Review of compliance

Meeraraj Limited Copper Beech Care Home	
Region:	South East
Location address:	154 Barnhorn Road Bexhill-on-Sea East Sussex TN39 4QL
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	Copper Beech Care Home is registered to provide nursing or personal care for up to 42 people with dementia type illnesses. It is registered for the regulated activities: treatment of disease, disorder or injury and diagnostic and screening procedures. All rooms are single occupancy with en suite facilities. The home is situated on the outskirts of Bexhill-on-Sea. It is set in its own grounds with views over the

	surrounding countryside.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Copper Beech Care Home was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Copper Beech Care Home had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 27 March 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us they had enjoyed their lunch that day. One person told us they had chosen to rest in their room after lunch, this was seen to have taken place. However, one individual spoken with told us they wanted a cup of coffee but had been given tea.

What we found about the standards we reviewed and how well Copper Beech Care Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

There was evidence of choice in the care plans. However there was no evidence of choice or flexibility in the care we observed being delivered.

People were not always treated with dignity, or spoken to with respect.

Confidential information was not stored appropriately.

People were not offered a choice offered in relation to meals and refreshments.

Overall improvements were needed for this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

People did not always experience effective, safe and appropriate care, treatment or support that meets their needs.

People living in the home including those with challenging behaviour did not have their assessed risks or identified support needs met.

Limited evidence was seen of activities taking place on a regular basis.
Overall improvements are needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The home layout and design was appropriate for people using the service. However, due to a lack of maintenance throughout the home areas such as the conservatory and garden were unusable.
We observed that some cleaning substances were not stored securely.

People may be at risk of infection due to insufficient gloves being available.

Overall improvements were needed for this essential standard.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

From our observations and discussions with people and staff, current staffing levels were not sufficient to meet the needs of the people living at Copper Beech. The layout of the home made it difficult for one RN to provide a safe level of cover. The current chef did not have relevant qualifications or experience.

Overall improvements were needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff had received mandatory training updates during the past year. However, there was limited evidence that all staff had received supervision or appraisals. No challenging behaviour training had taken place.

Overall improvements were needed for this essential outcome.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

There was evidence that some quality monitoring taking place. However, this was very limited and needed further development.

Overall improvements were needed for this essential standard.

Outcome 26: People who provide the service must have the financial funds to run a service that meets all essential standards of safety and quality

Records inspected, observations made, and discussions held during inspection indicated that the provider had not taken reasonable steps to ensure they achieved the aims and objectives of the service.

Analysis of the Provider's financial accounts showed that the financial position of the organisation was under pressure.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we found that improvements were needed for the following essential standards:

- Outcome 11: People should be safe from harm from unsafe or unsuitable equipment
- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 05: Food and drink should meet people's individual dietary needs
- Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
- Outcome 09: People should be given the medicines they need when they need them, and in a safe way

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Not all of the people we spoke with were able to tell us about their experiences of living in the home. However, one person told us that they were not offered a choice of drinks.

Other evidence
We looked at six care plans. We saw that people (and, if necessary their representatives) had been involved in planning their care, and had been consulted about choices and decisions regarding their day to day lives. For example, what time they preferred to get up and go to bed.

Bedrooms were seen to be personalised with individuals own photographs and possessions. Staff told us that people were able to get up and have breakfast at a time of their choice. During our visit we saw people eating their breakfast throughout the morning.

There was information in the care plans to inform staff whether individual bedroom doors were to be left open. If bedroom doors were shut they could not be opened without a staff swipe card. If people chose to keep their bedroom doors closed staff would assist them to return to their rooms if they wished. There was no evidence in care plans to state that people had agreed to be locked out of their rooms.

However, evidence from our inspection showed that although peoples' choices and preferences were recorded in their care plans, they were not always followed through or acted upon. For example. One plan informed us that the individual enjoyed a cooked breakfast. However, records showed that people living at the home were not offered this choice.

During the inspection we observed that people were not consulted or offered choices about their care and treatment, or offered choices about their diet or refreshments:

One person in their bedroom had a cup of tea and biscuit left on their tray. This person told us they would have preferred to have had coffee, but they were not given the choice. The same person had a television turned on in their bedroom, but had not been asked which channel they would like it set to.

People were not offered a choice of meal and there was no evidence that alternative meals were offered if people did not like the food provided. At 10.50am one person in the lounge requested refreshments. They were told that a cup of tea would be provided at 11am and lunch would be at 12.30pm. We observed people being given cups of tea. There was no evidence they were offered an alternative. We heard one person being asked if they would like a biscuit. They were then handed one biscuit, no choice was given although we observed there was a variety available.

We observed a member of staff cutting people's fingernails in the lounge in beech unit. This member of staff wore the same gloves as they moved from person to person. One person who had their nails cut was sat at a dining table. We did not observe these people being asked whether or not they wished their nails to be cut.

We found that people's health care needs had not been appropriately reviewed when their needs had changed following an improvement in health. For one person we saw a do not resuscitate (DNAR) form. This had not been updated following a change in their condition.

Communication was observed between staff and people who lived at the home. Whilst we observed staff talking respectfully and kindly with people, engaging them in conversations and activities, we also observed interactions which showed that people did not have their dignity respected. For example: We met with a resident in the lounge on Copper unit. He enjoyed talking with us and followed us towards the office. The acting manager advised the senior carer to "close the door quickly, so he doesn't go upstairs". At lunchtime in Copper unit we observed staff member talk loudly across the table to a female resident "you've got food all over your blouse".

We saw that the provider had not ensured that everyone living at the home had appropriate linen on their beds. This meant basic needs were not met, and that people's dignity was not respected. Some duvets viewed did not have covers on them. It was not clear if covers would be put on prior to people returning to bed. Staff we spoke with told us there was a shortage of covers. Fitted sheets were observed not to fit the mattresses properly causing them to curl up. Pillows were seen to be out of shape, flattened and lacking substance. Beds that did not have duvets had a sheet and only one blanket. Staff we spoke with told us there was a lack of bedding available.

Our judgement
There was evidence of choice in the care plans. However there was no evidence of choice or flexibility in the care we observed being delivered.

People were not always treated with dignity, or spoken to with respect.

Confidential information was not stored appropriately.

People were not offered a choice offered in relation to meals and refreshments.

Overall improvements were needed for this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Not all of the people we spoke with were able to tell us about their experiences of living in the home. One person we spoke with told us that she had enjoyed her afternoon nap.

Other evidence
Care plans and daily records were well organised. It was easy to access relevant information. They were stored securely in locked cupboards in the home. The records were accessible to staff as they required them.

Care plans viewed were person centred and reflected the individuals' needs. There was a wide range of assessments, risk assessments and care plans, which were used to inform care.

Risk assessments and care plans were documented as being reviewed monthly. All care plans viewed contained a photograph of the individual and care plan consents, signed by the individual or their relative. There was evidence that relatives were involved in six monthly care plan reviews.

Care plans seen showed people were weighed monthly. There was evidence in one care plan that an individual had lost weight. The nutritional risk assessment included guidelines for staff. These included providing snacks between meals, using drink supplements and assisting the individual to eat their meals. This person had gained weight and was now slightly in excess of their original weight.

Oral health assessments informed staff if the person was registered with a dentist and when the last dental inspection had taken place. If an individual was not registered with a dentist there was no evidence that dental assessments had taken place.

End of life care plans were seen. For one individual this had not been completed. The care plan was reviewed monthly. The review stated that the care plan had not been completed but there was no information why it had not been completed.

We observed untouched cups of tea and breakfast being removed from people who were asleep in bed. They were not woken to be asked whether they had finished. Fresh cups of tea were not offered. When the mid morning drinks and biscuits were served, the same situation was observed. Another individual was observed having a cup of tea removed from their bedside table. However, when asked, the nurse in charge of the unit informed us this individual had drunk all his drinks that morning.

We observed one individual who was spooning porridge into their teacup and tea into their porridge. A member of staff was present in the dining room although she was not seen to be supervising this person. This persons care plan informed staff that the individual needed support and encouragement to eat their meals. A risk assessment stated this person should not be left unsupervised when drinking hot drinks. There was a conflict between the pressure area risk assessments for this person which stated this person had a poor appetite. However, the nutritional assessment recorded that the person ate half of their meals. The comments detailed in the care plan stated that they continued to eat well. A detailed care plan for eating and drinking recorded that this person eats and drinks better if staff sit with her.

We observed a person sleeping on the very edge of their bed, with one leg hanging over. We perceived this person to be at risk and requested staff support for this person. Staff told us that the person "always sleeps like that". We were subsequently advised that this person was unwell that day and awaiting a visit from the doctor.

We identified that a number of the bedrooms did not offer the use of call bells. One member of staff told us that some these were still to be fitted. In other rooms where people were in bed, their call bells were observed to be hung on the wall out of reach. These people would have been unable to summon help should they have required it.
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We found that people's privacy and dignity were compromised at the home. We observed a bed in the lounge in Copper unit with a screen to the side. Staff later confirmed that one person used this bed during the day. Staff also confirmed that this person received personal care whilst in bed in the lounge.

We raised concerns with the person in charge about the way an individual was supported with their lunchtime meal. The care plan identified that this person was at risk of choking and stated that they should be re-positioned throughout mealtimes to maintain an upright posture. The staff member assisting this person at lunchtime was not seen to follow this guideline. The staff member was also seen to eat their own food before supporting the resident.

People who required one to one supervision were seen to receive this throughout our visit. However for one person there was limited interaction taking place. This person

was observed sitting in the conservatory. The member of staff was sitting away from the person and was not seen to engage with them. Eventually this person fell asleep and was seen slumped over the arm of the chair. The member of staff did not attempt to make this person more comfortable.

We spoke with a member of staff who provided activities for the people living at the home. There was a comprehensive programme in place which included word games, armchair exercises, and reminiscence sessions. Until recently there had been two members of staff running the programme. However, the one person had left and had not been replaced. Therefore, the amount of activities provided was reduced. The activity coordinator also worked as a member of care staff. We were told by staff that when staffing levels dictated this member of staff would be taken away from providing activities to assist with care needs.

We saw evidence in an individuals six monthly review that a relative had requested more activities for people living at the home. Staff we spoke with told us they would like the opportunity to take people out for walks. Staff also told us that they enjoyed spending one to one time with people however they did not have enough time to do this on a regular basis.

Our judgement
People did not always experience effective, safe and appropriate care, treatment or support that meets their needs.

People living in the home including those with challenging behaviour did not have their assessed risks or identified support needs met.

Limited evidence was seen of activities taking place on a regular basis.
Overall improvements are needed for this essential standard.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
People who use this service made no specific comments about this outcome.

Other evidence
The home is located in large, attractive grounds overlooking countryside. At the time of our visit none of the outside area had been levelled or secured and as such it was not safe for people to access from the home.

All bedrooms were en suite, and were seen to be clean, tidy and personalised. Stairway doors were kept locked and were linked to the fire alarm system. A lift provided level access throughout the home.

One persons room we viewed did not contain any furniture or personalised items. The television was not plugged in and there was no aerial. There was conflicting information from staff interviews as to whether the needs of this person required such a minimalist room.

There was a large conservatory adjoining the lounge and dining room on Beech unit. There were no blinds in the conservatory and this made the room too hot to sit in.

One door which was labelled 'keep locked' was found to be unlocked during our inspection. This room contained continence pads, bedding, dressings and catheter bags. Another door labelled as keep locked was locked, however a key was observed hanging from a piece of string. This room was seen to contain substances that were hazardous to health (COSHH).

Ground floor bedrooms which overlooked a front courtyard and car park did not have any net curtains or privacy blinds in place. As discussed in outcome 1, there was a lack of adequate bed linen.

Flooring in the communal hallways was found to be very sticky underfoot. A treatment room on Beech unit which contained peoples care plans was seen to be cluttered with various items which we were informed belonged to former residents (glasses, false teeth etc). The registered nurse (RN) told us that she had put up a notice requesting that the room was kept tidy. However, this had been obscured by the clutter. The RN cleared the room during our inspection.

The home was large and bright. It was well designed and able to meet the needs of the people who lived there. However, the home was in need of maintenance and areas of redecoration throughout.

Bathrooms were observed to be clean. However, one bathroom that we viewed contained paraphernalia such as make-up brushes, shoes and pads.

The maintenance personnel had recently developed a comprehensive programme to undertake regular maintenance checks throughout the home. The home had recently engaged the services of a health and safety consultant to provide support with this. There was evidence that the fire alarm was tested weekly, door releases were also tested at this time. Water temperatures were recorded and issues highlighted were raised with the plumber.

We saw maintenance certificates for electrical testing, sluice and hoists. We were told that issues raised at previous fire and health and safety inspections had now been actioned.

Gloves, aprons and paper hand towels were seen to be available throughout the home. However, staff that we spoke with told us that on occasions there were insufficient gloves and wipes available to meet the needs of the people who lived at the home.

Our judgement
The home layout and design was appropriate for people using the service. However, due to a lack of maintenance throughout the home areas such as the conservatory and garden were unusable.
We observed that some cleaning substances were not stored securely.

People may be at risk of infection due to insufficient gloves being available.

Overall improvements were needed for this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People who use this service made no specific comments about this outcome.

Other evidence
At the time of our inspection there was no registered manager in post. The position was currently being advertised. At the time of our visit the home was being managed by two RN's 'acting up' with the support of the administrative assistant. There was no clear evidence that these two members of staff had been provided with any protected time to undertake managerial roles. Throughout the inspection, there were concerns raised about the lack of overall management of the home. There was evidence from our observations, talking with people and staff interviews that the lack of one person having an overview of the entire service was to the detriment of Copper Beech.

In Copper House two people were funded for one to one care. In addition to this four other care staff were on duty including one RN.

In Beech House there was three care staff on duty, including one RN.

Between 5pm-10pm there was an additional member of care staff floating across both units.

During the afternoons there was only one RN on duty to cover both units. At weekends there was only one RN on duty all day. No evidence was seen as to why less trained nurses were required at the weekend. Staff we spoke with told us that they did not have

enough time to read the care plans.

There was one activity coordinator who covers both units. This person also worked as a member of care staff prior to commencing work as an activity co-ordinator. If there were insufficient care staff on duty then this person would be required to assist with care rather than activities.

We were informed of concerns in respect of an unqualified chef. When we looked at the staff file it was apparent that this person had no experience or qualifications in respect of being a chef. We were informed of concerns in respect of the quality of the meals prepared and the safety of the processes being used in the kitchen. A review of complaints also highlighted that some residents and relatives had expressed dissatisfaction with the food.

There were currently vacancies for two members of care staff.

Our judgement
From our observations and discussions with people and staff, current staffing levels were not sufficient to meet the needs of the people living at Copper Beech. The layout of the home made it difficult for one RN to provide a safe level of cover. The current chef did not have relevant qualifications or experience.

Overall improvements were needed for this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People who use this service made no specific comments about this outcome.

Other evidence
We looked at the training matrix. Out of 40 staff, 27 had completed infection control updates, 31 had completed safeguarding vulnerable adult updates and 37 had completed moving and handling updates in the past year.

Ten out of 40 staff had undertaken first aid updates. Out of 37 eligible staff 25 had undertaken food hygiene updates and 26 out of 38 eligible had undertaken dementia training in the past year.

Although a number of people living at the home had challenging behaviour needs there was no evidence that staff had undertaken any challenging behaviour training.

There was evidence that staff meetings had been held in August 2011, November 2011 and March 2012. We saw evidence that staff supervisions were being conducted, but not all staff had received regular one to one sessions. Currently there were no staff appraisals taking place.

Our judgement
Staff had received mandatory training updates during the past year. However, there was limited evidence that all staff had received supervision or appraisals. No challenging behaviour training had taken place.

Overall improvements were needed for this essential outcome.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People who use this service made no specific comments about this outcome.

Other evidence
Our inspection highlighted shortfalls that had either not been identified by the home's own systems or had not been actioned. There was no evidence that the home had used information gathered from stakeholders in a meaningful way to make improvements to the service. We saw evidence that a relatives meeting had been held in August 2011. Relatives' questionnaires had recently been sent out however, not all information had been returned or collated at the time of our inspection.

The home maintained logs in respect of weights, falls and pressure sores but this information was not being audited effectively. As discussed in Outcome 4, we found that people's care plans had not been updated when a change in support need or a change in risk had been identified.

There was no evidence of care plan audits or a provider annual audit.

Our judgement
There was evidence that some quality monitoring taking place. However, this was very limited and needed further development.

Overall improvements were needed for this essential standard.

Outcome 26:
Financial position

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that the service provider is able to meet the financial demands of providing safe and appropriate services.

What we found

Our judgement

There are moderate concerns with Outcome 26: Financial position

Our findings

What people who use the service experienced and told us
People who use this service made no specific comments about this outcome.

Other evidence
Evidence found during the inspection indicated there may be some financial concerns at the home. Staff told us that they arranged parties for people who lived at the home, requests to the provider for funds had been declined. Where areas of maintenance were identified to staff we were told there was "never enough money to do things". We observed there was a lack of bed linen available and on occasions there was a lack of personal protective equipment. Other professionals we spoke with also expressed concerns about lack of available finance to run the home. Following the inspection we required the provider to submit financial accounts for 2010 /11 and 2011/12 to determine financial viability. Accounts received for 2010/11 indicated that the financial position of the organisation was under pressure.

Judgement

Our judgement
Records inspected, observations made, and discussions held during inspection indicated that the provider had not taken reasonable steps to ensure they achieved the aims and objectives of the service.

Analysis of the Provider's financial accounts showed that the financial position of the organisation was under pressure.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: There was evidence of choice in the care plans. However there was no evidence of choice or flexibility in the care we observed being delivered. People were not always treated with dignity, or spoken to with respect. Confidential information was not stored appropriately. People were not offered a choice offered in relation to meals and refreshments.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: There was evidence of choice in the care plans. However there was no evidence of choice or flexibility in the care we observed being delivered. People were not always treated with dignity, or spoken to with respect. Confidential information was not stored	

	appropriately. People were not offered a choice offered in relation to meals and refreshments.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: There was evidence of choice in the care plans. However there was no evidence of choice or flexibility in the care we observed being delivered. People were not always treated with dignity, or spoken to with respect. Confidential information was not stored appropriately. People were not offered a choice offered in relation to meals and refreshments.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People did not always experience effective, safe and appropriate care, treatment or support that meets their needs. People living in the home including those with challenging behaviour did not have their assessed risks or identified support needs met. Limited evidence was seen of activities taking place on a regular basis.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People did not always experience effective,	

	safe and appropriate care, treatment or support that meets their needs. People living in the home including those with challenging behaviour did not have their assessed risks or identified support needs met. Limited evidence was seen of activities taking place on a regular basis.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People did not always experience effective, safe and appropriate care, treatment or support that meets their needs. People living in the home including those with challenging behaviour did not have their assessed risks or identified support needs met. Limited evidence was seen of activities taking place on a regular basis.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The home layout and design was appropriate for people using the service. However, due to a lack of maintenance throughout the home areas such as the conservatory and garden were unusable. We observed that some cleaning substances were not stored securely. People may be at risk of infection due to insufficient gloves being available.	
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities)	Outcome 10: Safety and suitability of premises

	Regulations 2010	
	How the regulation is not being met: The home layout and design was appropriate for people using the service. However, due to a lack of maintenance throughout the home areas such as the conservatory and garden were unusable. We observed that some cleaning substances were not stored securely. People may be at risk of infection due to insufficient gloves being available.	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The home layout and design was appropriate for people using the service. However, due to a lack of maintenance throughout the home areas such as the conservatory and garden were unusable. We observed that some cleaning substances were not stored securely. People may be at risk of infection due to insufficient gloves being available.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: From our observations and discussions with people and staff, current staffing levels were not sufficient to meet the needs of the people living at Copper Beech. The layout of the home made it difficult for one RN to provide a safe level of cover. The current chef did not have relevant qualifications or experience. Overall improvements were needed for this essential standard	
Diagnostic and screening procedures	Regulation 22	Outcome 13: Staffing

	HSCA 2008 (Regulated Activities) Regulations 2010	
	How the regulation is not being met: From our observations and discussions with people and staff, current staffing levels were not sufficient to meet the needs of the people living at Copper Beech. The layout of the home made it difficult for one RN to provide a safe level of cover. The current chef did not have relevant qualifications or experience. Overall improvements were needed for this essential standard	
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Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff had received mandatory training updates during the past year. However, there was limited evidence that all staff had received supervision or appraisals. No challenging behaviour training had taken place. Overall improvements were needed for this	

	essential outcome.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff had received mandatory training updates during the past year. However, there was limited evidence that all staff had received supervision or appraisals. No challenging behaviour training had taken place. Overall improvements were needed for this essential outcome.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff had received mandatory training updates during the past year. However, there was limited evidence that all staff had received supervision or appraisals. No challenging behaviour training had taken place. Overall improvements were needed for this essential outcome.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There was evidence that some quality monitoring taking place. However, this was very limited and needed further development. Overall improvements were needed for this essential standard.	

Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There was evidence that some quality monitoring taking place. However, this was very limited and needed further development. Overall improvements were needed for this essential standard.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There was evidence that some quality monitoring taking place. However, this was very limited and needed further development. Overall improvements were needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 13 CQC (Registration) Regulations 2009	Outcome 26: Financial position
	How the regulation is not being met: Records inspected, observations made, and discussions held during inspection indicated that the provider had not taken reasonable steps to ensure they achieved the aims and objectives of the service. Analysis of the Provider's financial accounts showed that the financial position of the organisation was under pressure.	
Diagnostic and screening procedures	Regulation 13 CQC (Registration) Regulations 2009	Outcome 26: Financial position
	How the regulation is not being met: Records inspected, observations made, and	

	discussions held during inspection indicated that the provider had not taken reasonable steps to ensure they achieved the aims and objectives of the service. Analysis of the Provider's financial accounts showed that the financial position of the organisation was under pressure.	
Treatment of disease, disorder or injury	Regulation 13 CQC (Registration) Regulations 2009	Outcome 26: Financial position
	How the regulation is not being met: Records inspected, observations made, and discussions held during inspection indicated that the provider had not taken reasonable steps to ensure they achieved the aims and objectives of the service. Analysis of the Provider's financial accounts showed that the financial position of the organisation was under pressure.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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 within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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