Inspection Report

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

Tabs@42

42 Stimpson Avenue, Abington, Northampton, NN1 4LP

Tel: 01604230457

Date of Inspections: 01 August 2013
31 July 2013

Date of Publication: September 2013

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

Respecting and involving people who use services	✓	Met this standard
Care and welfare of people who use services	✗	Action needed
Safeguarding people who use services from abuse	✗	Enforcement action taken
Safety and suitability of premises	✗	Action needed
Safety, availability and suitability of equipment	✓	Met this standard
Staffing	✗	Action needed
Supporting workers	✗	Enforcement action taken
Assessing and monitoring the quality of service provision	✗	Enforcement action taken

Details about this location

Registered Provider	Tabs@42 Limited
Registered Managers	Mrs. Jayne Marie Almond Mrs. Julie Amanda Sweeney
Overview of the service	Tabs@42 provide accommodation and support for up to five people on the autistic spectrum
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 31 July 2013 and 1 August 2013, observed how people were being cared for and talked with carers and / or family members. We talked with staff, reviewed information sent to us by other authorities, talked with commissioners of services and talked with other authorities.

What people told us and what we found

People who used the service were either unable to talk with us or decided that they did not wish to talk with us during our inspection. We spoke with three people's relatives and two of them gave us positive feedback. The relatives also raised individual concerns and one person told us that they had raised an issue about their relative's personal care and they had not seen an improvement or given feedback about the care that was provided. One relative said "Tabs@42 was amazing and any young man that gets the chance to go there is very lucky".

We looked at how people, or their representatives, were involved in the service and given information, and found this to be appropriate. We looked at people's support plans and found that they did not always contain accurate and updated information. We looked at the procedures the provider had put in place to safeguard people from abuse and found that the procedures were not robust. We looked at the premises and found that there was some maintenance work that required completion. We also looked at equipment and found this to be satisfactory, but the provider may wish to ensure all electrical equipment has received a safety check.

We found there were not always adequate numbers of staff to support people's needs, and that staff were not given appropriate professional development. We also found that robust quality assurance measures were not in place.

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

What we have told the provider to do

We have asked the provider to send us a report by 21 September 2013, 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 Tabs@42 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

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People who use the service, and/or their relatives, were given appropriate information and support regarding their care or treatment. We spoke with the relatives of three people who used the service and two of them told us that staff telephoned them on a weekly basis to provide them with updates and information about what their relative had been doing during the week. They told us that this gave them an opportunity to provide feedback about the support that staff provided.

We observed the care and support that was provided to all the people that lived at Tabs@42. We found that people were spoken to calmly and respectfully. We saw that one person required staff to offer reassurance, and this needed to be repeated several times. We heard a member of staff repeat the information with kindness and professionalism. This meant that the person was treated with dignity and respect.

We observed that people had schedules which helped them to understand what would be happening throughout the day. We found that people's schedules were in a format which best met their needs, for example in a picture format, and people were able to look at the schedules when they needed to. Where it was necessary, staff supported people to look at their schedules throughout the day so they knew what activity would be happening next. This meant that people were provided with information that met their needs.

We found that one person liked to have information written down and we found that staff had written letters to the person. The letters explained to the person what was happening and why and if necessary, gave the person information about what they needed to do. This person decided not to speak with us during the inspection however the manager told us that the written format of information worked well with the person and they could refer back to the letters if they felt unsure about what was happening. The manager also told us that the person told staff if they did not understand the information and needed further support. This meant that information was available in a format that met people's needs.

We spoke with the manager about how they kept people's relatives informed about the service and they told us that they provided a newsletter to people's relatives on a three

monthly basis. We looked at this and found that this contained information about the service, and about the staff that worked there. The newsletter also provided the manager's contact details and offered people the opportunity to make contact if they wished. This meant that people were informed about the service and any changes that had been made.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

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's needs were not regularly assessed and care and treatment was not always planned and delivered in line with their individual care plan.

The people that used the service were either unable to provide us with feedback, or decided that they did not wish to speak with us. We spoke with a relative of three people who used the service. One relative told us that they felt that Tabs@42 was "amazing" but that the support they provided for their relative's personal care needed to be improved. They told us that they had concerns that their relative was not provided with adequate support when attending to their personal and dental hygiene needs. The relative told us that they had told staff about their concern, but they had not noticed any improvement and had not received an explanation for the lack of improvement.

One relative said "The support staff are wonderful" and they were really pleased with the support their relative had received following a recent period in hospital but felt more could be done to support their relative to enjoy a variety of activities. We spoke with the manager about the care the person received and they told us that the person's care had been reviewed by a healthcare professional and they had received positive feedback. The relative and the manager also told us about an outing to the shop the person had been supported to enjoy. However we were told by the manager and the relative that there was some concern about the cost involved and so this had been stopped.

One of the relatives we spoke with told us about their concern that their relative was not adequately supported after other people using the service had displayed challenging behaviour. They told us about an incident which had made their relative become anxious and had resulted in actions of self-harm. During our inspection we observed staff provide appropriate support and reassurance to all the people who used the service. However we also observed an incident of challenging behaviour which impacted on another person. We saw that the person was not closely observed or offered any reassurance by staff for approximately four minutes. The manager told us that this was appropriate for this person as they needed their own time to refocus, and would often shout at staff if they attempted

to offer immediate support. The provider may wish to note we did not see there was any system in place for staff to observe how the person reacted to the situation. This meant there was a risk that the person could have reacted to the situation through an act of self-harm.

We observed staff interactions with people who used the service. We found that staff were kind and considerate and provided people with opportunities to make their own choices. We found that every person was given praise and encouragement at appropriate intervals. We observed one member of staff speak calmly to a person and give them advice and reassurance whilst they had become anxious. We saw a member of staff help a person put their shoes on, and we found that their support plan reflected this. We found that people were given opportunities to decide what activities they wished to do and what they would like to eat or drink. This meant that staff supported people and gave consideration to people's needs.

We looked at two people's support plans and found that they had not been updated on a regular basis. One persons 'aims & targets' had not been updated since April 2013 and their annual review had been outstanding since May 2013. We found that in the second person's support plan their 'aims & targets' had not been updated at appropriate intervals and their annual review had been outstanding since February 2013. The manager told us that they had delayed one person's annual review so that it would be held at the same time as the local authority review however this decision was not documented within the persons support plan and no date was documented for the reviews to take place. This meant there was a risk that people's long term support needs and aspirations were not being regularly reviewed and supported.

We found that it was recorded that one person required support to be aware of different celebrations and festivals for different religions, faiths and cultures however there was no plan for how this outcome would be achieved. We also found that for one person their timetable was not up to date with current information during the college summer break. This meant that current information about people's needs were not maintained.

We found that one person's support plan had personal goals identified however there was no monitoring of whether the person had achieved their personal goals. We also found that one person's support plan recorded that they had made good progress with financial management. However we found that no financial management goals had been set since April 2013 and there was no explanation for this and it was not clear if the person no longer required these goals or if they had forgotten. We found that one person did not have any eating and drinking or educational, goals set since April 2013 and there was no explanation documented for why this had stopped. This meant that there was a risk that people were not supported to develop their life skills and confidence on a regular basis.

We found that both people's files we looked at had a Malnutritional Universal Screening Tool (MUST) in place which stated that both people should be weighed on a monthly basis. We found that the records showed that neither person had been weighed since May. We found that it had been identified that one of these people was underweight and action had been taken to address this. We found that the MUST was not being used correctly and people's nutritional needs were not documented appropriately. This meant there was a risk that people were not being monitored and appropriately supported to have their nutritional needs met.

Safeguarding people who use services from abuse ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

People who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We spoke with staff about their knowledge and understanding of safeguarding procedures and found that whilst staff had an awareness of the different types of abuse, and of their responsibility to report it, they were not aware of the agencies they should contact if they felt it necessary to make a safeguarding referral.

The provider had not responded appropriately to allegations of abuse. We spoke with the manager and found that there had been an incident of suspected financial abuse that had not been reported to the safeguarding authority. We spoke with the manager about this and we were told that the provider had felt able to deal with the matter internally. This caused us concern and was not in accordance with safeguarding principles, or with the provider's own policy. This meant there was a risk that people may be exposed to unfair treatment and the matter had not been resolved promptly.

We looked at the records that the service held of safeguarding incidents and found that many had not followed the correct reporting procedures. We found incidents that had not been reported to the safeguarding authority, and incidents that had not been reported to the Care Quality Commission. This meant the service was not adhering to the requirements that were expected of them.

The safeguarding records showed a pattern of incidents between two people who used the service. We found that during a five month period similar incidents between the same two people had been recorded ten times. The service had not taken adequate steps to ensure such occurrences were not repeated and to minimise the risk. This meant there was a risk that people were not supported to live in a safe environment.

We looked at the safeguarding policy and found that it was due to be reviewed in May 2013. We found that the policy had an absence of information and was not personalised to the service. The policy did not contain contact numbers or full details for staff to complete safeguarding referrals if required. This concerned us as the policy was not adequate.

We looked at the physical restraint policy and found that it was due to be reviewed in May 2013 and had not been. We also found that the policy was not personalised to the service and contained information that was not followed through onto people's support plans. For example, the policy stated that physical intervention should only be used if it was recorded in people's support plans. We spoke with the manager about this and we were told that staff were in the process of developing these plans and they were not available for everybody that used the service. This concerned us as we were informed that physical interventions had previously occurred and this meant there was a risk that physical interventions could have been unlawful or excessive.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

The provider had not taken steps to ensure care was provided in an environment that was suitably designed and adequately maintained.

The premises had a number of communal areas which included a lounge, activity room, sensory room, kitchen and education suite. In addition the property had a garden which was accessible to people who used the service and there were two sets of stairs to the first floor which allowed for people to move around the building. Each person also had their own bedroom and a number of bathrooms were available throughout the building. This meant that people could choose from a range of areas they wished to spend their time whilst at the property.

We found the premises were of a suitable design and layout to meet the current needs of the people using the service. However we were aware that another person would be coming to use the service and the provider may wish to give this further consideration as doorways and hallways may not be wide enough to accommodate everybody who used the service and the support staff each person required. One relative we spoke with was particularly concerned about this and was in the process of considering whether it would be suitable for their relative to stay at the service. The relative told us that they had raised their concern about the suitability of the premises with the provider and had asked them to delay the admission of another person but this had been rejected.

We saw that throughout the property there were a number of areas in need of decoration. For example, the communal areas and one bedroom had plaster exposed which had not been decorated, and we found that some of these areas had been in this state since March 2013. We also found that the provider had begun a small extension to provide an additional area for people to use. This building work had started in February 2013 and had not been completed at the time of the inspection. Given the size of the extension this was a disproportionate amount of time for people's living environment to be disrupted. We asked the manager to show us the program for the completion of the building works and the manager was unable to provide us with any records relating to this. The extension was

blocked off by a curtain and this meant there was no direct daylight in the activity room which did not create a pleasant environment and was likely to have an impact on people's wellbeing. We saw one person enter the extension room but they were unable to complete any activity in there and they returned into the activity room.

We saw that the carpets were stained and one area of carpet next to a bathroom was water stained and in need of replacement. We were concerned that this had been noted at the previous inspection and no action had been taken to address this. We also found that one of the bathroom doors was not easy to open and close and was unable to lock. We noted that one person had a risk assessment in place related to their privacy and found that this bathroom door did not support their risk assessment. This also did not support the privacy needs of people and visitors that used the service.

We saw that the door stop in the activity room was not working and the door was propped open by a chair. We saw that one person had a risk assessment in place related to slamming doors and observed the person to attempt to do this. We saw that the chair had travelled across the room at speed and we were concerned that this could cause an injury to people who used the service, staff or visitors.

We looked at the building maintenance records and found that some issues had been resolved, however the maintenance records had not been updated with dates of completion. This meant there were no clear records to show the timeliness of maintenance and repairs. We also found that there were entries that did not contain information about when maintenance work would be completed, or why there was a delay. For example the maintenance book recorded an entry made in April 2013 which stated the downstairs bathroom was in need of the tile grout replacing, that the floor around the shower was coming away and the ceiling required painting. A response had been recorded as 'all to be done when refurbished' however no timescale for the completion of the work was recorded. We spoke with the manager about this and we were told that they believed the earliest this would be completed would be November 2013. This meant there was not an adequate programme of maintenance in place.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

There was enough equipment to promote the independence and comfort of people who use the service. We found that generally the equipment throughout the property was in a good state of repair; however we found that one of the two washing machines provided was out of order. The manager told us the washing machines were under a service agreement, but at the time of our inspection they were unable to produce any paperwork to evidence this. We were told that the washing machine did not regularly break down but when they did they were promptly repaired under the service contract agreement.

We found that the service had taken steps to ensure that equipment was protected and could be used by people who used the service. For example, we found that a television in the lounge had been securely fitted to the wall and a protective (Perspex) screen had been secured to prevent any damage. This meant that the provider had taken steps to protect people from harm and equipment from damage.

We looked at the Portable Appliance Testing (PAT) records that were completed in March 2013 and found that the electrician had recorded that the PAT tester had not recorded the results for the equipment within one person's bedroom. It was recorded that the electrician would complete this at a later date. We spoke with the manager about this and we were told that the PAT test for this particular piece of equipment was still awaiting completion. The provider may find it useful to know that this was still outstanding.

We asked to see the service records for the equipment within the home and found that the hardwire testing had been completed earlier in the year and the items requiring immediate attention had been resolved. This meant that measures were in place to protect people from harm from the electrics within the home.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

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

There were not enough qualified, skilled and experienced staff to meet people's needs. We spoke with two members of staff about the current staffing levels and were told that the service had adequate numbers of staff and there was no pressure to cover extra shifts. We spoke with the manager about the staffing levels and they told us that they were fully staffed. However they told us that 'ideally' there should be three members of staff on each shift, and another member of staff available throughout the day to provide additional assistance or to escort people on activities within the community. .

We were told that three people who used the service required continual one to one support and one person required regular supervision and monitoring by staff. We were told that three people required two to one staff support whilst out in the community and one person required one to one staff support whilst out in the community. This meant that the staffing levels the manager told us about would not ensure that each person had the correct level of support at all times, and that people were enabled to participate in the community. We spoke with the manager about this and they told us that in the mornings one person rarely chose to get up any earlier than 9am, and by this time during the week a member of management staff would be available to support people if required. At weekends we found that at least two people who used the service stayed overnight at home. This meant the staffing rota did not provide cover to ensure that people had access to the correct level of support at all times.

We looked at the rota for July 2013 and found that in the first week there were three days that did not have adequate numbers of staff to support people's needs, and at the weekend people would not have been able to visit the community if they wished due to a lack of staff resources. In the second week we found that for seven days there were periods when there were not adequate staff numbers to support people's needs. In the third week we found that there were five days, and in the fourth week we found that there were six days when there were periods that there were not adequate staff numbers to support people's needs. This concerned us as through July we saw there were periods when there was not sufficient staff resources available to fully support people's needs.

We were concerned about our findings as we had identified this as a concern at our previous inspection.

Supporting workers ✖ Enforcement action taken

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.

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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

Staff did not receive appropriate professional development. We spoke with two members of staff about the support that they received. One member of staff told us that they had received supervision meetings with their manager within the last month, and prior to this, seven months ago. Another member of staff told us that they had received supervision meetings on a three monthly basis. We looked at the supervision records and found that four members of staff had not received their three monthly supervision meeting and that their first supervision meeting for 2013 had not taken place until June.

We spoke with the manager about this and they told us that staff should receive a supervision meeting every three months. We also noted that at the previous inspection the manager had told us they wanted to have supervision meetings more frequently than every three months. The manager told us that staff had not received their supervision meetings due to the manager being unavailable, either the manager or staff member had been off sick or the staff member was required to assist people using the service. The manager told us that the one of the senior members of staff was going to be responsible for offering supervision to the waking night staff which would provide assistance to the manager. However the current arrangements meant that adequate systems were not in place to ensure that all staff received regular supervision.

We looked at the training records for the staff and found that 15 out of 17 staff had not completed all of their mandatory training, or received refresher training at an appropriate interval. We looked at the rota for July and found that up to 44 shifts out of 84 shifts did not have an appropriately trained person available as there was not a member of staff on duty who had received all of the mandatory training. This meant that people who used the service were often not cared for by staff with adequate training. This meant there was a risk that adequate measures were not in place to prevent people coming from harm.

We were concerned about our findings of this inspection as we had identified similar

concerns at our previous inspection.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive and did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

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

Reasons for our judgement

People who use the service, their representatives and staff were not asked for their views about their care and treatment and they were not acted on.

We asked the manager what systems were in place to audit the quality of care that people received. We were told that they regularly spent time with the staff and people who used the service and observed the interactions that they had. The manager told us that they did not maintain any records in relation to this, and there were no records to assess the standard of care staff provided. This meant there were inadequate systems in place to ensure that people directly received a good standard of care.

We looked at two support plans and found that there was a section for the manager to complete to show that the support plans had been checked and reviewed on a monthly basis. Both support plans we looked at had not recently been checked, and the last checks had been completed in May. This meant there were no systems in place to ensure that people's records were maintained and contained accurate information.

We looked at incident and accident records for the service. We did not see any evidence that incidents had been reviewed or evaluated to ensure that learning was considered and further action had been taken to minimise the risk of a reoccurrence. This meant there was a risk that incidents and accidents could be repeated and people and staff could be subject to unnecessary harm.

We asked the manager how they obtained feedback from people who used the service, or their representatives. We were told that they phoned three people's relatives every week and updated them with what had happened during the week. We were told that during this telephone call people often gave feedback. They also told us that in the newsletter that

was sent out every three months the managers contact details were provided and people were encouraged to make contact. We found that a questionnaire about the quality of the service had been sent out in May 2012 but no arrangements were in place to issue questionnaires or review the quality of the service this year. This meant that some of the people's relatives were contacted on a regular basis and were given an opportunity to provide feedback however not all of the relatives received this regular opportunity. This also meant that no regular opportunities were provided to people or their relatives to review the quality of the service provided on a standardised basis.

We asked the manager how they obtained feedback from the staff. They told us that they were openly available for staff to come and talk to them and they told us that they had staff meetings every six months. We looked at the dates of the staff meetings and found that the meetings had taken place every six months, or sooner. This meant that staff that felt able to provide feedback in a group setting were given the opportunity to do so, however there were no formal processes to ask each staff member for feedback about the service that the provider offered.
We looked at the training matrix and compared this with three staff files. We found inaccuracies which related to all three people. We found that the training matrix was not accurate with the information contained within people's files. For example the training matrix recorded each person had completed training that their staff file did not contain evidence of. We also found that the training matrix contained dates of training that had been completed that did not correspond with evidence in their staff file. This meant that staff files were not accurate with the training matrix and there was no evidence to show that staff had completed all the training recorded within the training matrix, or the dates of this did not correspond.

We were concerned about our findings as we had identified similar concerns at our previous inspection.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People's support files did not contain adequate and up to date information about how their support needs were being met and there was a concern that not everybody had their personal care needs adequately supported. Regulation 9 (1) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The property was not adequately maintained and areas that required attention were not done in a timely manner. The maintenance book did not record all issues or what action and when had been taken. There was no programme for the works to the property completion. Regulation 15 (1) (c)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**

This section is primarily information for the provider

	How the regulation was not being met: There were not adequate numbers of staff available at all times to ensure that people were supported with their needs. Regulation 22

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 21 September 2013.

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 10 September 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The provider failed to report a suspected incident of abuse and other safeguarding incidents had not been reported to the authorities correctly. Similar incidents of abuse had been repeated between two people and adequate preventitive action had not been. Staff were unaware that they could contact the local authority to report a safeguarding matter if necessary. Regulation 11 (1) (2)
We have served a warning notice to be met by 10 September 2013 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 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Staff had not received regular supervision and mandatory training

This section is primarily information for the provider

	had only been completed by two members of staff. Regulation 23 (a)
We have served a warning notice to be met by 10 September 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Systems were not in place to monitor the quality of care, or to obtain feedback on the quality of the service. People's support plans did not contain accurate information and managers reviews were outstanding. Incidents and accidents were not reviewed with actions to prevent reoccurrences & training records were inaccurate. Regulation 10 (1) (a) (b) (2) (a) (b) (i) (iii) (c) (i) (e)

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