Inspection Report

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

Highfield Care Home

34 - 36 Hoe Lane, Ware, SG12 9NZ

Tel: 01920467508

Date of Inspections: 02 April 2014
01 April 2014

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Notification of death of a person who uses services	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Tamhealth Limited
Overview of the service	Highfield Care Home provides residential and nursing care for up to 49 older people, some of whom have complex or nursing needs or who may also live with dementia.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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 1 April 2014 and 2 April 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

During our inspection of Highfield Care Home on 01 and 02 April 2014 we set out to answer five questions. These were whether the service is caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?
Below is a summary of what we found. The summary is based on our observations during the inspection, discussions with people using the service, their relatives, and the staff supporting them. We also spent time looking at records.
If you wish to see the evidence supporting our summary please read the full report.

Is the service safe?

There was no effective system in place to make sure that the manager and staff learnt from events such as accidents, incidents and investigations. This increased the risk of harm to people and failed to ensure that lessons were learnt from mistakes. We have asked the provider to tell us what they are going to do to meet the requirements of the law in relation to learning from incidents and events that affect people's safety.

We found that people's records were not an accurate reflection of the care they were being provided with and did not accurately record the progress of treatments given. Records were also in places illegible and difficult to read. This meant people were at risk of receiving inappropriate or unsafe care because an accurate record had not been maintained. We have asked the provider to tell us what they are going to do to meet the requirements of the law in relation to maintaining an accurate record for people who used the service.

Is the service effective?

People's health and care needs were assessed with them, but they were not always involved in writing their care plans. Some people were not aware of what was in their care plans. Some of the care plans had not been reviewed regularly. Care plans were therefore not able to support staff consistently to meet people's needs.

We looked at the support and professional development provided to the manager and staff. We found that the manager and staff had not received an appraisal of their development for over a year. In some circumstances this was in excess of five years. We found that staff had not all received training relevant to their role. We also noted that the manager had not received training in areas such as incident management and supporting staff. This put people at risk of being supported by staff without the appropriate skills.

We have asked the provider to tell us what they are going to do to meet the requirements of the law in relation to assessing people's needs and involving people in planning their care.

Is the service caring?

People were supported by kind and attentive care and nursing staff. We saw that staff demonstrated patience and gave encouragement when supporting people. People were treated by staff in a dignified manner.

People's preferences, interests, and diverse needs had not always been recorded. Because of this care and support could not always be provided in accordance with people's wishes.

We asked the provider to tell us what they are going to do to meet the requirements of the law in relation to involving people in planning their care.

Is the service responsive?

We found that the service did not always respond to issues identified through their own monitoring systems. We found that care record audits identified the need for updating records with important information, however this had not been done.

People using the service, their relatives, friends and other professionals involved with the service completed an annual satisfaction survey.

Is the service well led?

At the time of our inspection the manager had not applied to the Care Quality Commission for registration to manage Highfield Care Home. The manager has been in post for one year. We have informed the provider that we may take action against them unless they tell us how they are going to meet the requirements of the law in relation to having a registered manager in post.

The service had conducted a range of audits to ensure people received a safe level of quality care. However where these audits had identified shortfalls and the manager had not acted to remedy these.

We have asked the provider to tell us what they are going to do to meet the requirements of the law in relation to quality assurance, and the improvements they will make.

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 27 May 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

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 ✖ Action needed

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 not meeting this standard.

People's privacy and dignity was not always respected, and people's views were not always taken into account in the way the service was provided and delivered in relation to their care.

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

Reasons for our judgement

We observed two lunchtime meals being provided to people who used the service. We observed that staff were polite, courteous, and respectful when assisting people to eat. We noted one person refused to eat any more of their lunch, and the care assistant took the time to understand what the issue was. They encouraged them gently to continue to eat, and offered them alternatives. Throughout our inspection on 01 and 02 April 2014, we noted numerous examples where staff interacted with people in a manner that respected their dignity and independence. One person's relative we spoke with told us, "The staff are very caring, if [Relative] says they don't want to do a particular thing at a particular time, the staff accept that and will return later.

We sought the views of 18 people who used the service. Some of the people we spoke with told us that they felt listened to and that the staff responded to their individual needs. For example one person told us, "I am happy here, quite comfortable, the staff give me what I need, I am a vegetarian and they cater wonderfully for me." A second person who used the service told us that the home arranged visits for them to see their relative who was resident in another care home. This indicated that some people's individual preferences had been acted upon.

We looked at the care records for seven people who used the service. We saw that where preferences had been noted at the point of assessment they had not always formed a rounded view of a person's preferences. For example, one person's nutrition assessment had noted they liked ice cream and milk, but had not noted their dislikes. A second record we looked at asked the person's views on what a bad day looked like from the person's perspective. This had not been assessed, and just noted that, "[Resident] appears to like TV and music." This did not provide staff with the information needed to support the

person when they were having a bad day or signs to watch for so they could intervene.

We noted that where personal preferences had been identified these were not written in a person centred manner, and did not evidence involvement from the person or their families. For example, one record noted the person's preference to having a bath. However there were no instructions to staff to inform them how they preferred to receive this or what toiletries and routines the person preferred . We noted from two recent care record audits that the manager had identified care records lacked a personalised approach; however this had not been remedied.

We looked at one person's care record in detail with the manager. The initial assessment had indicated they would like a daily wash and a weekly shower. However the records of personal care provided demonstrated they had received only two bed baths within the last three and a half weeks. A second person told us that their shower day was for a set day, however they had missed this and three days had elapsed and they still had not received their shower. They also told us that they had been recently asked by staff to indicate if they preferred a male or female carer providing their personal care. They told us that they had said they wished only a female carer, however a male agency nurse attempted to provide intimate care. We spoke with one resident about their showering routine. They told us, "I ask the carer's when they shower me not to get my hair wet. I have my shower before I see the hairdresser and I like her to wash my hair. They never listen though." This meant that people expressed their views but they were not always acted upon.

People who used the service were given appropriate information and support regarding their care or treatment. We spoke with four people's relatives who told us that staff were very good at phoning them if there had been a change in their relatives health needs. One person told us that the staff contacted them during the evening to keep them updated after their relative fell ill. People who used the service told us that staff always informed them of what treatment they were providing and why it was needed. However people we spoke with also told us that when they approached staff, they were at times short with them and rude. One person who used the service told us, "When I ask the staff sometimes for something, they can snap at me, not all the staff, just the one's I don't know or haven't seen before. It's the way they snap at me that upsets me."

People's diversity was respected. During our inspection on 02 April 2014 we observed a local church group visited the home. This was at the request of people who used the service. We asked people who used the service if all faiths were included and they told us that they were able to access any denomination they just needed to ask the activities staff to arrange.

People's dignity and privacy was not always respected. We noted that when staff entered a person's bedroom to provide personal care, they announced they were there and asked if it was okay to enter the room. They then closed the door, and provided the required care in a dignified manner. However we also observed that people's bedroom doors were left open throughout the day. Where people were in their rooms either asleep in bed, watching television, or sitting in their chair, any visitor or resident could see them from the corridor. We noted that where some people were asleep in their beds, the sheets and their nightwear had moved which left them slightly exposed. We also spoke with one person who used the service and noted the positioning of a male person's bed allowed a clear line of sight straight into her room. This person told us they were not comfortable being watched by this person.

We asked people who used the service if they were happy with the door open. They told us they were not and had not been asked for their preference. We looked in people's care records and were unable to find any evidence to suggest people's preferences in relation to open doors had been considered. One member of staff we spoke with told us it was usual practice to have the doors open, unless it was requested by the person to be closed. We did note that two people's doors were closed during the day.

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.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

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 and their relatives were positive about the care they received from Highfield Care Home. One person who used the service told us, "I worked in nursing homes all my life, and this one tops them all." One person's relative told us, "The care [relative] receives is very good. They have a lot of care needs and the carers really are very patient and gentle."

We asked people who used the service and their relatives if they were involved in the planning and reviewing of their care. People we spoke with told us they were not. They told us they were informed of any changes, however they were not given the opportunity to formally review either their own, or their relatives care. We showed one resident a copy of their care notes and asked them if they had seen this before. They told us, "I see it sitting on my bed, but to be honest it's not much use. I have trouble seeing, so can't tell you what's in it." One person's relative we spoke with told us, "I think a formal review would be a good idea, they don't happen at the moment."

People's needs were assessed. We looked at seven people's care records and noted that each person had received an assessment of their needs prior to being accepted as a resident of Highfield Care Home. We saw from records we looked at that staff collated information from the person who used the service, relatives and also from other health professionals. Where it was felt further information was needed before a place at Highfield Care Home was offered to a person staff ensured this information was provided and reviewed.

However care was not always delivered in line with a person's care plan. We looked at seven people's care records and noted from one record that a person required repositioning every two hours. When we looked at the positioning chart for this person, we saw that they had not always been repositioned in line with this. One entry demonstrated to us that they had not been repositioned for five hours. This meant that as the person was identified as high risk of developing pressure sores, the lack of regular repositioning meant they were at risk of developing these.

We looked at another person's care records and noted a picture that had been taken of a pressure sore. When we spoke with the manager about this they asked staff to investigate the wound. They found that the photo did not relate to the person in question We asked the manager who the photo belonged to and they were unable to determine this before we completed our inspection. This meant that where it had been identified a person was experiencing a breakdown of their skin integrity, as the care record was inaccurate, the person may be at risk of not receiving appropriate treatment. Additionally, the person for whom the photo related was at risk of not having their wound care appropriately reviewed. We have spoken with the local authority and referred our findings to them in relation to this matter. This meant that care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We looked at a third care plan and noted that staff had identified that a bad day was when the person experienced pain. However we also saw that the person had difficulty communicating verbally. We were unable to find during our inspection any documentation to inform staff how to identify when the person experiences pain. This meant there is a risk that as the person was unable to communicate verbally; they may not be able to inform staff of their discomfort.

There were not always arrangements in place to deal with foreseeable emergencies. Staff had attended basic life support training, and the home employed the services of registered nurses. However, we noted that where people were receiving oxygen due to their health condition, staff had not received the required training for the management of the oxygen or equipment.

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 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

During our inspection on 01 April 2014 we asked the manager how many staff worked in the home. They told us that for the day shift the home employed two registered nurses, one senior carer and eight care assistants. They also employed one activities co-ordinator, a laundry worker, chef, kitchen assistant and three domestic staff. We checked the rota's and confirmed this number of staff were on shift for both days. Night shifts were covered by two nurses and three care assistants.

We asked the manager about the dependency needs of people who used the service. They told us that they currently cared for six people as residential care, and 41 people as residential nursing needs. Of these people, 33 required two carers to support their mobility and 18 people required assistance in their room with eating. Six people who used the service were nursed in bed due to their health needs.

We observed during both days that the morning medicine round on the ground floor continued up to 11am. This was because the nurses were the only staff qualified to administer medicines to people. However, they were at times required to support the carers, or provide nursing care to people. This meant they left their medicine round to tend to other tasks, which delayed people receiving their medicines when they needed them. We also observed during our inspection on 01 and 02 April 2014 that the delay in assisting people with their personal care needs in the morning meant there remained an offensive odour in parts of the home until lunchtime.

The manager told us that the provider used a dependency tool to calculate the required level of staff, and were currently satisfied with the ratio of staff to people who used the service. They told us that they assessed people's care needs monthly which calculated each person dependency requirements. This provided the manager with an indicator of low medium or high needs which they were able to use to calculate the numbers of staff required. However, when we looked at these assessments we noted they had not been completed for the previous month. The manager also told us that when considering dependency they reviewed a 'sample' of people's files. This did not provide the manager with a reliable overview of the changing needs of people who used the service.

We asked the manager how they were able to comprehensively assess staffing requirements against people's dependency needs if the information was both out of date and not a full reflection of the needs of people. They told us they agreed it was 'possibly not the most effective method'. This meant there was not an effective system in place to ensure the home was able to respond to people's changing health and mobility needs.

We observed during both days that call bells rang continuously throughout the morning up until lunchtime. We noted than in many cases these were not answered for between five and ten minutes. We noted the location of one person who had rung their call bell and observed it took staff fifteen minutes to enter their room and provide them with the assistance they needed. People who used the service told us that they had to wait far too long for carers to come and support them. They told us that this meant they were left at times requiring pad changes, or needing assistance with intimate care.

One person who used the service told us, "When I ring the bell they come . . . . Eventually." Another person told us, "I feel sorry for the staff, they have so much to do which makes them late getting us up and washed in the mornings." One person's relative told us, "There have been times when [relative] has to wait, which is generally when [relative] needs to go to the toilet. As [relative] is bed bound it is not very dignified to have to sit uncomfortably." However some people we spoke with were more positive. One person who used the service told us, "I don't need the staff for very much, but when I do need them they will help me." We did observe however that after lunchtime, once people who used the service were settled then the home was calmer and bells were responded to quicker than in the morning.

People we spoke with were very positive about the employed staff at Highfield Care Home. They felt they knew the carers well and felt comfortable with the care they provided. However, people were not so positive in relation to the use of agency staff. One person's relative told us, "There have been a lot of changes recently. The regular care staff are really very good, but the ad hoc staff don't seem to know what people need. The residents living here need regular staff with faces they know." One person who used the service told us, "I think we need more staff, more regular staff, not from other places."

The manager told us that they employed a deputy manager for the home and that they are expected to support the manager with the running of the home. However due to the nursing needs of people in the home, the deputy manager spends their contracted hours providing care to people. The manager told us that the budget to allow the deputy to work extra hours to provide managerial support has been removed. This meant that the home manager did not receive support from their deputy to assist with managerial responsibilities. When we spoke with the deputy manager they told us that in order to complete their tasks, they worked longer hours, and also worked on their days off. One staff member we spoke with told us that the lack of staff meant they needed to choose between providing safe care and maintaining people's care records. They told us they prioritised people's care, and this meant that the care records were not always updated because of this.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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 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

The manager told us that provider's policy regards supervision of staff was to provide five supervision sessions and one annual appraisal. Supervision and appraisal allows staff and the manager the opportunity to reflect on current objectives and work performance, identify training and future goals, and support staff with areas where they experienced difficulty.

The manager told us that staff had not received an appraisal within the last year as required by policy. They also told us that staff had not received the required number of supervisions. We saw from four staff records we looked at that there was no evidence to suggest staff had received an appraisal since 2002 and a second since 2005.

We asked the manager whether they had received an appraisal within the last year. They told us that they had not, and also had not received regular supervision with their line manager. The manager had been in post for one year when we carried out our inspection on 01 and 02 April 2014.

Staff we spoke with told us that they felt very supported by their immediate team. They told us they felt they could rely on other carers and nurse's to support them positively when they needed assistance. However staff we spoke with told us they did not feel supported by the provider.

We looked at the training completed by staff at Highfield Care Home. We noted that not all staff had received training in areas that supported them with their role. For example, we looked at the training records for five registered nurses. We saw that none had completed the registered nurse induction programme or mental capacity awareness training. Only two had completed the use of bed rails training. We noted that one domestic had not completed their induction training as well as the kitchen assistant.

We looked at the training records for the home manager. We saw they had completed training in a range of areas including medicines, conflict resolution, health and safety, deprivation of liberty and equality and diversity. However we saw that they had not

received training in areas such as supervising people, supporting care documentation, principles of care, Mental Capacity Act 2005, dignity in action and anaphylaxis. Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death. They also had not completed training in relation to investigating and reporting incidents, dementia, HR, palliative care and pressure ulcer prevention. This meant that staff, including the manager, had not been provided with the necessary development to ensure they were able to fulfil the requirements of their roles.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider 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 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 sought the views of people who used the service by asking them and their relatives to complete satisfaction questionnaires. We were told by the manager that one had been very recently completed, and the results had not been analysed. However, through discussion with the regional manager we noted that people were additionally able to request a telephone call with senior management and this was provided. This call was to enable relatives and / or people who used the service to discuss any positive or negative aspects of their care with a manager other than the home manager. We were unable to review the feedback of the recent survey.

The manager told us that as part of their regular quality monitoring they conducted audits of care records. We looked at two recent audits that had been conducted by the manager. The first was conducted on 11 February 2014 and had identified that not all care plans had been reviewed monthly as required by provider policy. We also saw from this audit that not all untoward incidents had been recorded accurately within the care record. This meant that incidents that had occurred were not consistent with the information held in the central incident register. In addition we found that the manager had identified screening tools had not been completed and reviewed as per policy. For example, in respect of those people at risk of developing pressure sore, their malnutrition universal screening tool (MUST) and Waterlow score.

We looked at a further audit conducted on 18 March 2014 and noted that untoward incident reporting appeared to have been resolved. However, the same issues remained from the previous month. During our inspection on 01 and 02 April 2014, we found these issues had not been resolved, and were not in the process of being updated. We saw from each audit that where there was an identified issue with people's records, there was not a clear action plan to remedy the issue.

For example in the March audit, it had been identified that people's assessments and relevant documentation did not reflect the involvement of the person or their relative. We

noted that the comment made stated, "More PC approach would be beneficial." There was no accompanying plan identifying who was responsible for this area, how it would be completed and by when.

We also noted from the audit documents we looked at that in the audit completed on 18 March 2014 the summary section identified the range of audits that were to be completed. These included areas such as infection control, training, medication, nutrition and safeguarding vulnerable adults. We saw that the home had given themselves an overall 'compliance' score of 18%. We noted that the safeguarding audit had only been completed for February 2014, and infection control, training, medication, management, nutrition, and skin integrity had not been completed. We also noted that an audit of people's falls in the home had not been completed since 30 June 2013. This was in spite of the fact that the incident register recorded a number of falls since that date.
We were unable to see evidence that learning from incidents took place and appropriate changes were implemented. We reviewed the accidents and incidents that had occurred in the home since 01 April 2013. We found by reviewing the home incident recording system that when staff identified an accident or incident they reported this appropriately. We saw that staff provided an explanation of how the accident or incident occurred, and actions they had taken. However, we also saw that where incidents required further investigation these had not always been carried out. For example, where staff had noted unexplained bruising to a resident, they had reported the cause of this as unknown. However, this did not trigger an investigation by the manager to ascertain the cause of the bruising. We also saw that this had not been reported to the Commission as a potential safeguarding vulnerable adults concern.

Notification of death of a person who uses services ✖ Action needed

Adult social care and independent healthcare services must tell us when somebody dies in their care. NHS services must tell us when somebody dies because they have not been given the right care

Our judgement

The provider was not meeting this standard.

The registered person did not notify the Commission without delay of the death of a service user.

We have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

During our inspection on 01 and 02 April we reviewed the incidents record for Highfield Care Home. We looked at the reporting period from 01 April 2013 to 31 March 2014. Where there is a death in a residential care home, the registered person is required to inform the Commission of the death at the earliest opportunity.

We reviewed the records held by the Commission and noted that seven deaths had occurred in this period that had not been notified to the Commission as required by law. We saw that five of these were expected deaths; however two of these were unexpected deaths. As the Commission had not received this information for the purposes of monitoring Highfield Care Home, this meant that an accurate reflection of the risks and incidents could not be accurately used to discharge our regulatory function.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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

During our inspection on 01 April 2014 we asked one care worker to access a care record for a person who used the service. They then walked to a desk that was located in a communal area and removed the care record from an unlocked cupboard that was accessible to anybody in the building. We observed that on the top of the desk were records relating to handovers and daily care routines which contained information that was private and personal to the people who used the service. This meant that although records could be located promptly they were not held securely.

People's personal records, including medical records, were not accurate or fit for purpose. We looked at seven peoples care records. In each record we found entries that had been handwritten but were unable to read or understand the handwriting in some of the records. In the event that a member of staff required information in an emergency, this posed a risk that they may inadvertently interpret the wrong care instruction, or may not be able to interpret at all. This may have led to the wrong, unsafe or inappropriate care being given, or care not being given at the appropriate time due to the delay.

We noted that information used to monitor people's nutritional and weight needs were not always accurately updated. For example we found that Waterlow and MUST records were not reviewed and weights recorded were at times conflicting. For example we noted on the weight recording chart a person's weight had been recorded as 35.6 kilograms. When we looked at the corresponding MUST record it had been noted as 38.7 kilograms. We also saw that the settings for people's air pressure mattresses also gave conflicting settings. For example in one person's care plan it had been recorded as one of either two settings. Staff were unclear what the correct setting was, however staff rectified this during our inspection.

We noted that the bed charts used in each person's room we looked at had not been updated with the care provided. We saw that this had been noted in a staff team meeting on 16 January 2014; however the records had not been amended to reflect this.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Regulation 17 (1) (a) (b) The provider had not ensured that people's dignity, and privacy was respected. They also had not ensured that people are enabled to make, or participate in making, decisions relating to their care or treatment and these are acted upon.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9 1(b) (i) (ii) 2 The provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that ensures the welfare and safety of the service user.

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: Regulation 22 The provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of persons employed for the purposes of carrying on the regulated activity.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Regulation 23 (1) (a) Staff did not receive appropriate training, professional development, supervision or appraisal.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Regulation 10 (1) (a) (b)

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	The provider had not identified, assessed and managed risks to the health, safety and welfare of people who use the service and others.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 16 CQC (Registration) Regulations 2009** **Notification of death of a person who uses services**
	How the regulation was not being met: Regulation 16 (2) (a) (i) The registered person did not notify the Commission without delay of the death of a service user.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Regulation 20 (1) (a)

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

This section is primarily information for the provider

The provider's report should be sent to us by 27 May 2014.

CQC should be informed when compliance actions are complete.

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

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.

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