Inspection Report

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

Swiss Cottage Care Home

Plantation Road, Leighton Buzzard, LU7 3HU

Tel: 01525377922

Date of Inspections: 22 November 2013
14 November 2013

Date of Publication: January 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Irvine Care Limited
Overview of the service	Swiss Cottage provides accommodation to people who require nursing and personal care; some of whom may be living with dementia.
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

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 14 November 2013 and 22 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

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

What people told us and what we found

Prior to our inspection on 14 and 22 November 2013 we had received concerns about care practices and staffing levels on the dementia unit at Swiss Cottage Care Home. During this inspection we concentrated the majority of our time within the dementia care unit called Cedar.

During our inspection we spoke with two relatives of people using the service and seven people who use the service, about their care. We found procedures for obtaining consent from people using the service were not always followed in practice, monitored and reviewed.

Care plans were complex and difficult to follow. Information contained within the plans of care lacked essential information about people's individual needs and preferences in relation to their care needs. In addition changes to people's care and treatment had not always been updated.

From the information we received from the service and from our observations on Cedar unit we noted there were gaps in staff training and development. In addition, systems in place were not robust enough to ensure that a quality service was provided to the people living at this home.

Personal documentation was not stored securely and was not always completed and up to date as people needs had changed. This meant that records about people's care, treatment and support did not maintain the dignity and confidentiality of the people using the service.

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 17 January 2014, 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

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.

Where people did not have the capacity to consent, the provider had not always acted in accordance with legal requirements. We found procedures for obtaining consent from people using the service were not always followed in practice, monitored and reviewed.

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

Systems to obtain, and act in accordance with, the consent of people living in the home in relation to the care and treatment provided for them, were not being applied accurately or consistently.

Over the two days, we observed that some people were given choices such as what they would like to eat or drink. We also observed situations where people were not able to provide written or verbal consent, but were able to show their consent in alternative ways, through actions or physical movement. We heard most staff explaining to people what they were going to do before they provided care and support.

Staff we spoke with understood people's right to refuse care, and told us they would involve people in making decisions about their care and welfare where they had capacity to do so. The manager told us that where someone's capacity was variable, they would speak to the person as often as possible, and relatives if appropriate, in order to make a decision.

Some records we looked at demonstrated good practice in that they made reference to people's right to refuse care, and one person had been recorded as providing verbal consent to a continence assessment and written consent to a flu vaccination. Another person had given written consent to the use of bed rails.

We found evidence that people's capacity was routinely assessed in relation to them giving their consent to the use of bedrails; to prevent them from falling out of bed. However, these had not always been completed accurately. For example, one assessment did not conclude whether the person had capacity or not, or whether a further assessment was

required. Another assessment had been signed by the person regarding the use of bedrails, but the form did not make it clear whether they had consented or not consented to their use.

Documentation we looked at did not always make clear whether each person had capacity; to determine their ability to make decisions about all aspects of their lives for themselves, or how this had been assessed. One person told us they did not want to be hoisted because they didn't like it and it was uncomfortable and staff we spoke with acknowledged this. It was recorded in the persons 'rights, consent and capacity' care plan that they should be involved in decision making as they had capacity to do so. However there was no record that the need to be hoisted, or whether any alternatives had been explored and discussed with individual.

Care plans were in place in relation to people's 'rights, consent and capacity' however, they lacked personalised information, focusing instead on what generic good practice should look like. For example, we read in one person's care plan that staff should continue to offer them choices and gain consent, but there was no information about how this should be done, or examples of when this had happened. This did not demonstrate the choices each person had been given, or decisions they had made in respect of how their care needs were attended to.

We read in one person's care record that their relative was advocating for them, despite staff and the person in question telling us they were not close. Records stated that the person also had capacity to make their own decisions. We spoke with the person and spent time observing the care and support provided to them. Our findings concluded that we could not be certain that some decisions had been made in their best interest's, particularly in relation to their accommodation needs, which they described as a "prison." There was evidence that their needs were different from the other people they were living with, and they told us the noise levels they experienced on a day to day basis distressed them. We brought this to the attention of the manager and regional manager at the time of our inspection. The regional manager acknowledged the need to improve consent and best interest's evidence for people living in the home. Afterwards, she wrote to tell us that she had arranged for an external authority to come to assess the person we had concerns about; to ensure the care and treatment being provided was right for them, and that they were not being deprived of their liberty. She also said that they were reviewing assessments to determine the mental capacity and decision making arrangements for everyone living in the home.

We found a 'Do Not Attempt Resuscitation' (DNAR) record in place for one person which had been completed by their GP. The manager explained that people and/or their relatives, where appropriate, were involved in making the decision not to undergo Cardiopulmonary resuscitation (CPR) if their heart were to stop or they were to stop breathing. She added that these decisions were reviewed regularly where the need was not indefinite, such as when someone was discharged from hospital. However, we saw a DNAR in place for one person dated October 2013 which had been put in place when they had needed hospital treatment. This recorded that the decision had not been discussed with the person. There was space on the DNAR to record the reason for not including the person in the decision, but this section had not been completed. The person was no longer in hospital and had returned to the home where the manager stated they were making progress. We looked at the person's care plan in relation to their 'rights, consent and capacity'. It had last been updated in November 2013, and although it did not make clear overall whether the person had capacity or not, it did state that they were able to make

decisions about their daily care needs. These findings demonstrated that the person had not been made aware that a significant decision about their life had been made, or that the decision had been reviewed following their discharge from hospital. This meant that people's human rights were not always respected and taken onto account.

Overall we found that suitable arrangements were not in place for obtaining, and acting in accordance with the consent of people using the service.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare and to meet the needs of people using the service.

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

Planning and delivery of care did not always meet people's individual needs or ensure the welfare and safety of people using the service was maintained.

We looked at the care records of four of the 22 people living in Cedar unit and two for people living in the nursing unit. Care plans were complex and not user friendly. Each plan of care was recorded on the same document as the care plan evaluations which were completed monthly. The paperwork used a tick box approach meaning that without additional narrative, we had to read the care plan and all the monthly evaluations to get a clear picture of each person's current care needs. This made it time consuming to find the information staff needed. In addition, care plan evaluations were often vague and not personalised. For example we saw entries such as: '[the person] recognises that care is offered in a dignified way' and 'care is based on best practice'. The status of the person's health and welfare needs were not described, and there was limited information about any progress or deterioration the person had made. This meant that staff did not have relevant and current information about each person which could result in unsafe and inappropriate care being provided.

Some entries in the care plans lacked detail, and had not been written in a way that promoted individualised care. For example, we saw evidence that some aspects of people's healthcare needs had been monitored for depression and pain. This meant that staff could respond in a timely manner if there was a change in people's condition. However, we were not able to evidence that blood monitoring for people with type 2 diabetes (diet controlled) was always being completed. We asked about this for one person whose care we were tracking. We were told that they had recently been informed that this person did not actually have diabetes after all. The care plan had not been updated to reflect this. This was a concern as this exposed them to the risk of inconsistent and inappropriate care.

We looked at four care plans in relation to 'drug therapy and medicines'. These contained a list of the medicines each person was taking and some generic expected outcomes such

as 'to reduce stress and anxiety' and 'to promote general well-being'. However, there was no guidance for staff to follow about how each individual person would like their medication administered. We observed a nurse giving one person their medication with water. The person using the service stated the water was warm and the nurse said she would get more water from the fountain but never did. The person had to take their tablets with what they described as warm water. This meant that the individual did not have their needs met appropriately in relation to taking their medicines.

In addition to the care plans, each person had a separate 'My Journal' and health monitoring forms such as food/fluid intake charts and repositioning charts. The 'My Journal' had a section to record people's preferences. Three of the four we looked at in the dementia care unit had not been completed, so staff could not be clear about people's preferred daily and sleep routines, social routines, significant life events, what they liked to do and wear and their interests.

On the first day of our inspection we went to the dementia care unit, Cedar, at 07:15am. We found most people were asleep in their bedrooms. However, people's bedroom doors were open and the corridor lights were all on. People using the service could potentially be disturbed by the lights and the noise at night. We were not able to find information in the care plans we looked at that supported this practice.

The environment was not supportive of the needs for people who had dementia. There was little in the way of signage, different settings and features of interest. Toilet and bathroom doors and people's bedrooms had not been made easily recognisable. The manager told us that there were plans to address some of these environmental concerns as part of a new approach the provider was introducing into the home; specifically in relation to the provision of dementia care. We noted that doors leading to an exit, the office and the kitchen were being repainted by the second day of our inspection.

We observed during both days of the inspection that the television was on constantly in Cedar Unit. We noted that the majority of people were not engaged with this activity. Staff explained that the television was on for one person, who did not have dementia. There was no music or any other activities taking place on Cedar unit throughout our inspection. This meant that we observed long periods of time when people were sitting around in a withdrawn state with no form of meaningful occupation.

To help us understand people's experiences we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us. This resulted in a majority of negative observations with little interactions from staff. Any positive contact with staff was very brief, such as a quick hug or a completion of a task. We saw no evidence of specialist dementia care being provided as described on the provider's website. We also observed people being ignored by various members of staff on a number of occasions throughout our inspection.

We noted that it was very noisy within Cedar unit. We observed at least two people calling out frequently during the first day of our inspection. They stopped calling out when staff had interaction with them, but this was only provided for a brief amount of time. Other people looked distressed. One person told us: "That's what we get all day" in response to someone who was shouting out loudly. They said: "I can't stand it" and at one point threatened to "kill" the person if they didn't stop. We were told there was no place for them to go to escape the noise in that unit. We learnt from speaking with care staff that this

person had been moved to Cedar unit from another unit in the home which had closed. The move and change of room had distressed them. We saw staff explaining on several occasions that the other person had dementia and couldn't help shouting out, but at one point they were sat so close to each other the other person was able to reach out and grab them from behind, causing further distress. We went to the aid of this person because staff were not within the vicinity.

We observed one person in the lounge who was getting ready for a hospital appointment. They told us they "feel dirty" because they had not had a proper wash. This person needed a lot of reassurance about their belongings and whether they were going to get their breakfast before they left for the hospital. The person requested a coffee but did not get this or their breakfast until an hour later. We observed both care staff and ancillary staff ignoring this person. Staff did not appear to prioritise this person's needs, and there was a risk that if the transport had come earlier, they would have missed breakfast.

We observed one person having difficulties drinking their tea and were spilling it on them self. There were no staff again in the vicinity and we went to the aid of this person. A regional manager (who would not normally have been in the building on the day of our inspection) was heard asking where the staff were.

One person using the service told us staff were "…not what they used to be". They talked about times in the past when staff would spend the time of day with them reading the newspaper for example. We were told that this didn't happen now. Our observations supported this as we found that staff tended to people's needs with a task orientated focus.

We observed at meal times that people were not supported to eat as staff had not provided them with the correct equipment or assisted them. For example, one person in an armchair had two boiled eggs in a bowl, toast on a plate and a hot drink on a tray, but they could not balance this all on their lap. There was no table for them at eating height. Another person was in a reclining arm chair for lunch and although they had a table in front of them, the reclined position did not make it easy for them eat their meal and they had to keep reaching forward for their food. This could result in people spilling food on their clothes which does not ensure the dignity of people using the service.

We spoke with two visiting relatives whose family member was living in the in the home. They told us they had some concerns with their relative's laundry so they now did all their washing themselves. They also told us they had concerns about the cleanliness of the environment but planned to talk to staff about this. Otherwise they were happy with the care and support their family member was receiving and felt able to raise concerns if they needed to.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who use the service were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People using the service, staff and visitors were not provided with the information necessary for them to report potential abuse and this placed people at risk.

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 had received concerns about care practices and staffing levels on Cedar unit at Swiss Cottage Care Home.

During our inspection, we spoke with four staff about their understanding of Safeguarding Of Vulnerable Adults (SOVA). All the staff we spoke with were aware of the need to report any issues of concern and said they would speak with the manager. Two members of staff said they had reported matters of concern to the manager, but did not have confidence that the issues had been responded to appropriately and felt that situations had not been resolved. Staff told us that this lack of confidence meant that care staff felt unable to follow the company policies and, in some instances, chose to raise concerns outside of the company.

We asked staff on two of the three units to show us the provider's safeguarding and whistle blowing policies. On one unit they were unable to locate a policy file and on the second unit staff found the file but there was no policy for safeguarding or whistle blowing. We noted on one notice board information was displayed for staff about who to contact if they needed to report suspected abuse. Information containing contact details of the local safeguarding team was not on public display where people using the service, their relatives or visitors could access the information. This meant that people, staff and visitors were not provided with the information necessary for them to report potential abuse and this placed people at risk.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were cared for by staff who had not always been supported to deliver care and treatment safely and to an appropriate standard. This could result in people receiving inconsistent care and support as a result.

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 with 16 staff employed to work at the service. One nurse told us the manager had been organising training and they had recently attended catheter care and venepuncture training. Staff we spoke with told us they had recently completed training in dementia.

We were provided with information from the manager in relation to staff training. The records showed that of the 20 staff working on the Cedar unit (the dementia care unit) 12 had not completed fire training, 13 staff had not completed practical moving and handling training and seven staff the moving and handling theory training. In addition, six staff had yet to complete basic food hygiene, five first aid awareness training and seven infection control training. Dementia training records for staff showed that seven staff had not received dementia training. Our observations during the day found that the staff's approach to dementia care was not person centred and we would question the quality of the dementia care training.

A regional manager, the manager and the deputy manager spoke about the provider's new approach to dementia care. This was called Positively Enriching And enhancing Residents Lives (PEARL). Staff had completed the initial training for this on 31 October 2013, however, some staff we spoke with told us they were still awaiting the date for their training to commence. We were informed it would involve all staff, in all roles. Although this is a positive step we were told that it would take a year to roll out in its entirety.

We looked at the induction programmes for registered nurses and care assistants. These showed that the induction consisted of a two day introduction to the organisation and the home. Following this, staff worked at the home and shadowed more experienced staff until they felt competent in their roles. A nurse we spoke with told us that they had not received a formal induction but had to pick things up as they went along.

We looked at a matrix for staff supervision. We saw that staff were receiving formal

supervision approximately every two months. Staff we spoke with confirmed that they received regular supervision. We spoke with a unit manager who told us she undertook the supervision of care assistants working in the unit. Staff told us they felt able to raise issues or concerns when necessary during their supervision sessions. The manager told us that staff meetings were erratic. The unit manager for Cedar unit said she was about to implement regular unit meetings.

Overall our findings demonstrate that systems for staff to share information and receive training and support were not adequately established. This meant that people could receive inconsistent care and support as a result.

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 had failed to identify, asses and manage the risks related to the health, welfare and safety of people using the service. This was because the quality assurance systems in place were not robust or effective.

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

As part of our inspection on 14 and 22 November 2013, we reviewed the quality monitoring systems in place within the service.

On arrival in Cedar unit, we found the environment was dirty with food on the floor, dust and spilt drinks on paintwork and radiators and dirty cutlery and cups on the floor and window sills. The fridge in the kitchen in Cedar unit was dirty, and the dustbin was full with some rubbish on the floor. We observed staff making some efforts to clean up, but we noted that some of the dust and dirt was still there on the second day of our inspection. Relatives we spoke with told us they also had concerns about the cleanliness of the environment. On the first day of our inspection the deputy manager was undertaking audits. She told us that there was a different audit for each month which was required to be completed. These included care planning, medication, the environment, nutrition, training and supervisions. We were told that these had not been completed monthly because the deputy manager had been on a secondment at another home. However, whilst internal quality audits were in the process of being completed, it was evident that on a wider level, the systems in place had not identified areas of concern which we found during our inspection. For example, the provider had failed to identify the issues with the cleanliness of the environment, gaps in staff training, the lack of detailed and personalised care records and incomplete records on people's preferences in relation to their care and a lack of meaningful activities for people using the service.

Complaints records showed that the manager took account of complaints and comments to address any concerns people raised. However, the concerns raised with us by people using the service regarding the noisy environment, the laundry and the cleanliness of the premises had not been identified or addressed. The provider had therefore failed to identify, assess and manage the risks related to the health, welfare and safety of people using the service.

This meant that the provider was not able to evidence robust quality monitoring practices within the service.

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 inaccurate and incomplete records were maintained. Records were not always stored safely and securely.

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

Reasons for our judgement

During our inspection we looked at the procedures in place to ensure personalised and medical records were kept and maintained for each person. We saw complex and incomplete care records which placed people at risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. We looked at four of the care files of 22 people living on Cedar unit and two for people living in the nursing unit. There was an 'outcome profiles tracker' which took the place of daily record reporting as staff ticked whether they had made any changes to the relevant attached sections of the care plan. We found gaps in one person's personal care record of 13 days during the first part of November 2013. An appointment attended by one person on the first day of our inspection had not been recorded within their file so there was no record of this visit or the outcome. Some entries in the care plans lacked detail, and had not been written in a way that promoted individualised care.

In addition to the care plans, each person had a separate 'My Journal' and health monitoring forms such as food/fluid intake charts and repositioning charts. The 'My Journal' had a section to record people's preferences. Three of the four we looked at in the dementia care unit had not been completed, so staff could not be clear about people's preferred daily and sleep routines, social routines, significant life events, what they liked to do and wear and their interests.

Where information had been recorded regarding people's preferences, this was very brief. One person raised concerns about the accuracy of the information recorded about them. The records did not demonstrate that the individual had been involved in the care planning process.

We brought our concerns to the attention of a regional manager at the time of our inspection who agreed that records required more detail and personalisation. She told us the organisation was piloting the use of some new electronic records in another region, but acknowledged that some of the concerns we had found were more to do with how well

staff were completing records.

We found that mental capacity assessments had not always been completed accurately. For example, one assessment did not conclude whether the person had capacity or whether a further assessment was required.

During the second day of our inspection we noted the care records for three people left unattended in the nursing unit, making them visible and accessible to people not authorised to view them. This did not ensure that personal information about people remained confidential.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Arrangements were not in place for obtaining, and acting in accordance with the consent of people using the service. Where people did not have the capacity to consent, the provider had not always acted in accordance with legal requirements. Regulation 18 (a) (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare and to meet the needs of people using the service. Regulation 9 (b) (i) (ii) (iii) (iv)

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service were not always protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People using the service, staff and visitors were not provided with the information necessary for them to report potential abuse and this placed people at risk. Regulation 11 (1) (a) (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: People were cared for by staff who had not always been supported to deliver care and treatment safely and to an appropriate standard. This could result in people receiving inconsistent care and support as a result. Regulation 23 (1) (a) (b) (2) (3) (a) (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Systems in place to identify, assess and manage risks to the

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	health, safety and welfare of people who use the service and others were not robust or effective. The provider had therefore failed to identify, assess and manage the risks related to the health, welfare and safety of people using the service. Regulation 10 (1) (a) (2) (c) (i) (ii) (d) (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 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records** **How the regulation was not being met:** People were not protected from the risks of unsafe or inappropriate care and treatment because inaccurate and incomplete records were maintained. Records were not always stored safely and securely. Regulation 20.- (1) (a) (2) (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 17 January 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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