looked in three of the bags we found repeat prescription forms and printed Medication Administration Record (MAR) charts . These contained the detail of the person the prescription was for and the repeat prescription form. We showed this to the manager who said they had been unaware of this.

We saw that medication was stored in two trolleys with stock medication in a cupboard. The cupboard and one of the trolleys were located in the manager's office. There was no thermometer in this room and no records of the temperature the medication was stored at had been taken. Temperature checks had been made for the storage of medicines in the second trolley.

We looked at the MAR chart for one person we had been told was ill and on antibiotic therapy. We saw from the MAR chart that the person had not been administered any of their six medications, including the antibiotic on the morning of our visit. We saw notes had been made on the reverse of the MAR which listed each medication and gave the reason for not being administered as "Asleep." A further column on the sheet had been completed with "To give later." We did not see any indication of any further attempts to give this person their morning medication. We saw the lunchtime dose of antibiotic had been signed

as given.

At the front of this person's MAR chart we saw a letter from the dietician saying that the person was to be given the dietary supplement Fortisip. We noted this was not on the MAR sheet. The senior care assistant said this had been discontinued and a different supplement prescribed. This meant that the information in this person's medication records was not clear or up to date.

We looked at another person's records in relation to the medicine Warfarin. We saw the person was prescribed 1 milligram tablets and 500 microgram tablets. A separate sheet had been put in this person's medication records on which the 500 microgram tablet had been recorded as 500 mg. We counted the stock of the of the 1mg tablets and found a total of 52 tablets. The MAR chart indicated only 25 tablets in stock. We found the same when we counted the 500mcg tablets. This meant that staff were not keeping accurate records of the amounts of medication in the home.

We had spoken to a person who lived at the home who told us they were not allowed certain foods or alcohol because of the medicines they were taking. We looked at this person's MAR chart and could not find any instruction to indicate that this person's diet had to be restricted.

We looked at another person's MAR chart which included the directions for Paracetamol tablets to be given four times each day. The MAR chart had started on 1 September 2014. We saw the Paracetamol had been signed as administered only three times each day. The recording code "N" had been used to indicate on each day that the bedtime dose had not been given. The instructions on the MAR chart were for the code "N" to be used when a person did not need their 'as required' (PRN) medicines. The Paracetamol had not been prescribed on a PRN basis. This meant the person had not received their medication as prescribed.

We saw a senior carer administer medicine to a person whilst they were being supported by two carers to stand up from a chair. The senior care assistant did not speak to the person and tipped their medicine into their mouth from a small medicine pot and then walked away. The person was not offered a drink with their medication. This meant the administration of this person's medicine was inappropriate.

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.

People who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

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

Reasons for our judgement

The provider had not taken steps to provide care in an environment that is suitably designed and adequately maintained.

During our visit we looked around all of the communal areas, looked in twenty bedrooms and visited the laundry.

We noted that some bedrooms did not have extension leads on the call bells and that the call bells were not accessible for people in bed or in other parts of the room.

We also noticed that where people had a sensor mat in place, there was no adaptor available to be able to plug in a call bell lead. We saw in one room a sensor mat was in place but this had been unplugged and was covered with a crash mat.

This meant people would not be able to alert staff for assistance and that staff would not be alerted to someone falling out of bed.

Prior to our inspection we had received information of concern regarding a lack of call bells in communal areas. We were told that visitors had needed to alert staff on several occasions when people who lived at the home needed assistance. During our inspection we found that call bell extension leads were not available in lounges and some toilets.

We found that some toilets did not have locks on the door and others did not have indicators to show when the toilet was engaged. This meant that people were not always afforded privacy when using the toilet.

We saw that some bedrooms had a toilet enclosed by a door and panel. We found that there was not enough room to close the door when a person was sitting on the toilet. In another room we saw the toilet was enclosed with a shower rail and curtain. The curtain was not hung properly and had been draped over the rail. Both of these arrangements were unsuitable for the purpose of ensuring people's privacy.

We saw the bay windows in bedrooms situated at the front of the house were mouldy and the paint and sealant around the windows was loose and flaking off. One relative we spoke with told us this made the room very cold. We saw fan heaters had been attached to the ceiling above the windows in these rooms. The fan heaters were coated in dust which presented a fire hazard.

We saw the laundry was situated below ground level. The door to the steep concrete steps leading to the laundry was propped open. This presented a safety risk to people living at the home.

We found the concrete floor in the laundry was not sealed, the area behind the washing machine was dirty with dust, cloths and other bits on floor. There was also a large hole in the plaster on the wall. There was no hanging space available and no baskets to put clothing in. Dryers were situated in a shed outside the home. Again we found this room very dusty and were unable to ascertain whether the dryers had been appropriately vented.

We saw an electrical wiring box on the wall of one of the bedroom corridors . We saw a sticker on the box which said the last inspection had been done in May 2009 and was due again in May 2014. There was no evidence this check had been completed. When we asked the manager they said they didn't know.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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

Reasons for our judgement

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.

During our visit to the service we identified a number of areas of concern. These included issues relating to care delivery, hygiene standards and safety and suitability of the premises.

We asked the manager if they did their own auditing. The manager told us they walked around the home on a regular basis to check on standards. We asked if we could see their records relating to this. The manager said these checks were not recorded.

We saw reports of regulation 10 visits which had been completed by one of the providers' compliance officers in July and August 2014. We saw the reports commented on the worn corridor carpets and that quotes had been received for the refurbishment of the laundry. The report also said 'awaiting quotes' for windows. The report did not comment on any of the bedrooms.

The August 2014 regulation 10 report included details of a person at the home having had a glass of water thrown over them by another person. The report goes on to say that staff informed the compliance officer that there had been "numerous occasions lately with both the residents where conflict issues have arose." There was no follow up recorded regarding this situation and no auditing of referral to safeguarding.

This meant that even when issues occurred during auditing, they were not followed up appropriately.

Auditing of care files recorded on the regulation 10 reports did not reflect the issues we identified during the inspection.

The regulation 10 report from June 2014 indicated that two complaints had been received by the home. There was no detail about these. The complaints section in the August 2014 report said, "QA not complete".

We had spoken with relatives and friends of people who lived at the home who told us they did not feel their complaints, concerns or requests were responded to appropriately.

This meant that although some auditing was taking place, it was not effective.

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 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

People's personal records including medical records were not accurate and fit for purpose.

Whilst looking around the home we saw a number of files located in the hallway. We saw that these files contained personal information relating to the people living at the home. This included details of people's intake and elimination. We also noticed a book which gave personal details of people living in the private flats situated at the rear of the property. This meant that personal records were not kept securely.

We looked at care records for five people living at the home. When we looked at care files we found that care documentation was poorly completed. This made it difficult to determine people's current needs. For example, when we wanted to establish the needs of one person with regard to their pressure care and skin integrity we were unable to locate the relevant care plan. We asked a member of senior care staff to show us where we might find it. They were unable to do so.

We saw that another person had been assessed as being at high risk of falls. Again we were unable to locate a care plan in relation to this assessed need.

In another person's file we found six different mental capacity assessment forms. All of the forms had been poorly completed and contained confusing and conflicting information. This meant the results of the assessment were not clear.

We looked at one person's 'repositioning' charts. Columns on the charts asked for detail of the person's position, the frequency of skin reacting to pressure and the result of the skin inspection. We saw none of these columns had been completed and comments including, "got out of bed", "toilet" and "walked to chair" had been written across the columns.

We looked at forms for one person entitled 'Input/output/pressure area care.' Again we found the forms to be inappropriately completed. For example, the column headed 'Action/observation/comments' had been completed with lists of the food and fluids offered

to the person. The columns headed Diet and Fluids had the word 'Declined' written across it.
This made the information held on the form confusing and difficult to follow.

We showed the care files to the visiting compliance officer who agreed they were confusing and in urgent need of review.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: People were not protected from the risks of inadequate nutrition and dehydration.
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: People were not cared for in a clean, hygienic environment.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.
Regulated activity	Regulation

This section is primarily information for the provider

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: People who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.
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: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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 18 November 2014.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 30 October 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
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: Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.
We have served a warning notice to be met by 30 October 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
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: People who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.
We have served a warning notice to be met by 30 October 2014	

This section is primarily information for the provider

This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: 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

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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