Review of compliance

European Care (Derby) Limited The Park Nursing Home	
Region:	East Midlands
Location address:	40 St Marks Road Chaddeston Derby Derbyshire DE21 6AH
Type of service:	Care home service with nursing Rehabilitation services
Date of Publication:	December 2012
Overview of the service:	The Park Nursing Home is owned by European Care (Derby) Limited. The Park Nursing Home is located close to Derby City Centre, and provides nursing and personal care for up to 41 older people.

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

Our current overall judgement

The Park Nursing Home was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 8 October 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

We were supported on this review by an expert-by-experience who has personal experience of using or caring for someone who uses this type of care service.

What people told us

People told us what it was like to live at this home and described how they were treated by staff and their involvement in making choices about their care. They also told us about the quality and choice of food and drink available. This was because this inspection was part of a themed inspection programme to assess whether older people living in care homes are treated with dignity and respect and whether their nutritional needs are met.

The inspection team was led by a Care Quality Commission (CQC) inspector joined by a practising professional.

We observed that when staff were supporting people when delivering care they treated people with respect and dignity. The registered nurses and care workers were polite and treated people in an appropriate manner. We saw staff were aware of people's preferred names and used this name when speaking with people.

We saw that one of the registered nurses and the majority of care workers were not particularly attentive when they were supporting individual people with their meals. For instance talking with them whilst supporting them to eat or drink and explaining what food was on their plate.

Staff were not attentive to people's needs. They did not recognise how one person's behaviour at the dining table impacted on other people, or see that people could not reach their meals comfortably as they were sat too far away from the table.

We saw that people were not supported to have sufficient food and drink. Two people left the dining room after lunch having not been offered a drink with their meal. No one was offered an alternative meal or snack if they did not eat their main meal.

Relatives and people spoken with did not raise any concerns about living at The Park or about the care they received. Staff had a good understanding of the forms of abuse people would need protecting from. Staff told us what action they would take if they witnessed any abusive practices and would "always report incidents to the nurse in charge or the manager."

We asked people if they thought there were enough staff to meet their needs. People did not raise any concerns that their needs were not responded to at any time. We spoke with three care workers about staffing levels.

They told us they felt the staffing levels were sufficient to meet people's needs as long as everyone was doing their job properly. They explained that this meant not taking additional breaks during the shift. The registered nurses told us they felt that the staffing levels for care workers were not adequate, and they had raised their concerns regarding this.

People were asked if staff spoke with them about their care needs. They told us staff did not speak with them about their care needs and they had not seen their care plans. They did not express any concerns about this. One person told us they hadn't seen their relative's care plan but they weren't concerned about this, as they knew what care was being delivered and were satisfied with this.

Care records and food and fluid diaries were not accurate and up to date. Several care records did not have up to date care plans and feeding regimes for people who required supporting with maintaining adequate nutrition.

What we found about the standards we reviewed and how well The Park Nursing Home was meeting them

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

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard. People's privacy was being respected, but staff did not always treat people in a dignified way. This was because staff did not always engage with people when providing support and assistance, were not attentive to people's needs and were not always respectful in the manner in which they referred to people.

Outcome 05: Food and drink should meet people's individual dietary needs

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard. People were not protected from the risks of inadequate nutrition and dehydration. This was because people were not provided with suitable and nutritious food, supported to be able to eat and drink sufficient amounts to meet their needs, or provided with food that met their cultural

needs.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate records were not maintained. This was because care plans were not updated to reflect people's current needs, the nutritional screening risk assessment and food and fluid diaries were not accurately completed, and some care records were not stored securely.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with two relatives and five people who used the service about their experience of living at The Park Nursing Home. A number of people who used the service had varying levels of dementia, so not everyone was able to tell us about their care and support. Therefore we spent some time observing how people were treated and how they were involved in their care and treatment. This helped us to understand the experiences of people who could not talk with us.

We observed life at The Park Nursing Home and found that not everyone who used the service were supported by staff in choosing how they spent their days. Some people chose to spend the majority of their time in their bedroom, rather than make use of the communal areas. Other people sat in the communal areas. However, we saw that after lunch care workers said to people "Shall I take you back to your room" rather than asking people where they wished to be taken to. This meant people did not always have the opportunity to make choices about what they did and where they spent their day.

Other evidence
Is people's privacy and dignity respected?

We observed that when staff were supporting people when delivering care they treated people with respect and dignity. The registered nurses and care workers were polite and treated people in an appropriate manner. We saw staff were aware of people's preferred names and used this name when speaking with people.

We saw that one of the registered nurses and the majority of care workers were not particularly attentive when they were supporting individual people with their meals. For instance talking with them whilst supporting them to eat or drink and explaining what food was on their plate. We observed several people being assisted to eat their meal with support from staff. One person constantly called out whilst sat at the dining table. This was clearly upsetting other people sat at the dining table, who complained to staff. They were told, "Don't worry, she will be going for a rest soon." The member of staff assisting this person did not recognise the effect on other people and continued to assist this person with their meal. They did not engage with the person whilst assisting them and frequently looked away to speak with others whilst providing assistance. This member of staff was also interrupted whilst assisting this person. They did not apologise or explain to the person they were assisting, just responded to the question whilst still providing assistance.

Another member of staff was observed placing mouthfuls of food into a person's mouth without explaining what they were doing. The member of staff called out the person's name and put a spoonful of food in their mouth. This continued throughout the time the person was being assisted with dessert, and there was no other interaction. This practice did not promote people's dignity.

We noted that a number of people sat in wheelchairs at the dining tables for their meals. We heard one person asking to be moved closer to the table as they could not reach their plate. We saw other people struggled to reach their plates as they were too far away from the table, and consequently spilt food into their lap. Staff were not attentive to people's needs and we did not observe any action was taken to address these issues.

We heard staff refer to people who needed assistance with their meals as 'the feeders'. This showed a lack of respect for people who used the service and did not promote people's dignity.

Are people involved in making decisions about their care?

Although personal information was obtained when people came to live at The Park Nursing Home, very little information was recorded in the care records. For example, people's preferences and dislikes were not recorded, which would have assisted staff to provide care to people in the way they preferred.

There was no information recorded in care records that supported people were asked if they wanted to be cared for by male or female staff. Staff we spoke with told us this was taken into account and described a situation when a person had expressed a wish to be cared for by male care worker. During our visit we observed some staff gaining people's views and promoting their choices, such as, asking what choice they would like from the menu, and what they would like to drink.

Both relatives spoken with told us they were kept fully informed about any changes in

care by the staff. One person told us they hadn't seen their relative's care plan but they weren't concerned about this. They told us they knew what care was being delivered and were satisfied with this. We asked people if staff spoke with them about their care needs. People told us staff did not speak with them about their care needs and they had not seen their care plans. People were not concerned by this.

Our judgement
The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard. People's privacy was being respected, but staff did not always treat people in a dignified way. This was because staff did not always engage with people when providing support and assistance, were not attentive to people's needs and were not always respectful in the manner in which they referred to people.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is non-compliant with Outcome 05: Meeting nutritional needs. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with two relatives and five people who used the service about their experience of living at The Park Nursing Home. A number of people who used the service had varying levels of dementia, so not everyone was able to tell us about their care and support. Therefore we spent some time observing how people were treated and how they were involved in their care and treatment. This helped us to understand the experiences of people who could not talk with us.

We asked people about the meals provided. They told us the food was acceptable, and they were offered a choice. One person said, "It's alright, mostly we get what we want to eat." They also told us, "There is a menu on the board but they often forget to update it, they come at breakfast time to ask what you want."

Other evidence
Are people given a choice of suitable food and drink to meet nutritional needs?

We observed people who lived at The Park Nursing Home were given choices of what meals they would like. We saw care workers asking people what choice they would like from the menu. Pictures of the meals were not used to help people make a choice. This would assist people with dementia and communication needs to make a choice about their meal.

We saw that people were offered drinks at certain times throughout the day and jugs of water / squash were also provided for people in their rooms. One person told us they felt they were not offered sufficient hot drinks during the day, but if they asked for a

drink, a member of staff would make them one. We saw people were not consistently offered a cold drink with their meal at lunch time. We saw two people leave the ground floor main dining room without being offered fluids at lunch time. One person who had not been offered a drink and had not been supported with their meal was observed by care workers to be coughing after eating. The care workers response was to comment that the person was coughing, but they did not offer this person a drink or ask what may be causing them to cough.

We saw people ate their meals in a variety of places. Some people chose to remain in their rooms for their meals, whilst others sat at the dining tables or in the easy chairs in the lounge area. We saw that a number of people remained in wheelchairs for their meals and not everyone was able to reach the table comfortably from their seating position. This made it difficult for people to eat their meal independently or with any dignity.

The menus provided did not include a full description of the planned meal, for example jacket potato or sandwiches. The detail and quantity of the protein planned for some of the meals was not included in the menus. The menus lacked variety, and there were numerous times when the main course or dessert was described as 'chef's choice'. Therefore it was difficult to assess whether the planned menus were nutritionally suitable for people who used the service.

Full fat milk and fortified milk was available for cereals at breakfast, and care workers decided which people received this. All desserts were made using artificial sweetener. Staff told us that all of the squash provided for people was sugar free. This means that people were not provided with food and drink that was suitable for their needs, as not everyone requires sugar free food.

Are people's religious or cultural backgrounds respected?

The chef showed some knowledge of the dietary requirements of the people at the home, and any special dietary requirements, such as diabetic, gluten free, soft or pureed diet. The chef told us there was one person who required a gluten free diet. He explained he manages this particular diet by label reading, and provides foods such as 'Angel Delight' pudding, mousse, yoghurt, and mashed down fruit and sauces made from cornflour. He also commented there would be "more of a better menu if there was more than one person with coeliac disease."

We asked the chef about providing specific foods for people from culturally different backgrounds. He told us he had not received any training on meeting the needs of people's religious or cultural diets. He told us people from different cultural backgrounds buy their own food, and the catering staff will prepare and cook it. He said he had never been asked to buy specific food items for people. This did not support that people's cultural backgrounds were respected by the service.

Are people supported to eat and drink in sufficient amounts to meet their needs?

We observed people's diverse needs were not met appropriately and saw people waiting for staff support during the lunch time period. This was partly due to insufficient cutlery being provided for people to eat their meals with. We saw people being supported with eating and drinking, where appropriate, but the support from staff was

rushed. We did not see anyone using adapted crockery and cutlery. Adapted cups for individual needs were observed in use to aid independent drinking. However, we observed one person asking staff to remove the sipping lid from a beaker, as they were able to use the beaker independently without the lid. Another person had the plate guard fitted to their plate after they had started to eat their meal. This did not support that staff were aware of people's needs.

Protective tabards and plastic aprons for people's clothes were available but were not always offered to people. One person was already eating their meal when a member of staff put a plastic apron on them. People were not offered napkins to use.

We did not see care workers offering people who did not eat their meal alternative foods. There was no evidence to support that a variety of snacks were available at all times, although biscuits were available with the morning drinks.

The serving of the meal in the ground floor dining room was disorganised. A system was not in place for serving meals, for instance those who could eat independently and those who needed assistance. All meals were plated up in the kitchen and served from a hot trolley. This meant there was no option for people to ask for or be offered additional food if they wished. The meals were labelled by room number. The plates were extremely hot and the care workers had two cloths between four of them to use to remove plates from the trolley and take them to either the dining table or to people's rooms. The meals were left on the side board in the dining room to cool down, and while staff tried to find enough cutlery for people to eat their meals. In the first floor dining room we saw one person who had already started to eat their meal, taken from the room at their request so that staff could provide care in private. Staff did not take any action to keep the meal warm, and this person was offered the same meal on their return to the dining table.

Catering staff were observed 'hovering' around the hot trolleys, waiting to take these back to the kitchen. They also took away used crockery and cutlery throughout the meal time rather than waiting until the end of the main course or dessert. The overall impression of the meal time was that it was rushed, and the main objective was for the meal time to be completed as soon as possible.

Staff had an awareness of the importance of maintaining adequate nutrition and hydration. Care workers were able to discuss ways in which they would assess nutrition on a practical level, such as not eating or loose clothes and explained that the nutritional assessment tool was completed by the registered nurses. They explained the system for notifying senior carers about feeding issues and initiating food and fluid diaries. The registered nurses had a broad understanding about nutritional issues. They said they had not been updated or trained regarding specific aspects, for example comprehension of diabetic diets. They could not recall any learning outcomes from nutritional training.

We saw in the care records people's nutritional needs were assessed to identify any risks, and care plans detailing how to manage the risk were then developed. However the care plans seen had not been updated to reflect people's changing needs. We saw people were being weighed on a weekly or monthly basis, to check if people were losing, gaining or maintaining their weight. It was not always clear from the records what action had been taken in response to identified weight loss. This meant that

people who were at risk of being malnourished may not always receive appropriate care.

We looked at the care records for three people who used the service. Two of these people were unable to maintain adequate nutrition with oral intake, and received complete nutrition via a tube into their stomach. Neither care record contained up to date and accurate information for staff to follow, which puts people at risk of receiving inappropriate food. The feeding regime for one person was dated 2011 and differed to the information staff told us about the feeding regime. Although the records showed discussions had taken place with the dietician about changing the regime, no documented updated regime could be found. The care plan for the other person had not been updated to reflect their change in needs, and still referred to the person eating a 'soft diet'.

We looked at the food and fluid diets that were completed for people nutritionally at risk. It was noted that by mid afternoon they had not been filled in following the lunch time meal. The information that was recorded in these was not an accurate reflection of true dietary intake.

Our judgement
The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard. People were not protected from the risks of inadequate nutrition and dehydration. This was because people were not provided with suitable and nutritious food, supported to be able to eat and drink sufficient amounts to meet their needs, or provided with food that met their cultural needs.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We spoke with two relatives and five people who used the service about their experience of living at The Park Nursing Home. A number of people who used the service had varying levels of dementia, so not everyone was able to tell us about their care and support. Therefore we spent some time observing how people were treated and how they were involved in their care and treatment. This helped us to understand the experiences of people who could not talk with us.

Relatives and people spoken with did not raise any concerns about living at The Park or about the care they received.

Other evidence
Are steps taken to prevent abuse?

Staff spoken with described how people living at the service could be vulnerable due to their age or disability. They had a good understanding of the forms of abuse people would need protecting from. Systems were in place such as the whistle blowing policy so that staff were able to share any concerns that may impact upon the wellbeing of people.

Do people know how to raise concerns?

Systems were in place to protect people. These systems assisted staff in identifying the possibility of abuse and to prevent it before it happens. For example, staff spoken with

were aware of the policies for safeguarding vulnerable adults. Staff told us what action they would take if they witnessed any abusive practices and would "always report incidents to the nurse in charge or the manager." This assured us that all staff had the knowledge to keep people safe from harm. Staff told us they had also received training in the protection of vulnerable adults from abuse.

The manager reported important events that affected people's welfare, health and safety to the Care Quality Commission (CQC) and other appropriate bodies so that, where needed, action can be taken.

Are Deprivation of Liberty Safeguards used appropriately?

We were told at the time of our visit that no one who used the service had a formal Deprivation of Liberty Safeguards (DoLs) in place. We did not speak with staff about their knowledge of the Mental Capacity Act 2005 (MCA) although we saw that training on this subject was provided.

We saw that people's capacity to make decisions about their lives was recorded in the care records. Mental capacity assessments and best interest assessments had been completed as required.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spoke with two relatives and five people who used the service about their experience of living at The Park Nursing Home. A number of people who used the service had varying levels of dementia, so not everyone was able to tell us about their care and support. Therefore we spent some time observing how people were treated and how they were involved in their care and treatment. This helped us to understand the experiences of people who could not talk with us.

People we spoke with did not raise any concerns that their needs were not responded to at any time.

Other evidence
Are there sufficient numbers of staff?

We observed interactions between staff and people who used the service. We saw staff ignore people on occasions. We heard one person sat in the first floor dining room saying 'hello' over and over. There were two staff stood behind this person at the sideboard. They continued to tidy up after the lunch time meal, even though this person was calling out. Eventually, the kitchen assistant acknowledged this person and asked them if they wanted some biscuits, which they did. The kitchen assistant gave this person biscuits to eat.

We looked at the duty rota and asked the registered manager about staffing levels. Staffing levels were based on occupancy. The registered manager told us she would

put extra staff on duty to meet the needs of individuals, for example end of life care. She told us they were able to maintain the planned staffing levels, and filled any gaps in staffing with staff who regularly worked at the service. This meant people would always be attended by staff who knew them.

We spoke with three care workers about staffing levels. They told us they felt the staffing levels were sufficient to meet people's needs as long as everyone was doing their job properly. They explained that this meant not taking additional breaks during the shift. They did comment that catering staff did not provide any support at meal times, such as serving the meals. This would provide care staff with more time to assist people with their meals. They also told us they felt rushed by the catering staff to complete the meal time in as short a time as possible.

The registered nurses told us they felt that the staffing levels for care workers were not adequate, and they had raised their concerns regarding this. They did not know if any action had been taken in response to their concerns.

We noted that staff did not always use their time proactively. We saw a number of care workers were chatting at the start of the lunch time, rather than completing the laying of tables, organising drinks and cutlery for people, and fetching the condiments.

Do staff have the appropriate skills, knowledge and experiences?

We saw that nursing staff completed people's nutritional assessments when people moved into the service. Where there were identified risks, staff had sought advice from other health care professionals, such as doctors, the speech and language therapist and the dietician. However, it was extremely difficult to follow through the changes in people's needs and the action taken by staff as the care records were poorly completed.

We saw a Malnutrition Universal Screening Tool (MUST) was used to assess nutritional needs and risks for people who used the service. Care workers told us they had received training on nutrition, and they informed senior staff if they observed anyone experiencing difficulties with eating and drinking. The registered nurses had a broad understanding about nutritional issues but said they had not been updated or trained regarding specific aspects, for example comprehension of diabetic diets. They could not recall any learning outcomes from nutritional training.

Staff told us they received training in moving and handling, health and safety, infection control, fire safety and protection of vulnerable adults. They told us training events were planned for the near future and they were booked on these.

The training matrix record clearly identified what training staff had attended, and areas where training was still required / needed updating. Training on nutrition was not included on the training matrix. The registered manager told us this was recorded in individual staff files, so it was not possible to easily see how many staff had attended this training. A number of the registered nurses were also trained to assess if people had any difficulties swallowing, and would refer people to the speech and language therapist if required.

Our judgement

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with two relatives and five people who used the service about their experience of living at The Park Nursing Home. A number of people who used the service had varying levels of dementia, so not everyone was able to tell us about their care and support. Therefore we spent some time observing how people were treated and how they were involved in their care and treatment. This helped us to understand the experiences of people who could not talk with us.

People were asked if staff spoke with them about their care needs. They told us staff did not speak with them about their care needs and they had not seen their care plans. One person told us they hadn't seen their relative's care plan but they weren't concerned about this, as they knew what care was being delivered and were satisfied with this.

Other evidence
Are accurate records of appropriate information kept?

We saw there were care records for people who used the service and these included information about their identified needs and identified risks, and how staff should support them. The records included minimal information about peoples' individual preferences.

We saw assessments had been completed to identify if people were at risk from not eating, developing sore skin or falls. These assessments had been completed when the person was admitted to the service, and reviewed and updated. A more detailed assessment and a care plan had been developed to manage and minimise any identified risks.

We saw a Malnutrition Universal Screening Tool (MUST) was used to assess nutritional needs and risks for people who used the service. This screening tool was reviewed, but not always at regular intervals. We saw in one person's care records that although their weight was being recorded, the Body Mass Index (BMI) and the percentage weight loss or gain were not recorded on the MUST document, so the assessment tool was not being used correctly to identify the level of nutritional risk.

We saw that the rationale for changes in the methodology of screening was not clear. One person was being weighed monthly. Earlier this year, the person stopped being weighed and mid-upper arm circumference was measured. We asked the registered nurse why this had occurred. They told us it was unsafe to weigh this person, and that was the rationale for no longer weighing them. This was not recorded in the care records.

We saw information related to nutrition and speech therapy was not always updated and care plans had not been amended to reflect significant changes to people's needs. We noted the feeding regime in the care records for one person was out of date and incorrect. This meant people were at risk of receiving inappropriate care. Although the care records supported advice was being sought from health care professionals, it was difficult to follow the sequence of events in the records.

We saw for those people identified as at risk of losing weight or having lost weight, food and fluid diaries were completed so staff could see if people were eating and drinking enough. However, these did not always appear to be an accurate reflection of people's actual dietary intake. Staff recorded 'soft meal' for people who had received a soft diet, there was no indication as to what types of food these people had eaten. We noted the diaries were not always fully completed across the 24 hour period and did not always provide sufficient detail as the amount a person had eaten or drunk. There was no evidence on the food and fluid diaries that snacks and drinks being provided outside of the set drinks rounds and meal times. This meant people's food and fluid could not be accurately assessed and a judgement made as to whether any weight loss was due to not eating enough.

Are records stored securely?

The care plans for people who used the service were kept in a cupboard in the manager's office. The food and fluid diaries and other observation charts were kept on the side board in the main lounge areas. This meant anyone had access to the information recorded in these records. This meant people's confidentiality, although considered was not fully respected.

Our judgement
The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard. People were not protected from the risks of unsafe or inappropriate care and treatment

because accurate records were not maintained. This was because care plans were not updated to reflect people's current needs, the nutritional screening risk assessment and food and fluid diaries were not accurately completed, and some care records were not stored securely.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People's privacy was being respected, but staff did not always treat people in a dignified way. This was because staff did not always engage with people when providing support and assistance, were not attentive to people's needs and were not always respectful in the manner in which they referred to people.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were not protected from the risks of inadequate nutrition and dehydration. This was because people were not provided with suitable and nutritious food, supported to be able to eat and drink sufficient amounts to meet their needs, or provided with food that met their cultural needs.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met:	

	People were not protected from the risks of unsafe or inappropriate care and treatment because accurate records were not maintained. This was because care plans were not updated to reflect people's current needs, the nutritional screening risk assessment and food and fluid diaries were not accurately completed, and some care records were not stored securely.

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

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

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA