Inspection Report

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

Oakwood Residential Home

192 West End Road, Bitterne, Southampton, SO18 6PN

Tel: 02380466143

Date of Inspections: 19 September 2013
16 September 2013
11 September 2013

Date of Publication: February 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖	Enforcement action taken
Safeguarding people who use services from abuse	✖	Enforcement action taken
Cleanliness and infection control	✖	Enforcement action taken
Management of medicines	✖	Enforcement action taken
Safety and suitability of premises	✖	Enforcement action taken
Requirements relating to workers	✖	Enforcement action taken
Staffing	✖	Enforcement action taken
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Records	✖	Enforcement action taken

Details about this location

Registered Provider	G & A Investments Projects Limited
Registered Manager	Mrs. Karen Perrin
Overview of the service	Oakwood Residential Home is registered to provide accommodation for up to 28 people. It is for people who are 65 or over and many of the people using the service have dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Oakwood Residential Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Requirements relating to workers
- Staffing
- Assessing and monitoring the quality of service provision
- Records

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 11 September 2013, 16 September 2013 and 19 September 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff and reviewed information given to us by the provider.

We also spoke with an external healthcare professional.

What people told us and what we found

During our last inspection on 25, 27 June and 1 July 2013, we found the provider was failing to meet essential standards.

We served three Warning Notices on the provider and registered manager in relation to continued non-compliance with regulations regarding the care and welfare of people who use services, cleanliness and infection control and the management of medicines.

We also set compliance actions regarding the safety and suitability of premises, safeguarding people who use services from abuse, requirements relating to workers and assessing and monitoring the quality of service provision.

We conducted a further inspection on the 11, 16 and 19 September 2013 to check the registered persons had taken the appropriate action to meet the requirements. During the inspection we also looked at essential standards relating to staffing and the maintenance of records.

We found improvements had been made to the laundry and a new sluice facility had been created. However, we found none of the essential standards we inspected were being met.

There were inadequate arrangements in place for the safe handling of people's medicines. Care plans and risk assessments did not reflect the current needs of people, which put them at risk of receiving inadequate care. The care plans had not been reviewed although the needs of people had changed and this may impact on the care they received.

People were not provided with a safe environment to live in. The checks on essential safety equipment had not been carried out. There were inadequate bathing facilities to meet people's needs. We found the hot water delivery in people's bedrooms were unsafe and put them at risk of harm.

The recruitment process and staff training were not robust to ensure staff were fit for the job. The staffing levels were decreased at the weekends that may put people at risk of not receiving the care and support they need.

There were some audits being carried out. However these were not robust and did not look at adverse incidents and develop strategies in order to minimise or eliminate risks. There was no action plan developed to show how shortfalls identified through surveys and audits would be addressed.

The management of records was poor and the records for the safe management of the service were not adequately maintained. This puts people at risk to their welfare and safety.

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

What we have told the provider to do

We have referred our findings to Environmental Health. We will check to make sure that action is taken to meet the essential standards.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights. Arrangements were inadequate to show how people's assessed risks and care needs would be met consistently. Emergency planning was inadequate and may impact on people's safety and welfare.

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

Reasons for our judgement

Following our last inspection on 25, 27 June and 1 July 2013, we found the provider was failing to meet this essential standard. We found arrangements to show how people's assessed risks and care needs would be met consistently and safely were inadequate. Emergency planning was inadequate and put people's safety and welfare at risk. We issued a warning notice requiring the provider to become compliant by 14 August 2013.

During this visit we looked at the care plans and associated records for 11 people using the service. The manager told us the staff had undertaken a review of care plans and were addressing the issues. We were told new care plans were being put in place for all the people using the service. We saw a new care plan format was in place. However, these records did not contain sufficient information to identify people's needs and show how they would be met.

We looked at the care records for a person who had been admitted in June 2013. At our previous inspection in June and July 2013, we found this person did not have a care plan to demonstrate how their care and support needs would be met. During this inspection we spoke with the manager who confirmed this person still did not have a care plan. The manager told us this would be developed. Their assessment showed they had Alzheimer's and a history of falls and that they were "unsteady due to a fracture of their hip". Under the heading 'Personal safety and risk', the record said "may wander". However, there was no plan in place to say how these risks would be managed. The record also showed they had poor appetite and "do not like wet food". At lunchtime we saw they were provided with a

meal in gravy, which they did not eat. Their continence and skin integrity assessments were blank; staff said these needed to be completed. A staff member told us the person used continence pads and was able to use the toilet independently, although they were not able to find it without help. The lack of care plans meant people were put at risk of not receiving care in a consistent manner.

We saw one person's care record showed risk assessments had been completed for bathing, trips & falls, nutrition, dementia, skin integrity, pressure sores, behaviour, isolation, hygiene, alcohol in bedroom and bowels. We saw the risk assessments had each been reviewed monthly for seven months during 2012, but had not been reviewed since then. The manager confirmed the person's needs had changed. The risk assessments had not been reviewed on a monthly basis as per the home's internal procedures and staff did not know why these had not been done. Staff also told us this person's needs had changed and the person was prone to self-neglect due to their dementia and other medical issues. The person's records showed several incidents of shouting and aggression. Two staff members said this person could be "difficult' and often refused personal care. Staff told us there were no care plans in place to support this person in managing their behaviours. They were not able to tell us how this person's needs and risks were managed effectively.

Two other people's records showed they had suffered a number of falls and the manager told us the needs of one of these people "had changed dramatically". However their care plans and risk assessments had not been reviewed and updated since April 2013 to reflect these changes. The manager told us their records should have been updated in order to provide information for the staff about their current needs. There was a risk of people receiving inconsistent care and not according to their needs.

We looked at the body maps and skin integrity charts for four people. All four showed a high number of unexplained cuts, bruises and skin flaps. Although the care staff recorded these incidents there were no risk assessments or care plans to demonstrate what action had been taken to manage and reduce the risks. We brought this to the attention of the manager who asked, "Where did you find this information?" Care staff told us they reported and recorded these, but said they did not know what action, if any, was taken. A senior member of staff told us these incidents were not monitored. People were put at risk as there was no care plan in place to show how incidents, such as cuts and bruises, were managed to ensure appropriate treatment was given.

People who were at risk of falls were provided with seat alarms, which should alert the staff of their movements. We found these alarms were noisy, went off constantly, causing distress to people and were not responded to for up to ten minutes at a time. They were not effective as those at risk were often out of their chairs, walking without their frames and often helped by other people who were not stable on their feet. This included a person who had been admitted to hospital following a fall a few days prior to our inspection. This put people at risk of falling as they were not monitored effectively.

During the three days of our visit we found the noise level in the lounge was very loud, especially during the mornings. This was caused by the television set to a high volume and two alarm systems used to monitor the call bells in people's rooms and a range of movement alarms. We found the alarms emitted a high pitched, unpleasant noise which people found irritating. One person told us "it's like a circus" and the noise is "something else". Another person said of the television, "It's a damn nuisance" as no one watched it.

A visiting health care professional also raised concerns with us about the noise levels in the lounge. They told us one person, who was not suffering from dementia, was over-stimulated by the environment and had become depressed. The manager responded there was not much they could do about alarm bells. There was a failure to recognise that over-stimulation, could have a detrimental impact on people using the service.

One person's record showed they had lost 10kgs in weight between April and August 2013. They had also been admitted to hospital following a fall in June 2013. Staff told us the person had become "very frail and their skin was fragile and at risk of tearing". Their skin integrity and body map chart showed they had suffered nine cuts, bruises or skin tears. We looked at their care plans and assessments and saw they had not been reviewed to reflect these changes to show how this risk would be managed.

Staff also told us this person was at increased risk of falling as their mobility had deteriorated. We saw their last fall risk assessment had been updated in November 2012 and was assessed as medium risk. The risk assessment and care plans had not been reviewed or updated to reflect this person's current needs and how they would be met. The district nurses' records showed the person had gained some weight and the fortified drinks, which they had been taking, had been ceased. However, there was no care plan to ensure their dietary needs continued to be monitored to ensure any further changes were identified and action taken.

We looked at the record for a person newly admitted, who was also a diabetic. This person had particular dietary needs due to their ethnicity. They told us they did not like "English food" as they found it very bland. They said they "did not want to make a fuss" so ate small amounts of the meals as they were aware they needed regular meals due to their diabetes. We brought this to the attention of the manager who told us she knew this person "wouldn't like English food" and suggested the family could bring food in for her. However, this person told us their family were busy and could only visit at weekends. The record showed the interim care plan, which was formulated prior to their admission, would be reviewed and updated on 19 August and a care plan developed to meet their needs. We saw this had not been completed. A staff member told us the staff had been very busy and that "things get missed".

We saw this person's record also showed they were prescribed tablets to control their diabetes. However, a staff member told us their diabetes medication had been discontinued. There was no action plan to show how their blood sugar levels were being monitored. A staff member said they would discuss this with the district nurse as they had not considered this previously. This showed care was not person centred and did not consider people's diverse needs, such as support with their diet.

Our previous inspections in March 2013 and June/July 2013 identified the absence of an emergency or business continuity plan, apart from an emergency contact list for the staff to call to seek help. At this inspection we found there had been no progress in the development of personal evacuation plans and assessments for people living at the home. The people accommodated had varying degrees of dementia. Staff told us that people would require full assistance in the event of an emergency and confirmed there was no risk assessment or action plan in place. This meant if people needed to be moved out in an emergency, their welfare and safety was at risk.

Safeguarding people who use services from abuse ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse. There were inadequate arrangements to monitor incidents of abuse and to develop appropriate action plans to improve practices.

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

Reasons for our judgement

Following our last inspection on 25, 27 June and 1 July 2013 we found the provider was failing to meet this essential standard. We found arrangements were inadequate to protect people from the risk of being subjected to unnecessary restrictions of their liberty as the necessary safeguards were not in place. A person, who had capacity, was being subjected to restrictions to which they had not consented, which should have been subject to Deprivation of Liberty Safeguards (DoLS). We set a compliance action for the provider to take action and become compliant.

During this inspection we found this person had resolved the issue by paying for someone privately to accompany them to the local shop and to church. The person told us this was "going well" and felt much happier, although they told us they did not think they should have to be paying extra for the support. The manager told us the provider would not pay for this and "cannot afford it". Their care records did not show how this decision was reached and any involvement of the person or their relative who was an appointee for their finances.

We spoke with a visiting healthcare professional who had completed a mental capacity assessment of this person. This showed the person's capacity to make decisions was not impaired and they had scored highly in their assessment. However, when we spoke with staff, they told us the person did not have capacity, due to them making what the staff deemed as unwise decisions. This showed a lack of understanding by staff, who we found had not received training in the Metal Capacity Act (MCA) 2005. This put people at risk of being deprived of the opportunity to make decisions.

At the last inspection a senior staff member told us the next safeguarding adult training had been booked and would include the deprivation of liberty safeguards (DoLS). We found this had not been completed and the manager was unable to tell us when this would

be done and how many staff would take part.

The safeguarding adult policy and procedure was available to staff and information on how to contact the DoLS team had now been put in place. We saw there was an internal safeguarding procedure in place; however, this was a generic template and did not contain adequate information for the staff at Oakwood. The manager told us a person at the home was subject to DoLS and this was in place for six months. We asked to see this application, but the manager told us it was not available.

A copy of the DoLS application was obtained from Social Services during the inspection. We saw it came into effect in July 2013 and was due to expire on 1 October 2013. This meant staff had not had access to this necessary information to ensure appropriate procedures and safeguards were followed to protect the person's rights and maintain their safety.

One person's care record showed they may have presented a risk to visitors. However, there was no risk assessment or action plan in place to protect visitors or people using the service. The manager told us this would be looked into.

There were inadequate procedures in place to protect people from abuse. We spoke with the staff about safeguarding vulnerable adults. They were able to tell us what constituted abuse and they said they would report incidents to the manager or person in charge. They said they "thought action would be taken"; however none of the staff said they would follow this up themselves. We saw the manager had made a referral in response to a recent safeguarding incident, which was investigated by the police. However, the outcome of the investigation had not been followed up and an action plan had not been produced to reduce the risk of recurrence.

Cleanliness and infection control ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because the procedures for infection control were not robust and staff's practices put people at risk of cross infection. The staff did not follow appropriate guidance and people were not always cared for in a clean, hygienic environment.

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

Reasons for our judgement

Following our inspection on 25, 27 June and 1July 2013, we identified there were inadequate arrangements in place to ensure people were provided with a clean and hygienic environment to live in. Some bedrooms, mattresses and bed linen were dirty; the laundry area was not fit for purpose and the process used for cleaning commode pots were unsatisfactory. This posed a serious risk to people's health and welfare. Infection control guidance had not been followed and there was no quality assurance framework in place. We issued a warning notice requiring the provider to become compliant by 14 August 2013.

During this inspection we found improvements had been made to the laundry and a new sluice room had been created for cleaning commode pots. However, improvements had not been made to all bedrooms and no quality assurance framework had been put in place.

Providers are required to have regard to the Department of Health's 'Code of Practice on the prevention and control of infections and related guidance'. The Code of Practice sets out the basic steps to ensure compliance with the infection control requirements of the Health and Social Care Act, 2008. We found the provider and manager had not taken the steps necessary to meet the requirements of this standard.

The Code of Practice required the lead person for infection control to produce an annual statement. This should include details of outbreaks of infection; audits conducted and risk assessments undertaken. The manager told us they were jointly responsible for infection control, together with one of the deputy managers. The manager showed us a statement entitled "Oakwood Statement January 2013 August 2013".

We saw the statement mentioned an outbreak of infection during this period that had affected four people using the service. It showed action taken by the service to deal with it. However, it did not show the date of the outbreak and the manager was unable to tell us the date. It was, therefore, not possible to examine other records relating to the outbreak, such as daily care records or records of cleaning. This meant it we could not confirm that appropriate action had been taken in response to the outbreak. There was no audit or analysis of the outbreak so that preventative measures could be put in place. The statement also showed that the home's 'monthly audit' did not cover the prevention and control of infection.

There was no quality assurance framework in place to reduce the risk and spread of infection. We asked to see copies of any infection control audits and risk assessments which had been carried out. The manager told us none had been completed. We looked at the home's policy entitled "Control and Outbreak of Infection" which stated that a record of all activities and actions relating to an outbreak would be recorded in the infection control log book. This log should contain details of people affected and date and time this was reported to the communicable disease team. The manager confirmed that no such log book was maintained. This meant staff were failing to follow their own procedures in recording and responding to outbreaks of infection.

We spoke with a member of domestic staff about cleaning they performed. They showed us a cleaning schedule for each area of the home and each bedroom. However, the staff member told us the schedule was not being used as the cleaning specified could not be completed in the time available. For example, the schedule said that each bedroom should be vacuumed each day. The staff member told us in reality they were only able to vacuum around a quarter of the bedrooms each day. The bedrooms were not cleaned at the weekends as there were no domestic staff employed at weekends and care staff told us they did not have time to clean.

We spoke with the chef and looked at cleaning schedules for the kitchen. We saw these were appropriate. We looked at records of daily cleaning, which showed cleaning had been completed in accordance with the schedules on most week days. However, the records showed no cleaning was being undertaken at the weekends. Staff told us this was an issue they intended to raise with the manager as there was no chef at weekends and care staff prepared the meals. The lack of cleaning in the kitchen at weekends put people at high risk of infection.

We viewed the home at the start of our inspection. We found communal areas such as the lounge, dining area and the kitchen were clean and in satisfactory decorative order. We looked at the laundry, which we saw had been refurbished and cleaned. A hand washing sink had been installed, although this was blocked by two large laundry bins. Staff were unable to access the sink easily, which meant they were unable to wash their hands effectively after handling dirty laundry.

We looked at the newly constructed sluice room. We saw this provided an appropriate environment in which to clean commode pots hygienically. However, we saw there was an open clinical waste bin without a lid in the room, which contained used personal protection equipment (PPE). The room was not locked, so was accessible to people using the service which posed an infection control risk to them.

We also looked at the adjacent toilet (signed 'Toilet 6') which was also accessible to people using the service. We saw this also contained an open clinical waste bin without a

lid. Inside the bin was a used incontinence pad and used PPE. The failure to manage soiled infected continence pads posed an infection control risk to people using the service.

In toilet 6, we also saw that the wall-mounted soap dispenser was not working and there was a used bar of soap on a shelf. A member of staff told us they used the bar soap to wash their hands because they knew the dispenser was not working. Guidance issued by the Department of Health (DH), entitled "Prevention and control of infection in care homes" specified that liquid soap from a dispenser should be used. Bar soap, used communally, puts people at risk of cross infection.

We looked at the only bathroom in use on the day of our inspection. This was located at the rear of the building on the ground floor. We saw it contained four used bars of soap, a portable urinal, an old flannel and a used pair of tights. The underside of the seat on the bath hoist was dirty and stained with yellow deposits of an unknown substance. The clinical waste bin contained a used incontinence pad which had not been disposed of safely. The manager told us it was the home's policy to wrap all used pads in plastic bags before placing them in bins; this pad had not been placed in a plastic bag. The bathroom was unlocked and accessible to people using the service, which put them at risk of infection.

In the home's main lounge we saw two open bins for general waste. We saw each contained used PPE. These were accessible to people and put people making contact with them at risk of infection. On the landing of the first floor of the building we saw a yellow clinical waste bag and a black waste bag left unattended on the carpet. Both bags were full, and the clinical waste bag contained used continence pads. People using the service had access to the bags, which put them at risk of infection. There was also a risk of leakage from the bags onto the carpet, which could have led to the spread of infection. The manager agreed this was not acceptable practice and said staff were failing to follow the infection control procedures.

We observed staff working during our inspection. We saw one member of staff wearing a cardigan, with the sleeves pulled down over their hands, while supporting people on several occasions during the day. This was unhygienic and could lead to cross infection. We saw another member of staff carrying soiled linen by holding it close to their body on two occasions. The staff member did not use any PPE. We brought this to the attention of the manager as this posed an immediate infection control risk. A third staff member was seen wearing the same apron for an extended period during the day while moving around the home, going from room to room. DH guidance states that "The apron is as a single-use item used for one procedure or episode of care and then discarded as clinical waste on completion of the task". The manager told us staff had received training in infection control. The staff's practices put people at risk of cross infection as they continuously failed to follow simple guidance in the prevention of infection.

We spoke with staff about hand washing practices. One member of staff told us they washed their hands in people's bedrooms after handling soiled linen "using the soap dispensers and paper towels". We asked the staff member to show us these in two bedrooms. We saw neither of the bedrooms contained soap dispensers or paper towels. The staff member was unable to explain how they did wash their hands. We discussed this with the manager who told us none of the bedrooms contained soap dispensers or paper towels. They said staff should wash their hands in the laundry after depositing the laundry there. Correct procedures for the use of PPE and hand washing were not being followed by staff. This put them and people using the service at risk of infection.

On the first day of our inspection we looked at seven bedrooms. Two of these smelt strongly of urine. The carpet in one of the double rooms, occupied by two people, smelt of, and was smeared with what appeared to be, fresh faecal matter. We showed this to the manager, who agreed with our findings. We spoke to a domestic staff member who confirmed they had "hoovered the room" and the room had been cleaned. We checked this bedroom three times during the day and saw the faecal matter had not been removed from the carpet. The domestic staff member told us they had not had enough time to clean the carpet and would be doing it tomorrow. This meant the two people using the room would have spent that night in a room that was not clean and hygienic. We viewed the room again on the third day of our inspection. We saw that an attempt had been made to clean the carpet, but the stains were still visible. Cleaning had not been effective and people's welfare was not considered whilst providing care.

In the same bedroom we found a dirty tubular mousetrap in one of the corners of the room by the radiator. We asked the manager if they had had problems with infestation of rodents. The manager told us the trap had been placed there by maintenance staff, but did not know why. The deputy manager told us there had been a problem with mice several years ago, but it was not a current problem. The mousetrap was unhygienic and accessible to people using the bedroom. This put them at risk of infection.

Mattresses in three bedrooms were stained with dried urine and bed linen on two beds was dirty and stained. Pillows on two beds were badly stained and a cushion on a bedroom chair was impregnated with urine. These were similar issues we had found at our last inspection which put people at risk of infection.

On the third day of our inspection we saw an invoice showing 14 new bed bases and 14 new mattresses (28 items in total) had been ordered. Records showed 17 of these items had been delivered and had replaced some of the old beds. Staff told us there was a list showing the priority in which beds needed to be replaced.

The infection control processes and staff's practices we observed continued to put people at risk as the provider had not taken adequate action to manage the risk of and spread of infection at the service.

Management of medicines ✖ Enforcement action taken

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. People were at risk of not receiving their medicines as prescribed, safely and consistently.

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

Reasons for our judgement

Following our inspection on 25, 27 June and 1July 2013, we identified there were inadequate arrangements in place to ensure people received their medicines in a safe and consistent manner. We issued a warning notice requiring the provider to become compliant by 14 August 2013.

At this inspection we found appropriate arrangements were in place for storing medicines on two days of our inspection; however, medicines were not stored safely on the third day of our inspection. There were large quantities of medicines in a room which was closed by a latch on the outside. The manager told us these were the new supplies of medicines for the month. There was a risk of other people having access to this room and the medicines as the latch could be opened from the outside. Staff told us this was due to inadequate secure storage space during the changeover period when new stock was received. At the last inspection we told the provider about a medicine cupboard that contained a stock of creams and ointments that we found was unlocked and insecure. At this inspection we found this cupboard was still insecure. Staff told us a lock was required but had not been fitted.

We found a controlled drug (CD) register had been put in place since the last inspection. We saw this was a bound book with numbered pages, as recommended. Staff told us each person's CD would be recorded on a separate page. At this inspection we had concerns as information we viewed following an incident showed the controlled drug cabinet had not been locked. There is strict guidance that staff must follow regarding the management and storage of CDs. CDs that were not stored and managed safely put people at risk of accessing or receiving medicines not prescribed to them.

We looked at a random sample of 13 medication administration record (MAR) charts. We found the arrangements in relation to obtaining medicines were not robust. The records for

two people showed they had not received their medicines as prescribed. One person was on a long term course of antibiotics, which was used a preventative measure, as they were at risk of recurrent infections. Their MAR chart showed they did not receive this medicine over a period of four days. A staff member told us they had run out of stock and said staff should have checked and re-ordered new stock in time. However this had not happened and meant this person had not received their medicines.

Another person's record showed they did not receive six medicines over a period of two days as they were out of stock. People were put at risk as they did not always receive their medicines as prescribed as these medicines were not available to them.

The record for another person showed they had received the wrong dosage of their medicines. This person had been discharged from hospital on a new regime of medicines that included a blood thinning drug and cortisone tablets. Their record showed they were prescribed Warfarin, a medicine to thin their blood. We saw they had received the wrong dosage on two occasions and did not receive their medicine on one occasion. Also, they did not receive their prescribed Prednisolone tablets for three days and then received extra dosage of ten (10) milligrams of their Prednisolone for three days. The staff and manager we spoke with could not explain how these errors had occurred. This had not been reported and people were at risk to their health from receiving the wrong dosage of their prescribed medicines.

There were no clear management processes for "as required" medicines. Staff told us not all the people would be able to express their needs for pain control, for example due to their cognitive difficulties. For people who were prescribed "as required" medicines there was inadequate information in care plans to inform staff's practices and ensure people received their medicines consistently, as prescribed and when they needed them. A staff member told us this needed to be developed. We had raised this with them at the last inspection and the issue remained outstanding.

We looked at six medications to check their stock levels and found they did not match with the MAR records we checked. There were extra or missing medications that could not be accounted for. For one person there were 11 eye drops missing; these were individually packaged. A staff member told us they were using the single eye drop four times a day and then the package was discarded. There was no procedure or care plan in place in order to ensure this was adhered to by all staff. This could lead to inconsistency in practice.

Another person's MAR chart showed there were eight extra tablets that the staff could not account for, although the record showed the person had received all their medicine. This meant the record was not accurate and the person may not have received their medicine as prescribed. This put people at risk of not receiving their medicines as prescribed. The records for administration of creams and ointments were also incomplete and staff were unable to tell us if they had been administered as prescribed. There was no process in place to ensure medicines, which were stored in people's bedrooms, were checked to ensure they were managed safely including their 'use by' dates. This put people at risk of receiving medicines that were no longer fit for use.

Medicines were not managed safely. We saw eye drops were dispensed in June 2013 and had been brought into the home by the service user. Staff confirmed they were open when they received them and may have been open since June 2013. The staff had failed to ensure the date of opening was recorded and the eye drops discarded after 28 days, as

recommended in guidance issued by the Royal Pharmaceutical Society (Handling Medicines in Social Care). A staff member confirmed a new prescription would be raised and these eye drops discarded.

The lack of clear procedures and a robust system for the management of people's medicines put people at risk of not receiving their medicines in a safe and consistent way.

Safety and suitability of premises ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

There were inadequate arrangements to ensure hot water was delivered safely. There was inadequate maintenance of safety equipment of other facilities, such as bathrooms and shower facilities, to meet people's needs.

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

Reasons for our judgement

Following our last inspection on 25, 27 June and 1July 2013, we identified there were inadequate maintenance arrangements and insufficient bathing facilities, such as bathrooms and showers, to meet people's needs. We set a compliance action for the provider to take action and become compliant.

During the last inspection the manager told us that half the people accommodated would prefer and benefit from having a shower facility. Staff told us there was a shower facility, but it was not fit for purpose and had not been used for about five years.

At this inspection we saw work had been started on the construction of a new shower room, but had not been completed. We spoke with the manager about a completion date, but they were unable to give us a timescale for when the facility would be available to people using the service.

The bathroom on the first floor was not being used, as we reported at our last inspection. This was due to the lack of assisted facilities; staff told us none of the people were able to use the bath without an assisted bath hoist. The manager told us the provider had no plans to put an assisted bath in this bathroom, due to the costs.

Staff told us it was "difficult" trying to manage people's bathing needs with only one bathroom in use. They said the issue had "been going on for a long time" and were not confident it would be resolved. We found there were still inadequate bathing facilities to support the 23 people who were currently accommodated. The limited bathing facilities and lack of options did not promote choices for people and meant their bathing needs were not always met. The provider had failed to take sufficient action to ensure appropriate facilities were available to people and were fit for purpose.

We tested the hot water in 11 sinks, to which people had access, as part of our inspection. We found in all cases the hot water was delivered at over 50 degrees centigrade. The manager confirmed there were no thermostatic valves fitted to the sinks. We looked at maintenance records which showed the issue about hot water being "too hot" dated back to 2012. The manager told us they had emailed the provider and told them "it's urgent", but confirmed there was no plan in place to remedy the problem.

The home accommodated people with varying degrees of dementia, who staff agreed were vulnerable and at risk. People's health and safety was put at risk as the provider had failed to take appropriate action to ensure hot water was delivered at a safe temperature. We brought this to the attention of the manager as immediate action was needed. Following our inspection we made a referral to the environmental health officer, as people using the service were at risk of scalding.

We found there were inadequate arrangements to ensure repairs and remedial work was carried out in a timely manner, in the interests of people living at the home. The staff told us they had a maintenance book where they requested work to be carried out to the environment. At our last inspection the "safety arm" hand rail in one of the communal toilets was broken and we found this had not been repaired. The maintenance book contained three pages of work the staff told us was still waiting to be done. We randomly checked six of these requests and found none of the repairs had been carried out. These included bedside lights not working and a broken drawer which a person told us "had been broken for ages". The maintenance book showed one person did not have any curtains in their room. This had been entered in the book on 20 July 2013 and was still outstanding on the 19 September when we inspected.

Other maintenance concerns included a wall light outside one of the bedrooms. We saw this was at head height and had a cover missing, meaning people could access live components inside the light. There was broken plaster on the wall, curtains hanging off rails in bedrooms and a fire door needing a new battery. We spoke with the maintenance person who told us they had about an hour a day to carry out repairs at this home as they were also working in the provider's other homes. This meant people's health, safety and welfare were put at risk. The needs of people sleeping without curtains, or with curtains that couldn't be closed properly, had not been considered.

People living at the home were all elderly and many had been identified as having poor mobility. However, we saw handrails were only in place on the stairs and along one of the corridors in the home. We found there was a lack of handrails in other corridors and communal areas to provide support and promote people's independence. During our inspection we observed people on a number of occasions holding onto the dado rails for support. This method of support was ineffective and put people at risk of falling. At other times we saw confused people holding onto other confused people to walk along corridors. The manager told us they were not aware of missing handrails and said this would be looked into.

We observed people repeatedly entering the kitchen and being guided away by staff. We saw on several occasions one person using the service leading away another person by pushing on their shoulders and walking behind them. People accessing the kitchen were at risk of harm, as were people whose movements were controlled by others using the service.

We asked to see the safety checks which included fire safety and emergency lighting. A

senior staff member told us this was carried out by the maintenance person. However the maintenance person was not aware of this and told us the care staff carried out the checks. No fire safety records were available when we asked to see them. Staff told us the fire safety log book had been missing for three weeks. This meant the provider was unable to demonstrate that safety checks had been carried out. This meant people were at risk as it could not be confirmed that essential safety systems and equipment was in working order and fit for purpose.

Requirements relating to workers ✖ Enforcement action taken

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

The recruitment process was not always followed and all necessary checks were not completed which put people at risk of poor care. The recruitment and selection process did not ensure staff were fit and able to perform their role.

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

Reasons for our judgement

During our inspection on 25, 27 June and 1July 2013, we identified there were inadequate checks carried out to ensure staff employed were fit to carry out their work. We set a compliance action for the provider to take action and become compliant.

We looked at the records for a member of staff we had identified at the last inspection as having not had the necessary checks completed prior to being employed. A senior staff member told us an application had been submitted to the disclosure barring service (DBS) regarding this staff member. However, there were no records available to provide evidence of this. We asked for evidence of this, such as the DBS reference number, to be sent to us within two days. However we did not receive this.

The duty roster showed this person had continued to work at the service. This included a number of shifts on night duty as the senior member of staff responsible for care delivery and for other members of staff. There were no records available of any supervision of this person or their practices. The lack of necessary checks put people at risk of harm and poor practice.

The manager told us they had employed one new member of staff since the last inspection. This person was interviewed the previous day and had started work on the day of our inspection. The manager told us the necessary checks had not been completed and this person was undertaking their induction. The provider failed to ensure adequate checks were completed when employing staff to ensure they were of good character, had the necessary skills and experience and were fit for that type of work.

We looked at the induction process in place. A staff member told us they had not had an induction, but had worked with another staff member when they started work. This was limited to an introduction to the service and a tour of the location. This was not adequate

and the manager told us they were developing an induction process to meet with the skills for care guidance. At this inspection this was being developed and we were told would be put in place for all new staff.

We looked at information checks that the home maintained in relation to agency staff. The manager and staff could not tell us the name of an agency worker who had been employed on a recent night duty and we saw this information was not recorded on the duty roster. A staff member told us they did not receive any information about agency staff prior to them attending for work. This meant the provider could not be assured this person had the necessary skills and was suitably trained to deliver safe and appropriate care. The provider had failed to ensure any temporary/agency staff were subject to the same level of checks as staff recruited directly.

Staffing ✖ Enforcement action taken

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.

The arrangements were not adequate to ensure there were sufficient number of qualified, skilled and experienced staff to meet people's needs at all times.

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

Reasons for our judgement

We had not planned to inspect this outcome area, but did so as we identified concerns during the course of our inspection.

We looked at the duty roster and the planned staffing arrangements the home had in place to enable them to meet the needs of people using the service. We also spoke with four staff about staffing. They told us the mornings were "always very busy" and there were "not enough staff" to monitor people in the lounge. Staff described the home as "manic" at times, especially at weekends, as was no chef or domestic staff on duty at weekends, meaning care staff had to cover these tasks.

During the three days of our inspection we observed people were left in the lounge without supervision for up to 15 minutes at a time. We observed people entering other people's bedrooms and people exiting from the fire doors in the lounge. An alarm alerted the staff and the people were brought back indoors. We brought this to the attention of the manager who said they could not have staff in the lounge to monitor people in the morning as they were busy helping people to help get up. People who required help were sometimes kept waiting as call bells were not answered for up to ten minutes. A staff member told us this was "not good", but that they tried their best.

We saw these included people who were at risk of falling, and a member of staff told us "there should be someone keeping an eye on them". There was no system in place to assess the dependency of people in order to ensure adequate staff were available. We saw a dependency tool had been sent to the home by a healthcare professional. A senior staff member told us this would help, but had not been introduced.

The manager told us the required staffing levels were set at six care staff for day shifts and five care staff for the afternoon/evening shifts. In addition, a chef and a cleaner were required during the day. We looked at the duty rosters from the 29 July – 15 September

2013. We saw the home's set staffing levels in the morning were only achieved on 28 out of 56 days and the set staffing levels in the afternoon/evenings were only achieved on 32 out of 56 days. This was due to one member of care staff on each day being assigned to cover the chef's duties when the chef was on leave and at weekends. We also saw there were no cleaning staff available at weekends. Care staff were required to cover the cleaning, which meant care hours were eroded by time spent cleaning. Visiting healthcare professionals also told us they were concerned about staffing levels at weekends, as the number of staff available to provide care were reduced. The provider had failed to ensure there were adequate staff to meet the needs of people.

Records showed not all staff had completed moving and handling training. This meant staff did not have the appropriate training in order to support people. Information received from the ambulance service showed they were called to the home 19 times during the four months before our inspection. Five of these occasions were to lift people who had fallen but were uninjured. They told us such calls were inappropriate and were due to staff not being trained to use the hoist and there being no hoist sling available.

Staff told us they did not have sufficient trained staff on night duty to manage people's medicines. They said the day staff members administered the night time medicines before going home. However, people who may have needed "as required" medicines, such as pain killers, were at risk of not receiving them. The duty roster showed on average there were two nights a week over an eight week period when there was no staff member on duty who had completed training in the management of medicines. We asked the manager for evidence of staff's training in medicines management and were told this was not available. The provider had not ensured there were sufficient staff with the right knowledge, experience, qualifications and skills to support people.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

There was no effective system in place to regularly assess and monitor the quality of service that people received. A system to identify, assess and manage risks to the health, safety and welfare of people using the service and others was not effective

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

Reasons for our judgement

During our inspection on 25, 27 June and 1July 2013, we identified there were inadequate systems in place to regularly assess and monitor the quality of service people received. The system to manage risks to the health, safety and welfare of people using the service and others was not effective. We set a compliance action for the provider to take action and become compliant.

At this inspection we found incidents and accidents were recorded, for example we saw records of falls were kept. We also saw records were kept of the number of falls people had suffered. However, this information was not used to review people's risks and care plans to ensure any necessary changes were identified and implemented. Similarly, we saw records of multiple incidents of cuts, bruises and skin flaps recorded in skin integrity body maps. These incidents were not recorded in accidents books, although they were unexplained injuries. This meant they were not collated or analysed to enable causes to be identified and measures put in place to reduce recurrence. A senior staff member told us they did not know what to do with the information about falls. There was no system in place to demonstrate that learning from incidents took place and appropriate changes implemented.

We asked the manager about the system the provider was using to regularly assess the quality of the service provision. The manager gave us a copy of the last visit by a person appointed by the provider which was dated 4 February 2013. This report had highlighted a number of issues that required action. These included lack of care plans, risk assessments, the fire log could not be found and no supervision programme. The manager was required to develop an action plan and ensure these were addressed. We found these actions remained outstanding during this inspection. The manager told us they had all the systems in place previously and agreed their current systems were not working.

Although there was some auditing in place, which identified concerns such as fire safety checks, cleaning records and medicines management. However, an action plan had not been developed to ensure the issues identified were addressed, together with a timeframe and the person responsible for them. Staff told us the issues were constantly raised with the provider. We found there was no continuous quality improvement system in place that was used to protect people who used services and others at risk.

We looked at an audit of staff views completed in August 2013. This had raised several issues about the lack of staffing, support from management, not enough time to provide care and the lack of staff supervision. There were negative comments also about teamwork and feeling valued. One comment said, "No comment about anything good." Staff told us they were not confident any of their concerns would be addressed as "nothing changes". There was no plan to show what action would be taken to address these issues. We brought this to the attention of the manager who told us a staff meeting would be arranged.

We looked at a survey of people or their relatives conducted in August 2013. We saw five responses had been received. Of these, two people were positive about the care they received; four people were not satisfied with the amenities and three were not happy about the availability of the manager and the efforts to keep up with their hobbies. The responses also showed two people were dissatisfied with staff's attitude, choices available, and arrangements for personal care, repairs and general maintenance of the service. They were also negative about activities and the "way staff help to look after you". No action plan was available, but the manager said they would be looking at the surveys.

The provider did not have a system in place to improve the service by learning from adverse events, incidents, errors and near misses that happened. The manager told us they had audited medication at the service. However, they had not identified the serious concerns we found with medicines management during our inspection, including errors such as wrong dosages being given. We also found there was no system in place to analyse safeguarding referrals and investigations to ensure lessons were learnt and appropriate measures put in place to prevent further incidents. We saw that an audit of care plans had identified some shortfalls and we provided feedback to the manager about these during our inspection. The manager told us their audits had not identified the issues we had found and said they would be looking at their systems again.

Following a visit from the environmental officer in June 2013, a recommendation was made that a barrier was needed to ensure people using the service did not enter the kitchen. We found this had not been constructed. On several occasions during our inspection people were seen entering the kitchen. The staff told us these people were confused and at risk. The provider had not taken adequate action to ensure the health and safety of people entering the kitchen.

The health and safety checks and safety audits were inadequate to ensure the safety of people using the service. An internal audit showed the hot water temperature in some of the bedrooms had been recorded as "too hot". The audits dated as far back as June 2012. The last audit, completed in January 2013, identified 10 bedrooms where the hot water was delivered at 50 degrees centigrade. From February 2013 to June 2013, the records showed staff were unable to check the water temperatures as there was no thermometer available. The manager told us they did not know why action had not been taken to obtain a new thermometer.

Records

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Records for personalised care, treatment and support were not always accurate and fit for purpose. Not all records were stored in a secure and accessible way that allowed them to be located promptly.

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

Reasons for our judgement

During our inspection we found people's records were not maintained effectively or held securely. We saw care records, such as care plans and risk assessments, did not always contain the names of people, which put people at risk. The home operated a system where people's daily records of care and body map/skin integrity charts were all maintained in one folder. We saw the name of a person on one care record had been crossed out and did not contain any other person's name. A staff member told us they could not tell who this record belonged to as it did not have a name. We looked at the entries and deduced it belonged to a particular person as it mentioned their relative's name.

We found people's personal records were not accurate and did not reflect their current needs. These included information about current medicine requirements not being accurately recorded, which could have impacted on their care. We saw not all care records had been reviewed and updated and this was brought to the attention of the manager. We were told they were in the process of introducing new care plans for all the people using the service and this would be addressed. This meant record of care and treatment were not current and up to date.

The record for a person who was subjected to a deprivation of liberty safeguards (DoLS) was not available. This was a current document which the staff should be working from to ensure legal safeguards were followed and this person was not subjected to unlawful restrictions.

Records we requested could not be could be located promptly and we found records were not maintained securely. The personnel records for two prospective members of staff were found to have become mixed up with the record for another member staff. These contained sensitive information, such as financial details. This was brought to the attention of the manager at the time of our inspection.

The records relating to the maintenance of essential equipment such as fire safety, electrical maintenance and fire logs were not available. We were told the fire logs had been missing for three weeks and no action had been taken to ensure these records were available. We requested to see a copy of the current electrical certificate. The manager told us it had been archived at another home run by the provider.

The manager agreed the records for the safe management of the service were not adequately maintained and put people at risk. They said they used to keep a fire log and added they were "embarrassed" at their current records management.

This section is primarily information for the provider

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

Enforcement actions we have taken

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

Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: There were inadequate steps to ensure people were protected against the risks of receiving care or treatment that was inappropriate. The planning and delivery of care did not always meet the service users' individual needs. Regulation 9 (1) (a) (b).
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met:

This section is primarily information for the provider

	There were inadequate arrangements to ensure people were not put at risks of abuse, neglect and acts of omission which cause harm or place at risk of harm. Regulation 11(1) (d).
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: There was a lack of effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection. There was a failure in the maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity. Regulation 12 (1) (2).
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not always protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for recording, handling, safe keeping, dispensing and safe administration of medicines. Regulation 13.
Imposition of condition of registration	

This section is primarily information for the provider

This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: There were inadequate arrangements to ensure people using the service were protected against the risks associated with unsafe or unsuitable premises. Regulation 15(1) (c).
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: There was a lack of effective recruitment procedures in place to ensure that no person was employed for the purposes of carrying the regulated activities without all the necessary checks completed. There was a failure to ensure that appropriate information specified in Schedule 3 was available in respect of a person employed. Regulation 21 (a) (b).
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

nursing or personal care	**Staffing**
	How the regulation was not being met: Appropriate steps had not been taken to ensure there were adequate staff employed to safeguard the health, safety and welfare of service users. Regulation 22.
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set in the regulations. There was a lack of effective processes to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk. Regulation 10(1) (a) (b).
Imposition of condition of registration This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The service users were not protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Records

This section is primarily information for the provider

	were not kept securely and could not be located promptly when required. Regulation 20 (1) (2) (a).

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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