Inspection Report

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

Kingsthorpe View Care Home

Kildare Road, off the Wells Road, St Ann's,
Nottingham, NG3 3AF

Tel: 01159507896

Date of Inspection: 05 June 2013

Date of Publication: July 2013

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

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cleanliness and infection control	✖ Action needed
Safety and suitability of premises	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Notification of other incidents	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	HC-One Limited
Registered Manager	Ms. Lynne Belinda Brewell
Overview of the service	Kingsthorpe View Care Home provides accommodation for up to a maximum of 50 persons who require nursing or personal care in the Nottinghamshire area.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 June 2013, checked how people were cared for at each stage of their treatment and care and talked with carers and / or family members. We talked with staff, reviewed information sent to us by other regulators or the Department of Health and talked with other regulators or the Department of Health.

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

What people told us and what we found

We spoke to two relatives of people using the service during our visit to Kingsthorpe View Care Home. One person said, "I have found the manager very open to speak with. My [relative] has had some personal belongings go missing in the home." Another person said, "My relative is content here."

We observed staff talking to other staff whilst supporting people and we also saw some staff carrying out tasks without communicating with the person.

We examined the communal areas, people's individual rooms, cleaning and food preparation areas. The home had not acted upon the risks identified from a recent infection control audit and this meant people were at risk of infection. During our inspection we identified a number of areas within the home in need of redecoration or updating.

The staff we spoke to raised concerns about staffing levels within the home. We also observed medication not being administered on schedule due to the insufficient number of nurses available.

The provider had not notified the Care Quality Commission of all incidents which had occurred within the home as required by the Care Quality Commission (Registration) Regulations 2009. We prompted the manager to provide this information prior to our inspection and on the day of our visit.

We found risk assessments had not consistently been reviewed and we also found some gaps in some of the daily 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 16 July 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence were not consistently respected.

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

Reasons for our judgement

We spoke to a relative of a person who was visiting the home and they said, "From what I have seen my relative is treated with dignity." Another relative said, "I do feel my relative's privacy is respected."

We observed activities taking place on the day of our inspection; and a number of people were able to get involved in the lounge area. Some were able to participate in clapping when people came into the home to sing with people using the service.

We looked at the care plans for eight people who were using the service to make sure these covered people's individual and diverse needs. A care plan should document a person's needs and how staff can meet those needs. People's individual preferences had been discussed and documented including likes, dislikes and religious preference within individual care plans. We also saw a complaints policy displayed on the notice board. This meant people using the service and their relatives were provided with information detailing who to contact if they had any concerns.

To help us understand the experiences of people living in the home we used our SOFI (Short Observational Framework for Inspection) tool during the visit. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

We observed a few positive interactions with people using the service during the lunch period, including an offer to cut a person's food so they could eat more easily. One member of staff offered a person an alternative meal as they did not appear to want to eat the food which had initially been provided. We also observed a member of staff assist when a person's dignity was compromised.

Menu choices were displayed on a board within the main dining area of the home;

however the information displayed was incorrect. We also observed four separate members of staff ask the same question about one person's meal choice. This meant the meal time period we observed was disorganised and people were not being provided with the correct information to make a choice.

One member of staff supporting a person to eat explained what was on each spoonful; however they kept glancing at the television whilst providing support. We also observed the manager of the service and three members of staff talking about a number of people using the service in the middle of the lounge area, in the presence of people using the service. This meant people were not being treated with respect.

We found staff were talking to other staff whilst supporting people and we also observed some staff carrying out tasks without communicating with the person. This included a member of staff who moved a chair whilst a person was using it.

We observed one member of staff in the main dining area talking about who was going to "feed" a person and provided little interaction when helping a person to eat. In the lounge area we observed a member of staff bang on the window and pull a face at someone outside in the car park. This member of staff turned their back on the lounge and specifically the people within their care in order to do this. We also observed one person using the service trying to get the attention of a member of staff who ignored them. This use of language and lack of interaction meant staff were not respecting and involving the people using the service.

Overall we found people who were using the service were not consistently treated with consideration and respect.

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Before people received any care or treatment they were not asked for their consent and the provider did not consistently act in accordance with their wishes.

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

Reasons for our judgement

Before people received any care or treatment they were not always asked for their consent and the provider did not always act in accordance with their wishes.

We spoke to two relatives of people using the service. They told us they were happy with the care their relative received.

To help us understand the experiences of people living in the home we used our SOFI (Short Observational Framework for Inspection) tool during the visit. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

During lunch we observed a person being moved with a sling from a wheelchair to a chair. The member of staff did not explain to the person what was happening when carrying out this manoeuvre. The brake was not on the wheelchair so the person moved forward without knowing what was happening.

We looked at the care plans for eight people who were using the service to make sure these covered people's consent to care arrangements. Under the Mental Capacity Act 2005 we saw some evidence that best interest or capacity assessments for people who lack capacity to make decisions about certain aspects of their care had been considered. The Mental Capacity Act 2005 puts safeguards in place when people do not have the mental capacity to make an informed choice. A mental capacity assessment had been completed in some care plans, but not others. This meant that there was a risk that some people living within the home may not have their best interests considered.

Three of the care plans we looked at contained a 'do not attempt cardiopulmonary resuscitation' document which had been signed by a GP with the consent of a relative of a person using the service. There was no mental capacity assessment provided within the care plan to support this decision. On the day of our inspection the manager said they would speak to the GP regarding this documentation.

Some of the staff we spoke to were not aware of the safeguards aimed to protect people in care homes, from being inappropriately deprived of their liberty. We asked three staff if they had heard of the Mental Capacity Act and two said, "No". One member of staff said, "I don't know what this is." We also saw records on the day of our inspection which demonstrated 36% of staff were out of date with their Mental Capacity Act training. This meant people using the service could not be assured that all staff were able to take account of a person's capacity to make their own decision when staff provided care.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

Relatives of people using the service told us, "My relative is content here," and, "I have found the manager very open to speak with. My [relative] has had some personal belongings go missing in the home. We have lost a number of pairs of trousers and they recently lost a new pair of glasses. I was very annoyed."

To help us understand the experiences of people living in the home we used our SOFI (Short Observational Framework for Inspection) tool during the visit. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

During lunch we observed a person with discharge from their eye and a white substance round their mouth. The individual's clothing had also lifted up potentially compromising their dignity. A staff member was sat beside and whilst looking at the person they made no attempt to adjust the individual's clothing, clean their eyes or wipe their mouth. We provided feedback to the manager and they said they had asked a member of staff to address this.

We saw a person who had been positioned with their back to a loud television but were unable to move. There was no attempt made by staff to move the person to a quieter area so they could sit peacefully. We also observed a person being provided assistance to eat. Each time the person took a mouthful of food, the member of staff used a spoon to remove excess food which had been left on their face. The Deputy Manager informed us wet wipes were available in the lounge. This meant staff were not using the appropriate equipment to provide care and support to people within their care.

We looked at the care plans and associated risk assessments for eight people using the service. A care plan is a document which should identify a person's needs and how staff can meet those needs, including assessments or identified risks for each person.

Care and treatment was not planned and delivered in a way that was intended to ensure

people's safety and welfare.

We found a number of records for people had not been completed. In one case we found a Malnutrition Universal Screening Tool (MUST) record dated back to March 2013, this person should have been monitored on a monthly basis. Within a separate care plan we found an individual's MUST score had not been reviewed since April 2013, despite the eating and drinking plan stating this should be checked weekly. Another person's care plan revealed the person had angina and their weight had increased by 4kg in the last month. There was no weight loss care plan or healthy eating guidance to support this person's individual needs. This meant weight records and healthy dietary requirements were not being monitored effectively within the home.

One of the care plans for another person confirmed they had type two diabetes controlled by diet. There was no reference to a low sugar diet in the eating and drinking plan. The diabetes care plan stated blood sugar levels should be monitored weekly, including detail of the point at which a GP should be contacted, yet there was no reference to confirm what a low/high blood sugar level was within the care plan. The Deputy Manager confirmed blood sugar levels were monitored if the person appeared unwell.

We saw evidence in people's care plans of GP and other professional involvement. However, within one care plan we found the involvement was not always sought in a timely manner. The care plan made no reference to intake of fluids, despite a reference within the daily records to encourage fluid as a urinary tract infection (UTI) was suspected. The home took 48 hours to call a GP in response to a suspected UTI. This meant people were not assured of receiving care appropriate to their needs and identified risks in a timely manner.

The staff we spoke to during our inspection felt the service provided good levels of care. We asked the staff how they maintain effective communication with people using the service. One member of staff said, "If a person was not able to talk or a person was losing colour in their face, I might be worried. I would speak to the nurse." This meant staff knew who to refer concerns or queries to if they experienced any difficulty.

Overall we found care was not consistently planned and delivered in line with individual assessed needs.

Cleanliness and infection control ✖ Action needed

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 appropriate guidance had been followed and people were not cared for in a clean, hygienic environment.

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

Reasons for our judgement

Prior to our inspection we received concerns about cleanliness within the home. We also received a copy of an audit carried out by Nottingham CityCare Partnership further to an initial visit carried out on 1st March 2013 and a follow up visit on the 17th April 2013. We followed up these concerns during our inspection. An infection control policy was in place at the time of our inspection; however we found the issues which had been identified within the audit had not been addressed by the provider.

We spoke to two relatives of people using the service. One person said, "My relative's room is kept clean." Another person said, "The home is kept clean to a degree. When they do clean, they do a good job."

Upon entry we found no alcohol hand gel or signage about hand hygiene at the reception entrance. This meant good standards of hand hygiene were not being promoted upon arrival to the home.

We found pressure cushions which required cleaning and we also found some stained wheelchairs. We brought each issue to the attention of the manager on the day of our inspection; they confirmed these would be addressed.

A number of the individual bedrooms had no bins to dispose of paper towels after hand washing. These were made available on the day of our inspection.

Within the corridors, communal areas and individual bedrooms we found stained ceiling tiles in need of replacement.

We found one stained mattress in one of the bedrooms we examined, we also found cob webs on a number of the extractor fans below individual bedroom windows and the pelmets on some curtains had not been cleaned. The manager informed us the pelmets were being removed.

We found one person's individual bathroom in the residential area had a dirty toilet brush, the toilet seat needed replacing and the floor near the toilet was stained.

We found commodes which had not been effectively cleaned after use. Two days after our inspection the provider informed us 22 new commodes had been ordered for the service.

We found the sluice was still doubling up as a store cupboard for the domestic staff and clean mops were being stored next to the sluice sink which posed an infection control risk. This issue had been identified in the previous infection control audit carried out by Nottingham CityCare Partnership; however the service had failed to address the issue identified.

Outside the kitchen we found the alcohol hand gel empty. When we examined the kitchen we were informed by one member of staff that the kitchen cleanliness had, "Gone to pot whilst I have been on leave." We found the oven had not been cleaned and the oven gloves were thread bare. One staff member said, "The oven is filthy." We asked if there was a cleaning rota available for the kitchen and the service did not have one. This meant that cleaning records were not being maintained for this area of the home and there was a risk that the kitchen was not being cleaned on a frequent basis.

In the laundry room we found the ironing board cover was stained and dirty. With regards to linen storage, all clean linen was stored off the floor. We also observed that systems were in place for the segregation and collection of dirty laundry; however we found some clean pillows stored in a bin. Cleaning audits were available within the laundry room for certain areas of the home; including individual bedrooms and communal areas. The effectiveness of these audits was questionable given the issues identified on our inspection.

We found old and fresh dog faeces in the courtyard area outside the home. People living in the home could access this area and this posed a risk. We asked the manager how often this area was cleaned and were informed every few hours; however the area looked as though it had not been cleaned as frequently as indicated.

Overall we found inadequate standards of cleanliness and hygiene in a number of areas throughout the home.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We conducted a tour of the home which included looking at communal areas, cooking areas, toilets, bathrooms and individual rooms. Some areas had been redecorated including easy to clean floors; however the home was in need of redecoration and maintenance in a number of areas.

We spoke to two relatives of people using the service. One person said, "I have seen maintenance carried out within the home." Another person said, "I feel sorry for the maintenance man. There is a lot to be done. There used to be carpets in some areas which have now been replaced. It is a bit better."

During our tour of the building we identified some toiletries and bleach had been left in some of the bathrooms. There were some people who were able to walk without aid; this meant people within the home could potentially gain access to harmful substances. We raised this issue with the manager on the day of our inspection and they said they would consider an alternative storage solution in the interest of safety and address this with staff.

A number of the radiator covers were twisted which meant it was easy to catch or injure oneself when passing in the corridor. We observed handrails in the corridor were not secure and needed replacing. The general paintwork on skirting boards and door frames also needed updating.

In one person's room we found the door slammed itself shut. This presented a risk to the person using the service.

We observed one person being assisted in a wheelchair with a flat tyre. This meant there was a risk that the equipment people used was not being regularly maintained.

We observed fire escapes were clear and fire extinguishers had been checked. We did however find that the fire escape in the laundry room was blocked by the ironing board. We were informed that there were plans in place to resolve this.

During our inspection the fire alarm sounded. Staff assembled in the car park; however there was no fire assembly point sign. Fire action signs had also not been completed within the home.

With regards to linen storage, all clean linen was stored off the floor, however clean linen was on shelving that needed repairing and we also found clean pillows stored in a bin.

We spoke to staff on duty who said the home was in need of redecoration and maintenance in certain parts. One member of staff said, "I think the decoration could be made better and some parts need painting." Another member of staff said, "There is definitely room for improvement. Some areas are not inviting." When asked if action was taken quickly to identified issues, staff agreed action was taken relatively promptly. One member of staff said, "There is a maintenance person within the home and they do help with things that need doing."

The outside area for people using the service was not being maintained. There were no flowers, dog faeces in a number of areas and hazardous cleaning fluid had been left unattended. When we observed the door frame for the residential unit from the outside, it was apparent it was rotting and in need of replacement.

Overall we found inadequate maintenance of the premises and the surrounding grounds for people using the home.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

The low staffing levels within the home meant there was a risk that people's needs were not consistently met. In addition to the care staff there was one nurse on duty during our inspection.

We spoke to two relatives of people using the service. We asked them what they thought about the staffing levels within the home. One person said, "They are occasionally short staffed." Another person said, "I think they do what they can with what they have got."

We looked at the staffing rota for the last month and checked to ensure that the service had maintained staffing levels in line with their view of staffing requirements for people's needs. The staff rota we saw was not fit for purpose, there were gaps where we were informed people had been working but they not been included within the rota. The manager and deputy manager were able to provide a verbal explanation of who had worked when and confirmed there was a minimum of one nurse available at all times. The remaining staff consisted of a group of senior carers and carers, cooking, cleaning and administrative staff. No consideration appeared to have been given, in terms of the mix of staff available. For example, on one occasion we observed four senior carers working with a smaller number of care staff and on a separate day there was only one senior carer with more junior staff. The manager explained that a number of the carers were experienced and did not require senior support. We were also informed there was an electronic system which had been used to record staff hours, which would support the verbal explanation provided for the staff rota.

To help us understand the experiences of people living in the home we used our SOFI (Short Observational Framework for Inspection) tool during the visit. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

Some people ate their lunch in the dining area but other people ate their meals in a separate lounge within the home. We observed people in the dining area were mostly able to eat their meals independently; however they sometimes had to wait for assistance if it

was needed because staff members were assisting other people. In one instance a person left the dining area without receiving any interaction from staff at all. Staff realised this person had left and had not yet been offered a dessert. This meant people did not receive assistance in a timely manner and staff were not always available to help.

During our inspection we observed medication had not been administered on schedule due to the insufficient number of nurses working within the home. There was one nurse on duty upon our arrival and this meant people were at risk of not receiving the appropriate levels of care and support.

We spoke to four staff. One member of staff said, "There used to be two nurses and now there is one. This is not enough." Another member of staff said, "There are not enough staff to meet the needs of people."

Overall we found there were insufficient numbers of staff to meet the care and welfare needs of people using the service.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We spoke to two relatives of people who were using the service. The people we spoke to told us they felt they could speak to the manager and they would be listened to. One person said, "If I were worried about anything I would speak with the manager." Another person said, "I have been asked to complete a survey to give my views on the service."

People who used the service were asked for their views about their care and treatment and this information had been documented within the care plans. We did not see any evidence to indicate responses to surveys had been analysed in order to improve the quality of the service provision.

Staff meetings took place within the home. We reviewed the most recent minutes dated 17th May 2013. The minutes demonstrated a number of concerns which had been discussed in the manager's presence including bullying amongst the staff and safeguarding concerns relating to people using the service. The manager told us after our inspection that she had not had the opportunity to review the minutes and they were not an entirely accurate reflection of the discussion which took place. The minutes had initially been taken by an administrative member of staff within the home. The minutes raised a series of concerns in respect of inappropriate behaviours and practices. This meant the system to discuss, monitor the quality of service for people living in the home and make changes in response to any problems was ineffective.

We saw that fire equipment and other equipment was checked and maintained regularly.

A complaints policy and a whistleblowing policy were in place. The complaints policy was also displayed in the main entrance of the home. There were no complaints for us to review at the time of our inspection.

Staff told us that audits were carried out by the manager. One person said, "The manager does a room check every day to make sure everything is in order." Another member of

staff said, "The manager walks around the home to see if things are being done." We found the quality assurance processes within the home were ineffective as there were a number of actions which had not been followed up, as identified within other sections of this report.

Notification of other incidents ✖ Action needed

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was not meeting this standard.

The provider had not notified the Care Quality Commission (CQC) of all incidents which had occurred within the home as required by the CQC (Registration) Regulations 2009.

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

Reasons for our judgement

The provider had not notified the Care Quality Commission (CQC) of all incidents which had occurred within the home as required by the CQC (Registration) Regulations 2009. We prompted the manager to provide this information which had been omitted on two recent separate occasions.

One instance had occurred on the 20th May 2013 and had been referred to the local authority. We asked the manager to provide a notification regarding this incident and this was provided on the same day.

Prior to the inspection we also made a call to the home on the 22nd April 2013 to prompt the service manager to provide us with information relating to a separate incident. CQC had again been informed by the local authority.

We found that the care home had been appropriately notifying the local safeguarding authority about safeguarding referrals, but had not consistently notified the Care Quality Commission (CQC). Informing CQC of safeguarding incidents is a regulatory requirement.

Overall we saw evidence that where some incidents had occurred, appropriate notifications to CQC had not been made.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We looked at the care plans and associated risk assessments for eight people using the service. A care plan is a document which should identify a person's needs and how staff can meet those needs, including assessments or identified risks for each person.

In one person's care plan we found two folders running in tandem, which meant it was difficult to locate information.

Risk assessments had not been reviewed at the appropriate timescales to ensure the plan of care was current and that staff supported people in a safe way. The lack or regular risk assessment reviews meant that updated information was not available in care plans and people could not be assured of receiving care appropriate to their specific care needs.

We also found daily records had been omitted within some people's care plan, for four consecutive days on one occasion. This meant any records indicating any changes in a person's health could be missed and not acted upon.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: There was insufficient evidence to demonstrate the registered person had made suitable arrangements to ensure service users were treated with consideration and respect. Regulation 17 (2) (a).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: There was insufficient evidence to demonstrate the registered person had suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided to them. Regulation 18.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**

This section is primarily information for the provider

Treatment of disease, disorder or injury	**How the regulation was not being met:** There was insufficient evidence to demonstrate the registered person was taking proper steps to ensure each service user is protected against the risk of receiving care or treatment that is inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (b) (i) (ii).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: There was insufficient evidence to demonstrate the registered person had ensured service users, persons employed for the purpose of carrying on of the regulated activity and others were protected against the risk of acquiring an infection, as there were inadequate standards of cleanliness and hygiene. Regulation 12.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: There was insufficient evidence to demonstrate the registered person had ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises, by means of adequate maintenance and use of any surrounding grounds. Regulation 15 (1) (c) (ii).
Regulated activities	Regulation
Accommodation for	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Staffing**
	How the regulation was not being met: There was insufficient evidence to demonstrate that in order to safeguard the health, safety and welfare of service users, the registered person had taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purpose of carrying out the regulated activity. Regulation 22.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: There was insufficient evidence to demonstrate the registered person had an effective operation of systems designed to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. Regulation 10 (1) (b).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 CQC (Registration) Regulations 2009** **Notification of other incidents**
	How the regulation was not being met: The registered person was not notifying the Commission of all incidents whilst services were being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity including any abuse or allegation of abuse in relation to a service user. Regulation 18 (2) (e).
Regulated activities	Regulation

This section is primarily information for the provider

Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: There was insufficient evidence to demonstrate the registered person had ensured service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them, by means of the maintenance of an accurate record in respect of each service user which should include appropriate information and documents in relation to the care and treatment provided to each service user. Regulation 20 (1) (a).

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 16 July 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.

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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