Inspection Report

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

TRU ABI Rehabilitation Centre

200 Ashton Road, Newton-le-Williows, WA12 0HW

Tel: 01942707000

Date of Inspection: 05 September 2013

Date of Publication: November 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✗ Enforcement action taken
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	TRU Limited
Overview of the service	TRU ABI Rehabilitation Centre provides care and support for adults who have an acquired brain injury or those requiring treatment for substance misuse. The centre can provide care for people who are detained under the Mental Health Act 1983. The centre is in a rural setting in the Haydock area which is between Liverpool and Manchester. There is easy access via motor way networks with car parking on site. The centre is purpose built so is fully accessible to people with physical disabilities.
Type of services	Care home service with nursing Rehabilitation services Residential substance misuse treatment and/or rehabilitation service
Regulated activities	Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 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 5 September 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

We used a number of different methods to help us understand the experiences of people using the service, including observing care and speaking to those people who could give their views on the centre. We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. People we spoke with were positive about the care they received. One person who used the service told us: "I find it OK". Another person said: "I find it really well". One person said of staff that work in the centre: "Staff are very good". People told us that they felt listened to and their comments were taken seriously. One person told us: "I've complained about a few things but they get sorted pretty quick".

We went with a Mental Health Act Commissioner. The Mental Health Act Commissioner considers whether the Mental Health Act and the Mental Health Act Code of Practice is being followed. They also proactively visit and interview people who are detained under the Mental Health Act. The Mental Health Act Commissioner interviewed a number of detained patients and made contact with some others.

We found that the centre was the essential standards relating to consent, care and welfare, safeguarding, supporting staff and monitoring quality. The centre was not meeting the essential standards relating to the requirements regarding having sufficient staffing levels and the requirement in relation to records.

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 23 November 2013, setting out the

action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against TRU ABI Rehabilitation Centre to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. People commented that their consent was sought before care and treatment was given. When we asked if one person detained under the Mental Health Act was happy taking medication and had consented to it, they commented "Yes, I'm happy taking it. They bring them [the tablets] with a drink".

We observed how people were cared for. We saw that staff treated people who were being cared for with respect. We saw staff give people choices throughout our inspection. The staff we spoke with were knowledgeable about the individual preferences of people at the centre. Staff understood that people had the right to refuse care or treatment.

We saw people were involved in their care through attendance at multi-disciplinary meeting, which was a meeting of professionals to review people's care with them. We saw that detained patients were supported by the Independent Mental Health Advocate (IMHA) to help them raise their issues and help involve them in the planning of their future care and treatment.

We saw that some people were detained under the Mental Health Act. We visited with a Mental Health Act Commissioner. The Mental Health Act Commissioner considered whether the Mental Health Act and the Mental Health Act Code of Practice was being followed. They also proactively visited and interviewed people who were detained under the Mental Health Act. The Mental Health Act has special rules around medication for mental disorder, including a formal procedure and safeguard if treatment is given beyond three months (section 58 of the Mental Health Act). Where people had been detained under the Mental Health Act for more than three months, the centre had procedures in place to ensure that these special rules and safeguards were adhered to. The medication records relating to people detained were seen by the Mental Health Act Commissioner

(MHAC) who confirmed that the hospital was complying with the Mental Health Act in relation to rules around treatment with some minor recording issues which we have included in our judgement about records.

We saw records that showed that the centre had assessed people's capacity to make particular decisions. We saw records that showed that the centre had considered people's best interests where they did not have capacity to consent to a particular decision. On one file we looked at, we saw records relating to a best interest decision which did not have a capacity assessment prior to the best interest decision. However we did see other evidence on this person's file which showed that they lacked capacity over this matter. We also saw that on occasions best interest decisions were not formally reviewed on a regular basis. The provider may wish to ensure that where decisions are made in people's best interests, capacity assessments are carried out as part of the process and such decisions are reviewed on a regular basis.

We saw that the provider was regularly checking that people who were not detained under the Mental Health Act were not subject to restrictions which amounted to a deprivation of their liberty. The provider did this by regularly completing a Deprivation of Liberty Safeguards (DoLS) screening tool. DoLS are put in place when restrictions are placed on an incapacitated person's daily life which amount to depriving them of their liberty because it is in that person's best interest. There was no-one subject to DoLS on the day of our inspection.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We used a number of different methods to help us understand the experiences of people using the service, including observing care and speaking to those people who could give their views on the centre. We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. People we spoke with were generally positive about the care they received. One person said "I find it OK". Another person said: "I find it really well". Another detained patient said "I don't like it here - I want to go home".

The centre was divided into three units: The Willows, Lowton and Newton units. The Newton unit provided care for adults who were detained under the Mental Health Act 1983. The Willows provided accommodation with nursing care and Lowton unit provided accommodation with personal care (non-nursing). During the inspection we visited The Willows and Lowton units. The Mental Health Act Commissioner visited The Willows unit. We sampled four care files from across the three units. The Mental Health Act Commissioner looked at a number of care files for people detained under the Mental Health Act.

We found care files contained detailed assessments of care needs and assessments of risks for each individual. There was background information about each person, including hobbies and interests, and any cultural needs. The information gathered for these assessments made sure that particular individual needs were identified, and the centre could meet those needs.

We found that each person had support plans created from assessments carried out with them. On admission staff completed a risk assessment for each person to establish any risk of harm to themselves or others, including any historical risks.

We saw people had their cognitive impairment (people's brain functioning following their head injury) and their mental health care needs assessed and reviewed. The care plans we saw were based on the medical treatment and nursing care being provided. We saw that people had physical health checks. We found that care plans, although good, were often not fully individualised, and did not always capture the patient's views.

The staff we spoke with had a good understanding of the people's individual support needs. They told us they spent individual time with patients to ask their views and update their care plans accordingly. Although the care plans seen were not written in a person centred way, the staff knew about each patient's individual circumstances and how they should be supported whilst they were in hospital.

Staff on Newton Unit had a good understanding of the Mental Health Act and staff were proactive about ensuring that people were given information about their rights under the Mental Health Act.

We saw that the centre had systems in place for dealing with emergencies. For example, we saw that where people had significant disabilities, they had a written evacuation plan to help staff understood what to do in an emergency.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening

Reasons for our judgement

We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. Their comments did not relate to this outcome.

There was information available for people at the centre and visitors on abuse and what to do if abuse was suspected.

We spoke with staff who were able to identify what abuse was and the actions to take if abuse was suspected. The Safeguarding of Vulnerable Adults was part of the mandatory training programme. The centre had safeguarding policies available. This meant that staff had access to the policy and procedure where abuse occurs or is suspected when people are receiving or in contact with the service.

We saw that there had been some recent safeguarding incidents. The service had taken appropriate action to deal with these incidents, including referring alleged abuse to the local authorities' safeguarding team and informing the CQC. This meant that appropriate organisations received information about safeguarding incidents and allegations so they could take appropriate action, where necessary. The provider also followed their own procedures for responding to these allegations, including preventing individuals from having access to vulnerable people whilst the allegations were under investigation. The overall review of these matters was not yet concluded.

We saw safeguarding protection plans in place to prevent abuse from occurring and protect vulnerable patients.

On the day we inspected, there were people detained under the Mental Health Act. People who were detained under the Mental Health Act had access to an Independent Mental Health Advocacy (IMHA) Service to safeguard and promote their rights as detained patients. When we visited, no one was subject to further restrictions such as restraint, seclusion or deprivation of liberty safeguards. We looked at records of restraint that had occurred and saw that records relating to restraint episodes were maintained as well as

episodes when people are supported to go to their rooms when they are exhibiting disturbed behaviour to have 'time out'. We have included comments on the records relating to restraint and 'time out' episodes in the records section of this report.

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.

There were not enough qualified, skilled and experienced staff to meet the needs of people across TRU ABI Rehabilitation Centre.

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

The centre was divided into three units: The Willows, Lowton and Newton units. Newton unit provided care for adults who were detained under the Mental Health Act 1983. The Willows provided accommodation with nursing care and Lowton unit provided accommodation with personal care (non-nursing). The provider's statement of purpose confirmed the functions of these units.

We would expect any unit registered to provide nursing care and any unit registered to assess and treat patients detained under the Mental Health Act to have a qualified nursing member of staff on duty at all times. The centres staffing establishment recognised that there should be two Registered Mental Nurses (RMNs) on duty at all times across these units.

A recent safeguarding incident highlighted that there were on-going problems relating to the number of qualified nursing vacancies being carried, with a consequent high use of agency staff. Having received information that the service might have been operating on insufficient qualified staffing levels, we carried out a responsive inspection to check on these staffing levels.

On the day of our inspection we found that Newton unit had eight detained patients. There were two residents on The Willows. Lowton Unit had four residents. However, three of these residents were liable to detention or recall under the Mental Health Act (MHA) as two were detained under the MHA but on authorised leave and one was on a Community Treatment Order (CTO).

During this visit, we heard that the centre was still carrying a number of vacancies and relying heavily on agency qualified members of staff. We looked at the staff rotas for the last three months and this confirmed that the centre had to use agency nursing staff on a regular basis which was mostly regular agency nursing staff. However on the rota we saw

several shifts in the last three months where there was only one qualified member of staff on duty and on some shifts this member of staff was a qualified agency member of staff.

The nursing staffing arrangements at the centre were further exacerbated by the fact that the nurses were also expected to have involvement in the care of people who were on the residential unit. This was because people on the residential unit were liable to be detained under the Mental Health Act as they were on leave the Newton unit (section 17 of the Mental Health Act) or had been discharged from Newton unit on a Community Treatment Order. This meant that nurses from the centre were expected to provide medication and other duties across all three units.

We looked at the incident records and this showed that there were regular incidents on the Newton unit. These included incidents which required restraint to be used, incidents where patients were taken to have 'time out in their rooms, incidents of patients attempting to go absent without leave, and also occasional use of strong sedative medication to help control people's behaviour (rapid tranquilisation). These incidents showed the need for Newton unit to be supervised by a qualified member of staff at all times to ensure that people who use the service had access to skilled and experienced nursing staff. Where there was only one nurse on duty across the unit, this meant that eight detained patients were left without qualified staff support whilst the nurse attended other units within the centre. We did not see evidence of a correlation between incidents when qualified staffing levels were reduced to one member of qualified staff and there was no evidence of incidents directly attributed to lower staffing levels. However, people were not safeguarded from receiving inappropriate care and treatment because people were being left without professional input while the sole nurse attended other units.

The managers told us about their on-going plans to run nursing recruitment initiatives in the coming months and planned changes to the rota system to alleviate the nursing staffing situation. We were also told that two nurses had recently been recruited - one of these had started but had subsequently secured a job elsewhere and was working the notice period.

We spoke with the qualified members of staff on duty. They confirmed the duties expected of them and confirmed the problems in providing cover across the units. The qualified staff also described a lack of clarity for the role of nurses within the coaching model used by the provider. Given the highly specialised assessment function of the centre, and the associated duties to provide nursing care across the centre including into the residential unit, the need for a consistent group of staff is necessary to ensure on-going assessment and timely nursing care and treatment. The lack of continuity in substantive nursing care was having, or may have had an adverse impact on care and treatment provided to people in the centre.

The managers recognised the staffing situation was not ideal. We were told about well developed plans for improvement and changes as part of a review of staffing arrangements which is being carried forward by the company. However when we spoke with managers they could not give us a proper explanation why the centre was regularly using just one qualified member of staff and not using two qualified staff members at all times even if this was agency qualified staff.

We saw good evidence of other staffing input and sufficient staffing levels across non-nursing disciplines including senior coaches, coaches (which are equivalent to care assistants) and other multidisciplinary input including consultant psychiatry; psychology

and other multi -disciplinary input.

There was good evidence that detained patients could take section 17 leave, including authorised escorted leave to help aid people's recovery. We also saw a decision to increase coaching staff when a person presented with management problems to ensure appropriate observations.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. People commented favourably about the staff that supported them. One person said of their primary coach: "She does everything for me...she's absolutely perfect." They went on to say: "Staff are very good".

We saw records relating to staff training, supervision and appraisal. We saw evidence that there was a system of induction training in place especially for new recruits. The staff members who were interviewed stated that they felt very well supported in their training and career development.

Nursing staff were able to undertake training to meet their professional requirements which was a condition of their ability to continue to work as nurses.

We saw that records relating to updated mandatory training were kept on each person's individual file. This made it more difficult to check whether staff were up-to-date with regular mandatory training they were required to attend. On the sample of files we looked at it was clear that staff had received mandatory training within the stated timeframes or there were plans in place to ensure this occurred. The provider may wish to ensure that the service has an overall training matrix which clearly showed whether staff have received, are due or overdue relevant mandatory training to help ensure staff are kept up-to-date in key areas.

We spoke with three members of care staff who stated that they received regular supervision. We spoke with one new member of staff who felt supported. We saw evidence of supervision on employee files. The centre also has a system of group supervision for staff to reflect on their practices, talk through approaches that worked and help maintain consistent standards of care.

We saw that where there were issues that required monitoring, people would receive formal supervision, issues requiring improvement were discussed and action taken if significant issues were highlighted.

We saw that people had received an annual appraisal or there were plans to ensure that these were carried out. We saw a sample of these which showed that people working in the service were receiving appropriate appraisal to help maintain high standards of care.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We used a number of different methods to help us understand the experiences of people using the service, including observing care and speaking to those people who could give their views on the centre. We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. People told us that they felt listened to and their comments taken seriously. One person told us: "I've complained about a few things but they get sorted pretty quick". Another person said: "My time's been OK".

During our visit we looked at records relating to how managers assured the quality of the services provided at TRU ABI Rehabilitation Centre. There was evidence that care plans were audited against the essential standards.

The Mental Health Act Commissioner looked at the Mental Health Act paperwork and confirmed that all the correct paperwork was in place and the files were well ordered. The centre had systems and checks in place to ensure it was meeting its' responsibilities under the Mental Health Act. This included auditing patients' rights checks and audits in relation to consent to treatment rules under the Mental Health Act and compliance with the Mental Health Act Code of Practice

We saw evidence of recent clinical audits occurring to further improve medical and nursing care. The centre had a formal clinical governance committee in place which met regularly to consider the effectiveness of the service. Recent audits carried out at the centre included audits of staff supervision, patient files, complaints and compliments, medication charts and the use of homely remedies. Where shortfalls were identified there was evidence of action to help address these shortfalls. This meant that the centre was improving its systems for monitoring the quality of the service and safeguarding standards of care.

The health and safety risks of the centre were assessed and managed, including regular checks on equipment to make sure equipment was safe to use. For example we saw regular audits of the defibrillator equipment.

We saw that the centre regularly surveyed people who used the service and those acting on their behalf. A number of completed surveys showed that people were generally happy with the care they received and the environment. Where people had made suggestions, we spoke with the manager who told us how those suggestions had been considered. There was therefore evidence that the centre ensured that the service had regard for the views of people using the service. The centre was in the process of analysing the surveys to ensure there was more formal consideration of these written comments or suggestions.

We looked at the complaints log. This was indexed so that it could be clearly seen how many formal written complaints had been received over any time period. We saw that the centre had received a small number of written complaints. We saw that the written complaints were investigated and a response provided to the people raising complaints. The provider may wish to ensure that informal comments and complaints were recorded and considered, especially given that people at TRU ABI Rehabilitation Centre may not always be able to make a formal written complaint because of the nature of their condition.

We saw records of incidents. These incidents showed that the managers of the centre were reviewing these incidents on a regular basis. Through speaking to the managers it was clear that they were changing plans of care as a result of considering these incidents. For example, we heard that the managers had discussed with staff how one person could be supported differently to try and reduce incidents of disturbed behaviour. We saw that managers' checks on incidents had not picked up that the records relating to restraint episodes did frequently not record how long people were being restrained for. We have included this evidence in the outcome about records.

The centre had been without a Registered Manager for a number of months, since the last Registered Manager left the centre. Recently we received an application from an individual to be Registered Manager. We are in the process of considering this application.

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 always maintained.

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

We did not plan to look at this outcome but when we were looking at care files and quality assurance records, we saw issues relating to record keeping.

We spoke with three people who were being cared for in this centre. The Mental Health Act Commissioner met with a number of detained patients in private. Their feedback did not relate to this outcome.

During our visit we looked at the care plans of four patients. The Mental Health Act Commissioner looked at a number of records relating to patients detained under the Mental Health Act. Our review of the documentation and risk assessments showed that care plans and risk assessments were not always well collated and easy to follow. Care files on the Lowton unit were not orderly with a significant amount of historical data. On some files, it was difficult to locate the current support plan and there was no summary or pen picture. This meant new or agency staff would have difficulty understanding people's needs from looking at the records.

On one person's file, it was not clear whether they were currently on a Community Treatment Order because there was conflicting information within the care file about whether the CTO had been revoked or not. On another file, we saw a Waterlow Pressure Sore Risk Assessment Tool which was used to improve the care and prevention of pressure ulcers but the overall scores to assess the risk had been incorrectly calculated in the records.

We saw records that showed efforts to move people on to conditions of lower restrictions when it was decided that people no longer required detention under the Mental Health Act. Where people were moved or where there were plans for moving people on, it was not always clear that other options to meet people's needs other than TRU services had been considered. Whilst we accepted that there were limited numbers of services to care and treat people with acquired head injuries, staff should ensure that they consider other options to meet people's needs and work in their best interests where they lacked

capacity. Where people were on section 17 leave from the Newton unit to the Lowton unit for more than 7 days, it was not always clear from the records that the appropriateness of a Community Treatment order had been considered as required under the Mental Health Act. The centre may wish to ensure that care planning documentation explicitly includes written evidence of individual transfer or discharge plans and records consideration of a CTO when people are given longer term leave.

The daily running case note entries we reviewed had a number of issues relating to records. These included large blank gaps being left between daily entries without the gaps being scored through in care and nursing care files. Gaps should not be left in care records in this way to ensure accurate records are maintained and prevent records being made at a later date.

The Mental Health Act Commissioner looked at the Mental Health Act paperwork and confirmed that paperwork was in place and the legal files were well ordered. On one file it was not clear whether some medications were being administered to treat a person for epilepsy or anxiety and therefore whether the medication should have been included on the relevant legal form to authorise treatment for a mental disorder for people detained under the Mental Health Act. On other files, changes to medication for mental disorder or prescribed 'as required' medication for mental disorder were not recorded on these legal forms either. This meant that people were at risk of receiving inappropriate treatment because proper records authorising all relevant treatment for mental disorder were not being kept.

On Lowton unit, the medication administration records for one person had a number of recording gaps where medication was prescribed but was not recorded as given. There was no records in the daily records corresponding with some of these dates to explain why medication had not been given or recorded as not been given.

Records showed that the provider did regular checks on the quality of care. The checks involved reviewing incident reports, case tracking, reviewing complaints and checking other records. We looked at records of restraint that had occurred and saw that records relating to restraint episodes were maintained as well as episodes when people were supported to go to their rooms when they are exhibiting disturbed behaviour to have 'time out'. However on the records, it was frequently unclear how long restraint had occurred for because the time was not recorded. It was also unclear from the records whether the practice of 'time out' could be considered 'defacto' seclusion or a form of seclusion. This was because the total amount of time spent in 'time out' was not recorded . It was also not always clear that the person was not prevented from leaving the room in which 'time out' occurred because the records did not record that the person was not prevented from leaving the time out area. From looking at the incident records we also saw that there were no incident records when staffing falls below expected levels which had occurred frequently over the last three months. This meant that records relating to the management of the service were not being maintained properly to oversee the quality of the centre and manage the risks.

The provider had not been providing services long enough to warrant the need to dispose of any healthcare records at this centre. This was because the rules about health care and Mental Health Act records meant that they need to be stored for longer periods of time than in other care settings.

The provider had carried out an audit of care records. The recent audit highlighted a

number of areas we also saw with an action plan to address the shortfalls. This showed that the managers had identified the shortfalls in records and were attempting to manage the improvement of records.

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 Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records** **How the regulation was not being met:** People were at risk of receiving unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.[Regulation 20(1)(a) and (b) (ii)]

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

The provider's report should be sent to us by 23 November 2013.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

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

Enforcement actions we have taken

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

We have served a warning notice to be met by 29 October 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** People were not safeguarded because the provider did not take appropriate steps to ensure that there were sufficient numbers of qualified, skilled and experienced staff employed at all times to meet the needs of people using the service [Regulation 22].

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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