Inspection Report

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

Clifford House Residential Care Home

Clifford House, 11 Alexandra Road, Andover, SP10 3AD

Tel: 01264324571

Date of Inspection: 27 November 2013

Date of Publication: January 2014

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

Consent to care and treatment	✖	Action needed
Care and welfare of people who use services	✖	Action needed
Safeguarding people who use services from abuse	✖	Action needed
Safety and suitability of premises	✖	Enforcement action taken
Supporting workers	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Action needed

Details about this location

Registered Provider	Mr Roopesh Ramful
Registered Manager	Mrs. Lesley Anderson
Overview of the service	The service provides accommodation and person care for up to 21 people. People using the service may have dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 27 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

When we visited the service there were 19 people living at the home. We spoke with three staff, the manager and six people who use the service. We viewed the care plans for seven people. People we spoke to were positive about their care and treatment and the skills of the staff. People told us, 'staff are kind and come when called'. Another said, 'thank goodness I have found a place I feel at home in'. People told us they felt treated with respect and that staff provided care in a manner that promoted their dignity.

However, there were not adequate arrangements in place to make sure staff acted in accordance with legal requirements where people who used the service did not have capacity to consent to their care and treatment. Adequate arrangements were not in place for ensuring that the service took account of the requirements of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. We observed that the care plans did not always provide sufficient detail about key risks to a person's health and welfare and how these should be managed.

We found that people might not always be protected from abuse as staff did not have up to date safeguarding training. Key risks associated with the premises had not been identified including inadequate water safety checks and the risk of falls from unrestricted windows on the upper floor. We also found that the quality monitoring arrangements were not sufficiently robust.

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

What we have told the provider to do

We have asked the provider to send us a report by 11 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Clifford House Residential Care Home to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not made suitable arrangements to make sure staff acted in accordance with legal requirements where people who used the service did not have capacity to consent to their care and treatment.

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

Reasons for our judgement

Where people had capacity they were asked for their consent before they received any care and treatment and staff acted in accordance with their wishes. People using the service told us they felt involved in decisions about their care. One person said, 'you have the right to your own mind'. Another person told us he felt staff 'always respected his wishes'.

Staff we spoke with were aware of the need to seek the consent of people using the service before they provided care and support. For example, one care worker told us that she would always ask the person 'do you mind if I begin assisting you'. She added that if a person was declining care, she would respect this and leave, but would try again later. Another care worker said she always respected people's wishes to decline care, but would try and encourage people to accept support so that their care needs could be managed effectively.

The service provides support to some people with varying degrees of dementia or poor cognitive function. Our observations on the day indicated that some of the people using the service would have difficulties giving valid consent to complex or significant decisions about their care, treatment and support. We viewed seven care plans; each of these contained a judgement about the person's mental capacity. In three of these plans the person had been assessed as lacking capacity, but there was no evidence that these decisions had been reached in line with the principles of the Mental Capacity Act (MCA) 2005. The mental capacity judgements were non-specific and there was no assessment in care plans about the person's ability to make particular decisions about their care and support. We also did not see any guidance for staff as to when and in what circumstances best interest decisions might be needed for those people that lacked

capacity. For example, where a person needed to make a more complex or significant decision or were perhaps being resistive to care that was required to maintain their wellbeing.

When we spoke with the manager about this, he told us that he reached decisions about a person's capacity by talking with them and asking questions before forming a view. The manager told us that he did not use a specific tool to assist in assessing capacity. Staff we spoke to told us that that they had not received training in mental capacity and the manager confirmed that this was not currently offered to staff. This meant that the provider did not have suitable arrangements in place to ensure that at all times; staff were aware of and followed in practice the requirements of the MCA (2005).

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Staff supported people in a manner that was sensitive and considerate. However the provider had not taken proper steps to ensure that people were protected against the risks of inappropriate care by means of effective planning and delivery of care.

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

Reasons for our judgement

People using the service told us they were very happy with their care. One person told us, 'staff are very kind…they are special people'. Another person said the staff were, 'very friendly, you couldn't have better staff', whilst another stated, 'they (staff) do all there is in their power to make you happy'.

Staff also told us that tried to support people maintaining their independence. For example, one care worker said, 'I try to let residents do what they can but just keep an eye to make sure they are managing'. Another care worker told us that despite pressures at times, people using the service 'always got the best care'. However one care worker told us that she felt there was a risk of care being compromised at weekends. This was because there was no cleaning staff at weekends and this task had to be managed by care workers alongside their other responsibilities which included laundry and providing activities.

During our visit we reviewed seven peoples care records. We saw evidence that the service undertook an assessment of people's needs which took into account their personal circumstances and individual care requirements. We saw that daily care notes were detailed and reflected the care and support people had received during a particular shift. We also saw evidence, that where required, the service effectively communicated with doctors, district nurses and the community mental health team in order to manage people's needs. For example, staff had identified that one person's skin integrity was at risk of deterioration. There was evidence that the service had promptly contacted the community nursing team who visited the next day to assess the person's skin and provide any necessary pressure relieving equipment.

We observed a shift handover meeting during which there was a comprehensive discussion of people's needs. One care worker told us that she felt handover and the daily communication book were effective tools in providing the information she needed to know

about people's needs. However another care worker told us that she did not feel that she was always informed about changes affecting a person's wellbeing. For example, she told us that she had noted a bruise on a person she had been supporting earlier that day. She explained that she had later found out that the person had had a fall the previous day, but this had not been handed over to her.

During the inspection we found that some people's plans of care did not provide sufficient detail about the key risks to their health and welfare and how these should be managed. For example, the care plan for a person with insulin dependent diabetes did not contain comprehensive guidance for staff about the potential signs that might indicate their diabetes was becoming unstable. This person's care plan also lacked detail about how the care of their suprapubic catheter site should be managed. Staff we spoke to were able to tell us how they looked after the person's catheter site, but this was not recorded in the care plan. We noted that another person was experiencing on-going problems with catheter care and urinary infections. However their continence care plan simply stated 'has catheter'. This meant that people could be at risk of receiving inappropriate care and treatment due to care plans not containing sufficient detail about individuals' needs and how they should be met. This would be of particular concern where care was delivered by less experienced or agency staff.

During the inspection we noted that for one person it was unclear that the delivery of care and treatment followed the guidance given by health care professionals. For example, guidance was available on the Medication Administration Record (MAR) Sheets about a person's prescribed insulin levels and how to amend these according to recorded blood sugar levels. However, on two consecutive days in November 2013, the person's blood sugar readings had fallen below the prescribed level there was no evidence in care records, MAR or the communication book, that an amended dose of insulin had been given as per the guidance in their MAR. There was no evidence that staff had continued to monitor the person's blood sugar levels throughout the day to ensure that these were returning to a more normal level.

We looked at the arrangements the service had made to meet peoples' social and emotional needs. We saw that once a week entertainment provided by local groups and organisations. We saw the planned schedule of entertainment for December 2013 which included carol singing by a local school. On the other days, the care workers were responsible for arranging social activities including bingo, dominos or supporting people to participate in art projects. People we spoke to felt that improvements could be made to the activities arrangements within the service. One person said they usually sat in the lounge for most of the day with not much to do. Another person told us they felt there was insufficient variety of activities, but that they valued the opportunity to have Holy Communion. Another person said they wished there were more exercise type activities to keep them active. This meant that the provider was not taking adequate steps to ensure that people's welfare was enhanced through the provision of adequate daytime activity.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of abuse, because the provider had not taken reasonable steps to ensure staff could identify potential abuse through up to date training and knowledge of safeguarding policies and procedures. Safeguarding incidents were not always identified and reported appropriately. Adequate arrangements were not in place for ensuring that the service applied for Deprivation of Liberty Safeguards where people may have been experiencing restrictions on their liberty.

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

Reasons for our judgement

People who lived in the home said they felt safe living at Clifford House. Those we spoke with were confident they could share concerns with any staff member or the manager and that they would act upon these. For example, one person told us the manager had responded promptly when she had highlighted concerns about her security when in her room by enabling her to have a lock on her bedroom door. She told us that this had made her feel more secure.

Staff we spoke with demonstrated a commitment to protecting people from abuse and were clear about whom they would report any concerns about abuse to. They also felt that any concerns they might raise would be taken seriously and responded to appropriately. However we found some staff had not completed or recently updated their safeguarding training. Staff we spoke to only demonstrated a basic knowledge of the types of abuse and how these might be displayed within the context of the service. None of the staff we spoke with were aware of whether the service had a whistleblowing policy or what the term meant. The lack of suitable arrangements for making sure staff received, updated and understood training in relation to safeguarding and whistleblowing meant they might not recognise signs of abuse or feel confident to report concerns without fearing that they might be treated unfairly as a result.

During the inspection we were informed that there had been a recent incident where a vulnerable person had managed to leave the home through a ground floor window at night, without staff knowing. The person had been returned to the service by the police. This incident had not been raised as a safeguarding alert with the local authority safeguarding team by the service. The manager told us he did not know he had a responsibility to notify the local safeguarding team when a service user went missing. His failure to do this meant the safeguarding team was unable to assess in a timely manner whether the home had

taken appropriate action in relation to the incident that had occurred and this could have placed the service user at risk of receiving inappropriate care.

On the day of our inspection, we found evidence that a person living at the service who lacked capacity to make decisions around their care and treatment may have been experiencing restrictions of their liberty in order to protect them from harm. For example, staff were dissuading this person from leaving the care home despite this being his wish. In the event of such restrictions being necessary for the protection of the person, it is the responsibility of the care home (managing authority) to apply for an authorisation of the restrictions in line with the MCA (2005) Deprivation of Liberty Safeguards (DOLS). We spoke with the manager who told us that this had not been done. This was despite the fact that the person had been subject to a DOLS order in their previous care setting. When we spoke with the manager about this, it appeared that he did not have a full understanding of his responsibilities as the managing authority under the DOLS. This meant there was a risk that people were not subject to the safeguards introduced in law to ensure that the care and treatment they received was in their best interests and any restrictions were lawful and not excessive.

Safety and suitability of premises

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

The provider had not taken all the necessary steps to ensure that people who use the service, were protected against the risks of unsafe or unsuitable premises. There was inadequate maintenance and identification of environmental hazards.

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

Reasons for our judgement

The provider had not always taken steps to provide care in a home that was suitably designed and adequately maintained. During the inspection we were shown two upstairs bedrooms. In both of these bedrooms, the window could be opened in excess of safe limits and would have easily allowed a person to climb or fall through the opening. The service had 11 bedrooms on the upper floor and on the day of our visit, none of these were locked. We were aware from speaking with staff that there had been a recent incident at the home whereby a person had managed to leave the service, without staff knowing, from a ground floor window by breaking the chain restricting it from opening wider. We observed on the day of inspection and heard from other people who use the service that this person was able to access the upper floor and was at times entering the upstairs bedrooms. The failure to ensure that windows on the first floor were suitably restricted and that restrictors fitted to all windows were suitably maintained placed people at risk of harm.

During the inspection we found the water being discharged from bath taps hot to the touch. We used a thermometer to take the temperature of the hot water in two of the bathrooms we visited and found that in both cases this was at least 50 degrees centigrade. This is in excess of guidance in the Health and Safety Executive publication; Health and Safety in Care Homes. This states 'If bathing facilities are accessible by vulnerable service users then the following set of steps should be taken; Fitting of thermostatic mixing valves (type 3) - to prevent water at greater than 44 °C being discharged from taps where there is potential for whole body immersion.

We brought this to the attention of the manager who agreed the water was very hot to touch. The manager told us that when staff assisted people to bathe they routinely tested the temperature of the bath water using a thermometer. When the manager showed us the downstairs bathroom, there was no thermometer present. We were told this downstairs bathroom was the most commonly used. The manager had not, prior to our visit, identified

that the temperatures of the hot water being delivered to baths within the service were exceeding recommended temperatures. The bath taps also did not have thermostatic control valves fitted. This meant that the hot water from bath taps presented a risk of scalding to people using the service.

We found that the service had commissioned an external contractor to undertake an annual risk assessment for legionella. However, the manager was not undertaking regular monitoring and checks of the water system to ensure that temperatures remained within the parameters recommended to prevent the growth of legionella bacteria. We also found that there was no regular flushing of little used parts of their water system, for example the service had an unused shower which the manager could not confirm was being flushed in order to prevent the growth of legionella bacteria. This meant that people who used the service were not adequately protected from risks associated with the presence of legionella bacteria.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had failed to ensure that staff received appropriate training and supervision.

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

Reasons for our judgement

We spoke with five people who lived at Clifford House. They were all positive about the skills of the staff and felt their care was managed effectively and in a timely manner. Each shift was led by either the manager of the service, or a supervisor or senior carer. This provided support to staff in the day to day delivery of care.

We noted that all staff held a National Vocational Qualification (NVQ) in health and social care. The manager had a NVQ at level 4, six staff had NVQ at level 3 and seven staff had NVQ at level 2. Training records showed fire safety, first aid and moving and handling training as up to date and in line with the frequency determined by the service. Nine staff have completed end of life training. This included learning about how to work alongside the community nursing teams to deliver sensitive health care to people who were dying whilst also ensuring that their spiritual and emotional needs were met.

We saw records that showed a new member of staff had been provided with an induction using the Skills for Care Common Induction Standards. However, one care worker who had been employed by the service for two months had not completed their moving and handling training. This meant that staff might not have all the training they needed and were not properly equipped to provide care and support to people using the service. The manager told us they were trying to make arrangements for this care worker to access appropriate training. In the interim, the manager told us the worker was supervised to ensure that they were not required to manage any moving and handling tasks.

During our visit we spoke with staff who told us that training could be more comprehensive and tailored to their roles and the needs of people who use the service. One member of staff told us they felt staff did not always have adequate skills in, and knowledge of dementia care and that this meant they lacked understanding of how this condition impacted on a person's abilities to undertake some tasks. Training records highlighted that whilst nine of the permanent staff had completed training in dementia care, five staff had still to undertake this.

Staff we spoke with did not demonstrate a detailed understanding of, and knowledge about

the Mental Capacity Act (MCA) (2005) and its implications for their role within the service. For example, one care worker said '…mental capacity was being able to make a decision'. Another care worker told us that mental capacity meant identifying 'what a person could or could not do'. This care worker also told us she was not familiar with the term best interest's decision making. Both staff said they had not received training in the MCA (2005). The failure to provide staff with training on how to use the MCA (2005) meant they might not be clear about how to protect people, who had been identified as lacking capacity to give valid consent. This placed people who used the service at risk of receiving inappropriate care and treatment, particularly where this related to more complex decisions.

Training records we saw showed that no permanent members of staff had completed safeguarding training within the last two years as per the organisation's stated frequency. Only three staff had completed this training within the last five years and five staff had not undertaken any safeguarding training. We spoke with the manager about this and he explained that he had identified additional training was needed in this area and he was taking steps to arrange this.

We found that there were inadequate arrangements for ensuring staff receive regular supervision. Staff told us supervision was provided but that this was not regular. One care worker told us that her supervision was adequate, but another care worker told us that she did not feel that supervision looked at her training needs effectively. We saw that the service had a supervision policy that stated that there would be three 30 minute supervision sessions annually, one of which would count as an appraisal. However supervision schedules showed that whilst all staff had received one supervision session in the past year, only three staff had received two sessions since January 2013. The manager told us that in addition to formal supervision, the service operated an 'open door policy' that allowed staff to seek guidance or support when required.

We also noted that the service's training schedule stated infection control training should be undertaken every three years. However, we saw that one member of staff had last completed this training is 2002 and another in 2005. Four more had last undertaken infection control training in 2006 and five staff had not completed any training in this area, including the cleaner. The infection control lead for the service had last completed this training in 2009. The lack of regular infection control training was of particular concern given that care workers were responsible for cleaning the home at weekends.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Measures in place for monitoring the quality and safety of the premises had not been effective in identifying risks. There were not adequate measures in place for regularly assessing and monitoring the quality of the service.

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

Reasons for our judgement

People who use the service, their representatives and visiting professionals were asked for their views about the quality of the service. We saw that the manager had undertaken a customer satisfaction survey in November 2012. Responses from people using the service were generally positive and included feedback that they felt they were treated with dignity and respect and had confidence in the staff who responded promptly to their needs. There was evidence the manager had reviewed the responses from the survey and used the findings to reach judgements about how the service could be improved. However 30% of relatives and 54% of people who used the service, felt improvements were needed in the provision of social activities and entertainment. The manager told us he had tried to arrange additional outings but the take up had been poor and so this was an on-going challenge for the service. The manager told us he was due to undertake another satisfaction survey shortly.

We found evidence the manager was informally seeking the views of staff working within the service. The manager told us he held staff meetings two or three times a year. We saw minutes of the most recent meeting held in October 2013. This was well attended and showed evidence of opportunities for staff to raise concerns and discuss practice issues.

The service had commissioned external audits to help assist them in identifying issues that might affect the safety of the premises and people using the service. For example, the service had undertaken a fire risk assessment in 2013. In June 2013, the service had undertaken Portable Appliance Testing (PAT) and this resulted in two appliances being destroyed as they were not safe. The service had also had a legionella risk assessment undertaken in November 2013, but the results of this were not available on the day of the inspection. The service commissioned an annual fire risk report. We saw that the recommendations from the most recent report had been completed. This included the drafting of a Personal Emergency Evacuation Plan (PEEP) for each person using the service.

We saw that a health and safety environmental report had been produced following a site visit in March 2013. However, we noted that this report had not identified issues in relation to the upstairs windows opening too wide or the hot water temperatures exceeding recommended levels. This meant that whilst the service had arrangements in place to identify, assess and manage risks associated with the environment, these were not always effective or did not provide them with the information they needed to ensure the safety and welfare of service users.

It was also not always clear the provider was learning from incidents and accidents and that action had been taken to mitigate any further risk. For example, we were aware that a person had left the home without staff knowing through his bedroom window. Our review of this incident found that the manager had not carried out a suitable risk assessment to ensure this person, and others who might also be at risk, were not able to do the same. This meant that the service had not taken adequate steps to identify, assess and manage risks relating to the health, welfare and safety of people using the service.

We found that the manager did not have a robust system in place for regularly assessing and monitoring the quality or risks relating to the care provided. For example, we found the manager had not undertaken formal audits of people's care plans to ensure these provided staff with accurate and detailed information about how to meet their needs. In addition, the manager told us that medication audits were not completed on a regular basis. We also found that whilst the provider had taken some steps to identify what training staff required, the manager did not have appropriate measures in place to regularly assess and identify where staff training was not in line with the service's training stated schedule.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The provider had not made suitable arrangements to make sure staff acted in accordance with legal requirements where people who used the service did not have capacity to consent to their care and treatment. Regulation 18
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken proper steps to ensure that people were protected against the risks of inappropriate or unsafe care by means of the planning and delivery of care to meet individual needs of people, and to ensure their welfare and safety. Regulation 9(1)(a)(b)(i)(ii)

This section is primarily information for the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The provider had not made suitable arrangements to ensure people are safeguarded against the risk of abuse by taking reasonable steps to identify, prevent and respond appropriately to an allegation of abuse. The provider did not have suitable arrangements in place to protect people against the risk of unlawful restraint. Regulation11(1) (a) (b), (2)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The provider had failed to ensure that staff received appropriate training and supervision to enable them to deliver care safely and to an appropriate standard Regulation 23 (1) (a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not operate effective systems to regularly assess and monitor the quality of services or to identify, assess and manage risks relating to the health, welfare and safety of people. Regulation 10 (1) (a) (b)

This section is primarily information for the provider

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 11 January 2014.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

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

Enforcement actions we have taken

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

We have served a warning notice to be met by 31 January 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider had failed to protect service users and others against the risks associated with unsafe premises. There were not appropraite measures in place in relation to security of windows and inadequate maintenance or proper operation of the permises. Regulation15(1)(b)(c)(i)

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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