

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

## Firwood House

Firwood House, Brassey Avenue, Hampden Park,  
BN22 9QJ

Tel: 01323503758

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November 2012

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

<b>Respecting and involving people who use services</b>	✓	Met this standard
<b>Care and welfare of people who use services</b>	✓	Met this standard
<b>Safeguarding people who use services from abuse</b>	✓	Met this standard
<b>Cleanliness and infection control</b>	✓	Met this standard
<b>Safety and suitability of premises</b>	✓	Met this standard
<b>Safety, availability and suitability of equipment</b>	✓	Met this standard
<b>Supporting workers</b>	✗	Action needed
<b>Assessing and monitoring the quality of service provision</b>	✓	Met this standard
<b>Complaints</b>	✓	Met this standard

## Details about this location

Registered Provider	East Sussex County Council
Registered Manager	Mrs. Mandy Prior
Overview of the service	<p>Firwood House is an intermediate care centre for older people. The rehabilitation unit has 22 beds and people who meet the admission criteria stay between two to six weeks. At the time of our inspection the manager for this service had not been registered. Other community services are located there, including the 'living at home service.' This provides personal care and we recently inspected it and found they were compliant in the essential outcomes reviewed the manager is Mandy Prior.</p>
Type of services	<p>Care home service with nursing Domiciliary care service Rehabilitation services</p>
Regulated activities	<p>Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury</p>

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## Summary of this inspection

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### Why we carried out this inspection

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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.

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### How we carried out this inspection

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We reviewed all the information we have gathered about Firwood House, looked at the personal care or treatment records of people who use the service, carried out a visit on 17 October 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service, talked with carers and / or family members and talked with staff.

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### What people told us and what we found

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When we visited we were informed by the manager that 18 people in receipt of rehabilitative support were in residence. During our visit we spoke with six people and also met and spoke with two relatives. We spoke with six staff whilst visiting the service and other professionals, including a variety of health and social services managers.

The relatives we spoke with commented positively about the service their family member was receiving, comments included: "We can't fault it". "We have no complaints at all".

People who received support from the service said that they found staff to be kind and helpful. They thought they were kept informed about their care and support, and all felt they had made good progress in the time they had spent in the service.

Two relatives we spoke with were complimentary about the service. One gave examples of where they thought the service had been very proactive and had "gone the extra mile" to ensure the safety of their family member.

People admitted to the service who met the criteria of having the potential and commitment for rehabilitation experienced positive outcomes. They achieved a return to, if not full independence, a level of independence they may not have achieved without access to this intensive and specialised programme of support.

You can see our judgements on the front page of this report.

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### What we have told the provider to do

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We have asked the provider to send us a report by 05 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

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### **More information about the provider**

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

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

## Our judgements for each standard inspected

**Respecting and involving people who use services** ✓ Met this standard

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

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### Our judgement

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The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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### Reasons for our judgement

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When we visited we looked around the premises. Everyone was provided with their own bedroom and this had an ensuite facility.

People were placed at the service to regain some of their independence through rehabilitation. People we spoke with said that when they first came into Firwood House they had required more support with their personal care. They said staff had managed this well and they were never made to feel uncomfortable. As their rehabilitation progressed staff support was more about encouragement and supervision.

Each bedroom was provided with a detailed file of information about the service provided at Firwood house and what people admitted there could expect. Information was provided in a good sized print for easy reading. Some of the people we spoke with said they had read this information and it answered all their questions. They told us that they felt they were given enough information about their care and support and the progress they were making.

When we spoke with staff they demonstrated a good understanding of protecting the privacy and dignity of people who used the service. They understood the importance of closing doors, and curtains, asking people for their preferences around how their personal care was delivered, including the preferred gender of the care staff.

Staff said they consulted people who received the service and listened to them about what they could and could not do. When we spoke with people who were placed at Firwood House they provided examples of how staff enabled them to take things at a pace that suited them. People said they did not feel rushed by staff to achieve certain tasks in their rehabilitation. We were satisfied that people who used the service were given appropriate information and support regarding their care or treatment.

Relatives said they were made to feel welcome and visiting hours were very flexible.

When we looked at peoples records there was evidence in daily log entries that people

were being actively consulted about their support, and had been asked to sign their care plans and risk information.

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

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**Our judgement**

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The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

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**Reasons for our judgement**

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During our visit we spoke with six people who were at various stages of their rehabilitation at Firwood house. They all commented positively about their experiences at the service and felt they had made good progress since their admission. People said they did not feel pushed by staff and were left to do tasks at a pace to suit them. They told us that they had access to physiotherapy staff and had spent time in the gym.

We spoke to one person who was awaiting discharge, they told us that they had received input from the occupational therapist (OT) who had arranged for a piece of equipment to be installed at their home, this had delayed their discharge but they were accepting of this as it was for their benefit.

From our discussions with people and staff we understood that there was a gap in the OT cover. The impact of this had been that some people who were due to be discharged were delayed. People were not discharged until there had been a home visit by an OT to assess that they were able to manage, and whether any equipment was required to support this. Senior health managers acknowledged that the current situation had caused a backlog of people at the hospital and increased the number of delayed discharges. We were advised that there was currently a therapy review to look at all therapies provided, and that senior managers were aware of the present situation. They told us that they had reviewed options to provide cover during the review process. This had included the use of locum OT's.

We noted that a number of reported incidents related to inappropriate admissions to this service from hospital. When we spoke with staff they commented that information they received about new people from referrers was not always accurate. The registered manager confirmed this, and stated that as a result of this the service now ensured all new referrals were assessed at hospital prior to admission. The manager also said she checked the adult social care record system for any background information on the person referred. When we looked at the files of people we had spoken with we noted evidence of initial assessment of their needs. However, not everyone had previous contact with social services or was admitted from hospital. When we looked at assessments completed by Firwood house we found the quality of assessments was inconsistent. We highlighted this to the registered manager.

On files viewed we saw good recorded evidence of therapy input including physiotherapy and OT assessments. Daily logs were completed to a good standard and recorded the progression of people's rehabilitation.

We found that the care plans in place were functional, and provided information about rehabilitation needs. We found no evidence of omissions in recording or that important information was not included or expanded upon. The provider may find it useful to note that care plans were handwritten and were not always legible.

We found good evidence that people were consulted about their care and support and care and risk information was signed by the person they were about.

Care plans were supported by a range of risk assessments. These included nutrition, falls and risks of developing pressure area damage. Where risks were identified there was a clear indication of the action taken to minimise risks. For example the use of fortified drinks, or provision of pressure relieving equipment. We were satisfied that care and treatment was planned and delivered in a way that ensured people's safety and welfare.

We saw evidence that people were enabled to attend outpatient appointments whilst at Firwood house. Staff reported that a staff escort was provided if required. We saw that people's weights were routinely recorded. Health observations were also recorded where necessary. Firwood had a GP attached to the service who visited the service twice weekly for formal rounds. The manager reported that the service was always able to receive support from the GP during surgery times and the GP also called in most weekdays to catch up on any emerging issues. Files viewed evidenced that people who used the service had access to appropriate medical care.

Most of the people we spoke with had their medication initially administered by staff. People were supported to have more involvement if they wished during their rehabilitation and were assessed as to what level of support they needed. One person we met fully administered their own medications apart from one controlled drug. They said they had been assessed as competent and understood about keeping their medication secure. They felt reassured that they would manage their medications at home, now they were doing them at Firwood.

People's files contained individualised personal emergency evacuation plans (PEEP) which were to be implemented in the event of an emergency.

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

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## **Our judgement**

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The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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## **Reasons for our judgement**

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When we spoke with staff they demonstrated an awareness of safeguarding issues and understood how to escalate concerns where necessary. One staff member had personal experience of raising an alert and said that they had received feedback on the outcome from the investigation. When we spoke with the manager she advised that there had been learning from a previous alert, which had resulted in changes to staff practice in regard to recording. We were satisfied that the provider responded appropriately to any allegation of abuse.

We viewed incident and accident reports, these were completed appropriately and where necessary ensured other agencies were informed.

All staff spoken with said that they had received training in safeguarding vulnerable adults. We looked at a training matrix for both health and social services staff. This was current and indicated that social services staff are required by their local authority to have updates every two years. Seven staff were still to receive formal safeguarding training. However, six of these had received a briefing in regard to safeguarding. There was also evidence that all but one of the staff team had recently had their competencies in regard to their knowledge of safeguarding assessed. Health staff were required to have three yearly updates, out of 13 health staff, three had not received training. There was no evidence that in the interim they had received briefings or had their competencies assessed in regard to safeguarding. The provider may find it useful to note that housekeeping staff employed by the trust were excluded from this training. However, they came into regular daily unsupervised contact with the people receiving support at Firwood House.

When we spoke with the manager and staff they confirmed that no form of restraint was used at Firwood house. We were told that people were at Firwood House because they wanted to become more independent, and met the criteria for admission. The admission criteria usually excluded anyone who required any form of restraint.

We were informed by the manager that bed rails which were considered a form of restraint, were not normally provided in the rehabilitation unit. However, in exceptional circumstances these would be considered and we were advised that at present one person was provided with bed rails. We spoke with the person concerned and their

relative. They confirmed they had requested bed rails to be installed during their stay because of the risk of their falling from bed. The relative spoke very positively about the interim action taken by the service whilst sourcing the bed rails to be used. They told us that the service had provided one to one staffing at night to ensure the risk of the person falling from bed was reduced.

We visited the person's room and saw that the bed rails installed had bumpers fitted to minimise the risk of injury. We viewed the person's records and noted that a personalised risk assessment had been developed. Also consent to install this restrictive equipment had been obtained and approval for it to be used confirmed by the manager.

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

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**Our judgement**

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The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

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**Reasons for our judgement**

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When we first entered the rehabilitation service on the first floor at Firwood House we noted that there was an underlying odour. This seemed to be present more in the hallway areas than individual rooms visited. When we discussed the odour with the manager we were advised that this had been identified as an area for improvement by the service. As an initial step odour neutralising units had been ordered. The manager acknowledged that this was likely to mask the problem and not resolve it. However, the manager reported that some of the carpeting was old and that a review of carpet washing frequencies would be considered along with replacement of some carpeting. Staff advised that some carpets had already been replaced in some of the bedrooms.

The service had a team of eight domestics. Two cleaning and one laundry staff member were on duty each morning between 6:30 am and 1:30 pm. We spoke with one domestic about their daily cleaning routine and the underlying odour. They told us that carpets were routinely washed each month, including hallways. In some instances this may be several times per week because of specific continence issues. They reported that it was sometimes difficult to clean bedrooms thoroughly because of people who remained in their bedrooms. They told us that they had completed infection control training and this was updated. In addition, they reported that they received infection control information and updates on cleaning products from infection control representatives from the trust. We checked their training records and noted evidence of certificates for recent infection control training and also specialist cleaning activity training.

We noted that information provided to people who were receiving the rehabilitation service at Firwood House informed them about the cleaning of their room and what this would entail.

We visited five bedrooms and spoke with the people in those rooms about their experience at the home. All of them stated that they found the service was kept to a good standard of cleanliness. One person said that cleaners had not always used the vacuum cleaner in their room every day, which the cleaning schedule indicated they should. However, they acknowledged that it was difficult for cleaners to undertake cleaning, when people remained in their rooms and might not want the vacuum cleaner used.

The service had an appointed infection control lead and staff spoken with knew who this was. However, the provider may find it useful to note that the role of infection control lead

remained undeveloped with little evidence that dedicated time had been set aside to undertake infection control audits or cascade infection control information to staff. However, two staff spoken with said that the infection control lead had undertaken infection control hand washing audits. There was good evidence that health and social services had independently undertaken infection control audits of the service and these had highlighted areas for improvement. There were systems in place to reduce the risk and spread of infection.

We noted that toilets and hand washing facilities had liquid soap and paper towels available. Hand washing facilities in the sluice room and the visitor toilets had a good supply of liquid soap and paper towels. All staff had access to protective clothing.

We looked at a training matrix for health and social care staff who worked at the home. Frequencies of infection control training updates differed between the staff groups with health staff required to have annual updates, and social services staff required to have updates every three years. From the training matrix which was up to date we could see that approximately 30% of health and social services staff were overdue their regular update. We noted that of the 13 staff in total overdue training updates, nine were employed by the trust.

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

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**Our judgement**

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The provider was meeting this standard.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

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**Reasons for our judgement**

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During our inspection we visited people using the service in their bedrooms. We also visited the dining room, lounge areas and a small kitchen/diner.

We noted that maintenance work was underway with a new lift installation but this was not impacting on people's access to other areas of Firwood House.

We found the premises were well maintained and provided a comfortable environment for people. Bedrooms were furnished to a good standard and furniture and fittings were in good order. The manager advised that it had been recognised that duvet covers and curtains were somewhat faded and replacements had been ordered. Staff told us there had been some new carpeting in some rooms.

We were told that there was a 'handy person' to undertake minor repair works. Larger works were managed through the estates management team. We looked at recorded servicing of gas and electrical installations, testing of portable electrical items (PAT), and saw that that fire alarms and equipment had been checked. We found these were all in date, and a system was in place to ensure the routine update of these was arranged. The provider had taken steps to provide care in an environment that was suitably designed and adequately maintained.

The manager advised that she routinely undertook health and safety environmental checks of bedrooms and communal areas that ensured people were not placed at risk. There was good evidence that following incidents where people had fallen and developed skin tears equipment was routinely checked to ensure this had not caused any injury.

**People should be safe from harm from unsafe or unsuitable equipment**

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**Our judgement**

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The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

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**Reasons for our judgement**

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During our visit we were shown a small equipment store used by therapy staff. We were advised that once a physiotherapy or OT assessment had been completed, and identified the need for equipment to help with independence, this was sourced from the store.

We were told that in some instances that the equipment people arrived with from hospital was sometimes replaced with more appropriate equipment following assessment. We were advised that people were discharged home with the equipment provided from Firwood House which they then kept, and there was no policy for collecting equipment once it had been used.

Other larger equipment that may be assessed as necessary to aid support on discharge was sourced through larger equipment stores that therapy staff had access to. There was enough equipment to promote the independence and comfort of people who used the service.

New equipment was routinely purchased for the Firwood House store that ensured there was always a good supply available.

We looked at other equipment used by people who received a service at Firwood House. There was a small supply of wheelchairs, some of which had recently been purchased. We were informed by the manager that the 'handyperson' and some of the domestic staff team undertook routine checks of wheelchairs to identify faults. We saw recorded evidence of the checks made, and where identified faults had been reported and repairs or replacement arranged. The manager advised that they contracted with a company that undertook to repair wheelchair faults.

Bed rails were not provided in the service. However, where a need was identified the service was able to source these quickly. Bumpers were also placed over the rails to minimise the risk of people becoming trapped or injured. Personalised risk assessments were completed for their use.

The service had a passenger lift. People were also able to use a stair lift if they wished. We saw evidence of routine servicing for the lift. We were advised that the present lift was unable to transport unwell patients who may need to be carried by stretcher from the home. At present people were transferred to the ground floor in emergency chairs using the passenger lift. A second lift was being installed that would provide the facility for

stretchers to be used from the first floor of the service.

There was evidence that the equipment support needs of people using the service were kept under consideration. For example a new assisted bath had been installed to better meet the needs of people using the service.

We looked at other hoisting equipment used by the service and noted evidence of routine servicing.

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

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## Our judgement

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The provider was not meeting this standard.

Not all staff were in receipt of appropriate and regular training updates, professional development, supervision and appraisal to enable them to deliver care and treatment to service users safely and to an appropriate standard.

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

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## Reasons for our judgement

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When we visited we spoke with approximately 10 staff and managers from health and social services.

Staff we spoke with who worked at Firwood house told us that they felt supported and found their immediate line management approachable. They said they received regular supervision. When we spoke with the manager she reported that nursing and support staff received supervision every 6 to 8 weeks. Domestic staff also received regular supervision. Staff told us they felt able to raise issues important to them within their supervision and some people gave examples of this.

We looked at records of seven staff three of whom we had spoken with during our visit. We found that supervision agreements were in place and that there was evidence of supervision on every file viewed. However, the provider may find it useful to note that the frequencies of supervisions people received were inconsistent, and were not in line with the supervision policy. All staff files viewed indicated people had only received between two and four supervisions in 2012.

With the exception of one staff member all staff spoken with who worked at Firwood house said they had received a recent appraisal. When we looked at staff files we found these provided limited evidence of a history of appraisal for longer serving staff. The manager advised that staff had received their appraisals for 2012 and these would be placed on file once returned from individual staff.

The registered manager and their health counterpart told us that there were a range of staff meetings, the frequency of nursing staff meetings had drifted and they were hoping to re-instate these. Staff confirmed they had access to team meetings and that these were held regularly. They said they felt able to raise issues in the team meeting and had done so. We saw copies of staff meeting minutes and noted these were held regularly. We saw that some issues were followed through to later meetings.

When we reviewed staff files we noted that for newer staff induction had included completion of 'Skills for Care' common inductions standards workbooks. There was also evidence of probationary reports regarding individual staff performance before they were confirmed in post.

The manager reported that there was a rolling programme of mandatory and specialist training for health and social care staff. When we spoke with staff they said that they were kept updated in their mandatory training. We were provided with an updated training matrix for the health and social services staff teams. There was evidence that all staff were able to access specialist training appropriate to their role.

We were advised that for health staff training in moving and handling, infection control, first aid/life support and fire training was provided annually. The matrix advised that over 50% of staff had not received updated moving and handling training. 100% of staff had not updated their fire training although approximately 45% watched a fire training DVD but there was no evidence of how their competency around this was assessed. One person had not completed fire training at all. Approximately 75% of staff were still to update their infection control training and two staff were shown as not having completed this at all. 75% of staff were still to update their life support/first aid training and five staff were shown as not having completed this at all.

A training matrix for social service staff showed us that apart from fire training which was an annual update moving and handling training was updated every two years. First aid, food hygiene and infection control were updated every three years. The matrix showed us that approximately 95% of staff had completed fire training last year and two people had not completed this at all. 100% of staff were in date with their moving and handling training. Approximately 95% of staff were in date with their food hygiene two staff were overdue updates. Between 90%-95% of staff were in date with their first aid training.

Staff we spoke with told us that they had access to other specialist training, and this was confirmed on the training matrix viewed. One nursing staff member indicated that some specialist training was cancelled in order to ensure shifts were covered. The training matrix indicated a number of training gaps for health staff in regard to specialist training they were required to do. Training information made it clear that health staff who made up approximately 30% of the work force had not achieved mandatory training updates within the required timescales.

## Assessing and monitoring the quality of service provision

✓ Met this standard

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

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### Our judgement

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The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received

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### Reasons for our judgement

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In discussion the manager advised that she undertook a number of small audits including checks of documentation, health and safety and quality checks of the premises. The social services department had established a comprehensive quality monitoring system that involved a monthly quality audit visit of the service. This generated an action plan for the service to address any highlighted shortfalls within given timescales, in conjunction with this, the manager was also required to undertake their own quality audit and produce an action plan. We saw evidence of action plans that were currently being worked through.

In discussion with the manager and her health counterpart there was good evidence of joint working. There was acknowledgement that differences in policies and practice between both organisations had created some grey areas of practice that caused a lack of clarity for health and social care staff working alongside each other. Senior managers recognised that there was a need for all managers in both organisations to work together to look at ways of closer integration of policies and procedures to overcome this problem. Plans were underway to establish these working links.

We noted evidence of quality surveys for people who had used the service which they were asked to complete at the end of their stay. We saw that the majority of surveys provided positive feedback about the service. In those instances where people had made suggestions for improvements, there was good evidence that these had been considered and acted upon.

There was evidence of support systems for staff through supervision and staff meetings.

A complaints process was in place and we noted complaints were acted upon appropriately and within relevant time scales. .

A system of care planning and risk assessment was in place and people using the service were actively consulted about their care and associated risks. There was evidence that the provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

**People should have their complaints listened to and acted on properly**

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**Our judgement**

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The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

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**Reasons for our judgement**

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When we visited we observed that in every persons room there was a file providing information about the service. Within this people were made aware of the complaints system. This was provided in a format that met their needs.

When we spoke to people who used the service and two relatives they said that they found staff approachable and kind. They told us that if they had any concerns they raised these with staff. All of those spoken with said they had no complaints about the service they or their relatives had received.

When we spoke with the manager, she advised that any issues highlighted from people's feedback were acted upon. Where possible the person concerned was kept informed of any actions taken as a result of their comments. For example, we were able to track how a recent negative comment received through a quality assurance feedback questionnaire, had been dealt with. This included feedback to the person about the issue they had raised and how it was resolved.

We saw that the service maintained separate records of compliments and complaints. We looked at the complaints log. This recorded one outstanding and ongoing complaint. There was good evidence of how the complaint was initially dealt with, and whilst there was an acknowledged delay, we were satisfied with the reasons given for this. Whilst both East Sussex Social Services and East Sussex Healthcare NHS Trust have joint responsibility for managing complaints received. In this instance East Sussex Healthcare NHS Trust had accepted lead responsibility for responding to this complaint and we noted correspondence relating to the complaint investigation on file.

This section is primarily information for the provider

## ✘ Action we have told the provider to take

### Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care	<b>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</b> <b>Supporting workers</b>
Diagnostic and screening procedures	<b>How the regulation was not being met:</b> Not all staff had access to regular training updates, professional development, personal supervision or appraisal to enable them to deliver care and treatment to service users safely and to an appropriate standard in compliance with Regulation 23(1)(a).
Treatment of disease, disorder or injury	

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 05 December 2012.

CQC should be informed when compliance actions are complete.

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

## About CQC inspections

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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**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.

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**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.

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**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

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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)

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### **(Registered) Provider**

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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'.

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### **Regulations**

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

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### **Responsive inspection**

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

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### **Routine inspection**

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

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### **Themed inspection**

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

## Contact us

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