COMPLIANCE AUDIT TOOL (CAT) - CQC (England)

CAREPORT

Home:	Manager:	Date of Audit:	Completed By:
St johns Nursing Home	Kani Trehorn/Christine Harris	30th September 2016	AEBarker

THIS AUDIT TOOL IS DESIGNED TO MEASURE A CARE HOMES COMPLIANCE WITH THE FUNDAMENTAL STANDARDS IMPLEMENTED 1ST APRIL 2015 IT IS DESIGNED TO BE USED BY OPERATIONS MANAGERS TO AUDIT A CARE SERVICE'S COMPLIANCE. AND IS BASED ON THE KEY LINES OF ENQUIRY MODEL.

1	Fundamental Standard 1	Regulation 9	Person centred care
2	Fundamental Standard 2	Regulation 10	Dignity & Respect
3	Fundamental Standard 3	Regulation 11	Need for consent
4	Fundamental Standard 4	Regulation 12	Safe care and treatment
5	Fundamental Standard 5	Regulation 13	Safeguarding service user from abuse and improper treatment
6	Fundamental Standard 6	Regulation 14	Meeting nutritional and hydration needs
7	Fundamental Standard 7	Regulation 15	Premises and equipment
8	Fundamental Standard 8	Regulation 16	Receiving and acting on complaints
9	Fundamental Standard 9	Regulation 17	Good governance
10	Fundamental Standard 10	Regulation 18	Staffing
11	Fundamental Standard 11	Regulation 19	Fit and proper persons employed
12	Fundamental Standard 12	Regulation 20	Duty of candour

1. EVIDENCE MUST BE PHYSICALLY SEEN AND COMPLIANCE TO THE OUTCOMES WILL BE SCORED AS YES OR NO. WHERE COMPLIANCE TO AN OUTCOME IS NO THEN IT SHOULD BE ADDED TO THE FINAL ACTION PLAN.

2. ANSWER ALL YES/NO QUESTIONS AND PLACE NARRATIVE IN ALL COMMENTS BOXES.

3. THE AUDIT TOOL SHOULD ONLY BE COMPLETED IN THE LIGHT GREEN BOXES.

4. ALL SECTIONS MUST BE COMPLETED WITHOUT EXCEPTION.

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CAREPORT

Standard 1
Fundamental standards regulation: Regulation 9: Person-centred care
The intention of this regulation is to ensure that each service user receives care that is personalised specifically for them, that meets their needs and reflects their preferences. The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences.

1	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
1.00	At the front of each care file is there a front sheet available which contains a photograph, DOB, Know allergies, next of kin, end of life preferences etc.	x		Yes recent updated documentation in some of the files reviewed			x	
1.01	Is there evidence of pre admission assessment with the service user and/or their representative to ensure the care plan is designed to deliver care and treatment that is appropriate for each individual, that meets their needs and that makes all reasonable efforts to accommodate preferences, is the assessor considered competent and appropriate to undertake this task? have all needs, including emotional and social needs, been included in assessments and do they take into consideration who will deliver the care and treatment.		x	This is generally archived. Not all needs are concidered		x		
1.02	Is there a evidence that skin integrity assessment, pressure ulcer risk assessment (Waterlow), Nutritional & Falls risk assessments are undertaken within 6 hours of admission and are reviewed at least monthly thereafter.		x	No there is no skin integrity care plan. This is incorporated into the personal care plan		x		

1.03	Is there a care plan in place which includes future wishes and personal wishes in relation to End of Life care.	x		In some files not all		x		
1.04	Is information available for service users to reach informed decisions about their care and treatment in a format they can understand.	x		information kept in a format that is easy to use in the main foyer			x	
1.05	I s there evidence that residents and their families are involved in the assessment and care planning process with signatures in care files.		x	There is no evidence that relatives are not involved in the monthly reviews		x		
1.06	Are service users encouraged and supported to participate in decision making (as much or as little as they wish) given regard to their mental capacity	x		Care is discussed with the resident			x	
1.07	Do relevant persons have opportunities and information to be involved with and manage (as appropriate) the service user's care and treatment if they wish, has the provider made any reasonable adjustments to facilitate this.		x	There is no evidence that relatives are involved in the care of service users		x		
1.08	Has the care plan been reviewed regularly by a competent individual including if needs change, prior to transfer between services or discharge. (This should also include a minimum full review every 6 months and a rewrite of the care plan annually).		x	Reviews have taken place but this is not regularly monthly		x		
1.09	Do daily entry records reflect person centred care, i.e written in langue which describes the person and their response to care delivered.		x	Daily records are kept in a separate folder to the care plan they are dated and signed. We noted on the front of the file a notice saying daily records must not be written until after 130pm.		x		

1.10	Track- Daily Communication, Multi-Disciplinary Records, Accident Forms & ABC charts for evidence of incidents that require urgent review e.g. an infection that requires a short term care plan or conflict between residents that may require referral to safeguarding team etc.		x	There are no evidence of short twerm care plans in situ. Accident and incident form completed for gentleman who is at risk of swallowing foreign objects/items this was not written in the care file.		x		
1.11	Do daily entry records reflect person centred care, i.e written in langue which describes the person and their response to care delivered.							
1.12	Are all care profile entries accurate, legible, written in black ink, 24 hour clock used, signed and dated	x		written in black ink dated and timed			x	
1.13	Where a service user's preferences cannot be met, is this fully explained to the service user/relevant person, and documented A Short Term care plan is written and evaluated daily until the issue has resolved		x	no evidence of short term careplans for infections or post incidents/accidents		x		
1.14	Where a resident has dementia a sensitive plan is written that gives detailed information as to how that persons needs can be met		x	No evidence of any Demetia care p[lans		x		
1.15	Any decisions to use restrictive practice e.g. door codes are made with family and/or other health care professionals and recorded in the care profile, documented in a care plan, signed by the manager and reviewed monthly		x	No evidence		x		
1.16	Have life histories been completed and is there evidence to show that the activities this person undertakes are linked to past hobbies, interests like and dislikes.	x		Evidence kept in the residents individual room files			x	

1.17	Do stimulating activities take place every day in the home? (describe what activities you saw taking place)	x		Stimulating activities take place daily mon - Thurs. Service users do have recently written activities care plans there is no evidence that they are updated monthly		x		
1.18	Activities that take place or are offered are recorded on individual Record of Social, Religious & Cultural Activity Sheets		x	No evidence that daily notes are kept		x		
1.19	Information about facilities and forthcoming events in the home and local community are available on Residents Notice Boards		x	We did not see any evidence of forthcoming events		x		
1.20	Hairdressing & Beauty Services are flexible and meet the needs of the residents	x		Two weekly visits			x	
1.21	The home has a selection of newspapers and magazines for residents to access		x	No		x		
1.22	The home has activity equipment that residents can access independently e.g. books, jigsaws etc.		x	We did not see any evidence		x		
1.23	The home engages the service of a chiropodist either private or NHS, if diabetic, to provide treatment to service users.	x		chiropodistattends six weekly for those residents who have diabetes			x	

1.24	Access to dental services are available in the home		x	No access to a dentist		x		
1.25	A comments book or box is available in reception next to the visitor's book for people to use & Visitors sign the visitors book when entering and leaving the home	x		There is a comments box in the foyer however when staff were questioned there was no evidence that this is ever opened or comments reviewed		x		
1.26	Information on advocacy, IMCA, Age Concern etc. is available in reception and on Residents Notice Boards	x		Yes seen in situ			x	
1.27	Are resident and relative meetings held on a regular basis, planned in advance and dates displayed?.		x	There have been no resident meeting held however we noted that a relatives meeting was advirtised for October		x		
1.28	Minutes of the meetings evidence that residents participate in the meetings with staff support & that residents choice influences the running of the home for example, menu/activities etc.			No minutes of meetings are displayed or available		x		
1.29	Religious Services are offered in the home or arrangements made to access these in the community.	x		Some residents do attenc church and there are services held for those residents who wish to attend			x	
1.30	All staff wear name badges so they can be easily identified by residents / visitors	x		Yes all staff are seen to be wearing a name badge			x	

1.31	Residents are encouraged to remain active and supported to take part in the running of the home e.g. setting tables, washing up, making their own beds, preparing fruit & vegetable etc.		x	We did not see any evidence of this		x		
1.32	An Emergency stock of continence products are kept in the home in case a resident is admitted without being assessed for continence products A small stock of basic toiletries are kept in the home for emergency use	x					x	
				Regulation 9 Total Scores	**0**	**126**	**33**	**0**

Standard 2:
Regulation 10: Dignity and respect
The intention of this regulation is to ensure that service users are treated with respect and dignity at all times while receiving care and treatment.
Service users must be treated with dignity and respect.

2	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
2.00	Did you witness staff speaking to service residents sensitively with dignity and respect, did they treat people with care and compassion..	x		We witnesses some excellent interactions			x	
2.01	Do staff address service users in the manner they prefer, is this recorded in their care file. Can the provider demonstrate respect for service users by:	x		Yes staff refered to service users using the name they prefered and this was documented on a front sheet in the care files			x	
2.02	Does the home maintain service users' privacy at all times, including, for example, if they are asleep or unconscious.	x		Yes we witnessed this in practice			x	
2.03	Does the service understand the level of autonomy and independence that each service user requires and do they enable and promote their involvement in the community that is important to them (where this is relevant to their care and treatment).	x		This was witnessed in practice			x	

2.04	Do policies and practices in the home have due regard to the age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation of each service user, as defined in the Equality Act 2010.	x		Policies evidenced			x	
2.05	Does the environment provide adequate facilities to deliver care in private while maintaining dignity, e.g bathrooms and toilets where door close if using a hoist, care being delivered signs on bathroom or bedroom doors etc. and rooms available should the service user wish to hold a private conversation, or be alone.	x		Doors where closed			x	
2.06	Do staff knock on doors and wait for an answer prior to entering service users private space.	x		Witnessed in practice			x	
				Regulation 10 Total Scores	0	0	21	0

Standards 3:
Regulation 11: Need for Consent
The intention of this regulation is to ensure that all service users (relevant persons) have given consent in accordance with this regulation before any care or treatment is delivered.

3	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
3.00	Is the care and treatment of service users only provided with the consent of the relevant person. Is there evidence of consent to care and treatment in the care file, either a written signature or a description of a verbal agreement.	x		We saw that some MCA had been completed and there are best interest documentation in place. Hoever we also saw consent documentation signed for by relatives without LPA for health		x		
3.01	If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, does the registered person must act in accordance with the Mental Capacity Act, 2005, i.e complete an MCA assessment and make best interest decisions.		x	We saw limited consent forms signed		x		
3.02	Ask members of staff if they understand the MCA and describe how they help people to make decisions	x		Staff questioned understood the principles of the MCA			x	

3.03	Does the person who obtains the consent have the necessary knowledge and understanding of the care and treatment that they are asking consent for, so that they can discuss the risks and benefits and answer any questions from the service user.	x		All staff have received training			x	
3.04	Are discussions about consent carried out in accordance with service users' communication needs. Has the service user been provided with information about the care or treatment in a format that the service user or relevant person understands.	x		Service users receive information as per their individual needs. They also have a service user guide to refer to			x	
3.05	Where consent is given verbally, is this also captured in the service user's notes. Consent may be also be formally documented (normally using a form in this case).		x	Verbal consent is not documented		x		
3.06	Do current consent procedures ensure that service users are not pressured into giving consent.	x		Service users do not appear to be pressurised into giving consent however not all residents who are being deprived of their libity have a DOLs in place			x	
3.07	Are there policies and procedures in place for obtaining consent to care and treatment, do they reflect current legislation and guidance, and are they followed by staff at all times.	x		There are some consents in place		x		

3.08	Are staff observed asking permission verbally prior to delivering care?.	x		Yes staff have been witnessed asking for consent			x	
				Regulation 11 Total Scores	0	24	15	0

Standard 4

Regulation 12: Safe Care and Treatment

The intention of this regulation is to prevent service users from receiving unsafe care and treatment, in order to prevent any avoidable harm or risk of harm. Care and treatment must be provided in a safe way for service users.

4	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
4.00	Are risk assessments relating to the health, safety and welfare of service users completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so.	x		Yes risk assessments are completed but they are not updated monthly		x		
4.01	Where appropriate, have the risk assessments been carried out in accordance with the Mental Capacity Act 2005 (including best interest decision-making, lawful restraint and, where required, applying for authorisation for deprivation of liberty through the Mental Capacity Act deprivation of liberty safeguards or the Court of Protection).	x		Risk assessments are completed Dols have been applied for		x		
4.02	Care files contain risk assessments on skin integrity, moving and handling, nutrition, infection control, falls, fire evacuation as a minimum. Is there a care plan in place to minimise any risks which have been identified.		x	Care files contain risk assessment within the files. We did not always see a care plan that reflected increase risk		x		

4.03	Has Deprivation Of Liberty been considered and applications submitted where appropriate.	x		Yes DOL's have been concidered and applications made where appropriate			x	
4.04	Does the home act in accordance with relevant legislation in relation to: infection prevention and control Does the home hold a copy of the guidance guidance from the Department of Health about the prevention and control of health care acquired infections (The Code of Practice for health and adult social care on the prevention and control of infections and related guidance.)	x		Yes Infection control policies in place. We did not see any nice guidelines or policy displayed		x		
4.05	Is the home clean and free from malodour, are there cleaning schedules in place, are these audited on a regular basis.	x		The home is clean tidy well maintained. There are some aromas in rooms with carpets but there is a plan in place to replace all room flooring with wooded		x		
4.06	Observe and confirm that staff finger nails are kept short and free from false nails or nail polish and that rings (with the exception of a plain wedding band), wrist watches and bracelets are not worn	X		Confirmed			x	

4.07	Un perfumed liquid soap is available in dispensers, disposable paper towels and alcohol based gel is available for staff and visitors to use as an additional precaution after washing their hands	x		Yes all in order			x	
4.08	Carpets in the home are clean and there is a carpet cleaning programme in place	x		carpets are clean and maintained with a cleaning schedule in place although there are areas with a malodour		x		
4.09	All communal areas including lounge dining areas, corridors and communal bathrooms are clean, tidy and in a good state of repair	x		All in order			x	
4.10	Disposable gloves and aprons are worn for single use only when undertaking personal care, handling dressings, soiled linen, cleaning contaminated areas, serving food, handling waste etc.	x		All in order			x	

4.11	Bins in communal areas are foot operated and contain the correct bin liner for use, these are emptied twice daily and taken to the external bin store		x	Wate paper bins used. Some foot operated in bathrooms		x		
4.12	Infected or faecally soiled laundry is placed in a red disolvo bag and put in the machine unopened washing on a sluice cycle & then hot wash	x		All in order			x	
4.13	External bin areas are kept clean and clinical waste bins are kept locked at all times, domestic waste is placed in black bags, offensive waste (incontinence pads) in yellow bags hazardous waste (dressings etc.) in orange bags.	x		All in order			x	
4.14.	A Red Emergency File is established. It contains a completed Emergency Plan, Plans of the Home, Staff Contact details and an Individual Full Resident Details report, with Photograph and added notes of assistance required in an Emergency Evacuation		x	No evidence. PEEPs have been updated the day prior to visit and we saw them in individual files		x		

4.15	Are there systems in place for safe medicine management, this includes ordering storing administering and disposal	x		MSD systems in place			x	
4.16	A list of signatures and initials of staff who administer medication is kept in the MAR sheet file this form also is used to confirm that staff have read and understood the Medication Policy	x		Present in MARS folders			x	
4.17	Check that the person administering Medication in the home has been trained and been observed and deemed competent. This signed checklist is kept on the staff members personnel file	x		Trained on line. No evidence of competency assessments The newly appointed DM has not completed any mandatory training for the home. Previous employment certificates not used		x		
4.18	If any residents self-medicate is there a risk assessment and agreement in place that is reviewed at least monthly	x		No residents who self medicate			x	

4.19	Medication is dispensed from original containers – no secondary dispensing		x	We noticed one person with a number of different pots returning to the trolley with dirty pots ontop of a medication he was about to go upstairs to administer		x		
4.20	An up to date BNF (within 12 months) is available for staff to refer to and a file kept of all medication information sheets	x		Yes kept in the medication trolley			x	
4.21	Boxed or bottled medication is signed and dated when opened	x		Seen in practice no concerns			x	
4.22	Accurate and complete records identify medication ordered, prescriptions received, how much received, how much has been used, how much is left and how much returned – an audit trail	x		All sytems are in place			x	

4.23	MAR sheets are only handwritten as a last resort and where this takes place a witness checks the entry and two signatures confirm accuracy – this also applies to verbal changes from the GP	x		Printed in pharmacy only hand written as a last resort.			x	
4.24	PRN Guidelines forms are used for all PRN medication to give the details of what the medication is prescribed for and what are the common symptoms experienced	x		PRN guidelines are in place for PRN medication			x	
4.25	The clinic room cannot be opened with a master key and the spare set of medication keys are kept in the homes safe if required in the event of an emergency	x		Clinic room key is kept on the nurses keys. Room locked			x	
4.26	Controlled Drugs are always witnessed and administered by 2 people and the Controlled Drug book completed – stock balances are audited by the manager at least monthly	x		Process correct two signatures seen			x	

4.27	When a variable dose medication is prescribed e.g. Warfarin then the Variable dose record form is used with the MAR sheet	x		NA not seen			x	
4.28	Where creams or lotions are prescribed the Topical Medication form is used with the MAR sheet	x		Topical charts used effectively			x	
4.29	Medication is disposed of in a separate designated box and recorded in the returns book	X		Correct policy inplace			x	
4.30	Sharps bins are available in each clinic room and are available for nurses to dispose of syringes and needles, stitch cutters etc. and for staff in the home to dispose of razor blades etc. These are labelled with the name and address of the home	x		Sharps beins are located in the clinical room			x	

4.31	Medication keys are held by the person who is designated to be in charge of the shift.	x		Nurse in charge holds the medication keys			x	
4.32	Are allergies, contra indications clearly identified across all care documents e.e care file, MAR sheets etc	x		Documented clearly on the charts			x	
4.33	Does the home have environmental risk assess meant s in place to proomte safe working practices., are staff are of these and have they acknowledged this.	x		Environmental and H&S completed monthly by maintenance			x	
4.34	Are all incidents and/or accidents that affect the health, safety and welfare of service users reported internally and to relevant external authorities/bodies.	x		We observed accident and incident reporting and found good systems in place			x	

4.35	Are they reviewed and investigated by the manager using a recognised methodology, and are monitored to ensure that corrective actions, preventative actions and improvements are made as a result.	x		All documentation is filed in the appropriate folder documentation is given to the home manager for review and comments before filing			x	
4.36	Is information about incidents/accidents given to the staff involved and shared with others to promote learning.		x	There is no evidence that learnings take place		x		
4.37	Have changes been made to care plans following incidents or changes in need		x	We did not see following an incident that the care plan had been updated.		x		
4.38	The home has access to a falls team / nurse / physiotherapist to advice on fall risk reduction	x		Access is through the GP Champions have been aloccated			x	

4.39	Are policies and procedures in place for anyone to raise concerns about the care and treatment service users receive, and these are in line with current legislation and guidance, and are followed. Is there a whistleblowing policy in place, have staff signed to acknowledge they have seen this.	x		Complaints policy			x	
4.40	Are there arrangements in place to ensure the provider can take appropriate action in the event of a clinical/medical emergency.	x		Policies in place			x	
4.41	A list of useful contacts is made and available in the office E.g. Falls Team, Palliative Care Team, Continence Advisor, Infection Control, Funeral Director, Contracts, Social Workers, GP's, District Nurses, Community Mental Health Team, Churches, Pharmacy etc.	x		Yes contact details are available			x	
4.42	Do staff work within the scope of their qualifications, competence, skills and experience and are they encouraged to seek help when they feel they are being asked to do something they are not prepared for. Where staff are learning new skills, but are not yet competent, are they appropriately supervised.		x	We did not see any evidence that staff received competency assessments		x		

4.43	When service users move between services or providers (and/or with other bodies e.g. the police), whether registered with CQC or not, appropriate risk assessment should be undertaken to ensure the safety of service users is not compromised.		x	Risk assessments are not completed		x		
4.44	Does the home have an emergency contingency plan in place i.e. Are there arrangements in place to ensure compliance with the Civil Contingencies Act 2004 and to respond to and manage major incidents and emergency situations (e.g. having plans in place with other providers/bodies in case of events such as fires, floods, major road traffic accidents/or major incidents, natural disasters such as earthquakes/landslides etc.) to ensure services users are safe and risks to care and treatment are minimised should these situations occur. i.e an emergency contingency plan.	x		Yes in place and active			x	
4.45	Is there a member of staff who hold a current first aid certificate available on every shift.	x		RN staff are first aid trained.			x	
4.46	Are there arrangements in place to refer to outside professional staff for exaple chiropody, GP dentist Ophthalmologist TVM etc.	x		Yes all in order			x	

4.47	HACCP Manual is correctly completed recording temperature checks etc.	x		Kitchen staff work to SFBB			x	
4.48	Access to the kitchen is restricted to authorised staff only	x		Staff are restricted			x	
4.49	Access to the kitchen is restricted to authorised staff only						x	
4.50	Staff who enter the kitchen wear PPE and wash their hands before accessing food / equipment	x		No staff other than kitchen staff enter the kitchen			x	
Regulation 12 Total Scores					0	84	111	0

Standard 5:
Regulation 13: Safeguarding service users from abuse and improper treatment
The intention of this regulation is to safeguard service users from suffering any form of abuse or improper treatment, such as discrimination or unlawful restraint, while receiving care and treatment. This would include inappropriate deprivation of liberty under the terms of the Mental Capacity Act 2005.

5	Evidence of Compliance		Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
					Score Per Weighting	8	6	3	5
	5.00	Are there suitable policies and procedures on safeguarding in place that comply with current legislation and guidance. This should include details of the local authority safeguarding policy and contact number displayed throughout the home.	x		Yes new process with new flow chart			x	
	5.01	Does the provider take appropriate steps to ensure a zero tolerance approach to abuse, including neglect and subjecting service users to degrading treatment, and to prevent service users from being abused by its staff or others with whom they come into contact when using the services and those visiting.	x		The home operates zero tolerance			x	

5.02	Does t he provider take appropriate steps to ensure a zero tolerance approach to unlawful discrimination or restraint and to unnecessary or disproportionate restraint or deprivation of liberty.	x		Yes new process with new flow chart			x	
5.03	Are staff aware of their individual responsibilities in preventing and identifying abuse when delivering care and treatment. Have they received safeguarding training to the appropriate level for their role as part of their induction and kept up-to-date at appropriate intervals so that they are able to recognise different types of abuse and know what to do about it.	x		Training completed and up to date			x	
5.04	Are Incidents and complaints used to identify potential abuse issues and preventative actions taken, including escalation where appropriate.		x	We did not see any evidence of learnings		x		
5.05	Does the home work in partnership with relevant other bodies to contribute to individual risk assessments, the development of safeguarding adults at risk plans and the implementation of these plans, including the regular review of outcomes for the service user.	x		The home is working with a number of external professionals and there ae a number of large scale investigations in progress.		x		

5.06	Is support provided to service users were they allegedly or actually experience or cause abuse.	x		support is offered to residents		x		
5.07	Where allegations of abuse are substantiated, does the manager take suitable corrective action to redress the abuse and implement preventative actions to ensure the abuse is not repeated.		x	This is being developed by the compiance manager		x		
5.08	Does the provider ensure that any control, restraint and restrictive practices should only be used proportionately in relation to the risk of harm to the service user, the seriousness of that harm, and that they are applied in line with current legislation and guidance.	x		this is being developed by the compiance manager		x		
5.09	Do staff have appropriate training to ensure any control, restraint or restrictive practices are only used when absolutely necessary and as a last resort.	x		staff have received training		x		

5.10	Where a service user lacks mental capacity to Consent to the arrangements for care or treatment, deprivation of their liberty, have they been implemented and managed in accordance with the Mental Capacity Act 2005 (including the use of the Mental Capacity Act deprivation of liberty safeguards where appropriate).		x	Not all residents who require a DOLs have them in place the compliance manger is working on completion		x		
5.11	Do the manager and staff take all reasonably practicable steps to ensure service users are not subjected to any form of degrading treatment and are not treated in a manner that may be degrading (e.g. being left in soiled sheets or left on the toilet for long periods).	x		we witnessed dignity and respect			x	
5.12	Do staff have access to current procedures and guidance for raising and responding to concerns of abuse – they should have access to support or supervision when considering how to respond to concerns of abuse.	x		Yes new policy, flow chart and practices		x		
5.13	Where abuse is witnessed or suspected this is reported to the Home Manager/Owner as soon as possible	x		Staff responded to the home manager and the compliance manager		x		

5.14	Where abuse is witnessed or suspected this is reported to the Care Quality Commission as soon as possible	x		Yes but there is evidence that this has been slow in the past		x		
5.15	A file is kept in the manager's office containing copies of Safeguarding referrals and CQC notifications sent	x		New process. Compliance manager reluctant to show me file due to serious investigations ongoing		x		
5.16	Safeguarding referrals are reviewed by the home to see if there are any patterns, trends etc.		x	There is no evidence that they are reviewed to identify trends		x		
5.17	Residents monies received and spent are entered as individual transactions	x		all in order			x	

5.18	Receipts for all goods purchased are numbered and kept in the individual, labelled zipped plastic wallet	x		receipts in place			x	
5.19	All monies and receipts are kept in the homes safe with a record of all transactions	x		We did not see evidence but were informed the admin assisstant who does not work fridays maintains		x		
5.20	When resident money is received a receipt is issued and a copy kept in the home	x		reicept given			x	
5.21	Where there is a transaction of cash 2 witness signatures are in place	x		we were informed this was in order		x		

5.22	Only the home manager, and admin have access to the safe keys	x		we were informed this was in order			x	
5.23	A record of valuables that have been returned to the family, retained by the resident and secured in the homes safe is kept in the Residents Individual Care Profile		x	no record kept		x		
5.24	Records are held of the contents of the safe.		x	no evidence		x		
				Regulation13 Total Scores	0	96	27	0

Standard 6:
Regulation 14 Meeting nutritional and hydration needs
The intention of this regulation is to ensure that service users receive adequate nutrition and hydration to sustain life and good health, and to mitigate the risks of malnutrition and dehydration, while they receive care and treatment. The nutritional and hydration needs of service users must be met.

6	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
6.00	Does the home assess each service user's nutrition and hydration needs on an ongoing basis	x		Assessment carried out but not on a mothly basis		x		
6.01	Does the service provide food and drink to meet requirements, including accommodation of any religious/cultural needs and reflecting their preferences. .	x		Appears in order		x		
6.02	Is the food provided nutritious, presented in an appetising manner, can easily be consumed (the service user can eat it regardless of any limitations they may have) and is easily accessible to the service user.	x		Food appeared appetising and nutritious			x	
6.03	Where a service user is assessed as requiring a specific diet, this is provided in accordance with that assessment, e.g. a diabetic diet, low salt diet, and takes account of allergies or food intolerance.	x		Diet sheets are provided to the kitchen staff			x	

6.04	Drinks are always available and accessible to the service user, the staff help them if they need support to drink.	x		Yes this was seen in practice			x	
6.05	Does the home have access to relevant specialist expertise (e.g. a dietician or speech and language therapist) to ensure that the nutrition and hydration it provides adequately meets the needs of each service user.	x		Service users are referred to dietitian whenconcerns are raised			x	
6.06	Do staff follow the most up-to-date nutrition and hydration assessment for each service user and take appropriate action if service users are not eating and drinking in accordance with their assessed needs.	x		Care files are kept in the nurses office and care staff do not read the care plans however there are information sheets for the care staff to use in individual room files		x		
6.07	Do appropriately qualified, skilled, competent and experienced staff or relevant persons administer parenteral nutrition and dietary supplements.	x		NA none on site		x		
6.08	Are service users' religious and or cultural needs, or moral or ethical beliefs, recognised in their nutrition and hydration assessment, met?	x		Yes witnessed in practice			x	
6.09	Are service users' preferences accommodated as far as reasonably practicable, including preference about the time meals are served, quantities, place, etc.		x	We did not see evidence that service users are involved. Although there are plans to have meetings		x		

6.10	Are service users encouraged to eat and drink independently if they are able, but appropriate support, which may include encouragement as well as physical support, should be provided when needed.	x		Witnessed in practice			x	
6.11	Are monthly catering and food audits completed, is there evidence the manager verifies the chefs weekly records.		x	New process requires developing		x		
				Regulation 14 Total Scores	0	36	18	0

Standard 7:
Regulation 15: Premises and equipment
The intention of this regulation is to ensure that the premises and/or equipment used to deliver care and treatment are clean, stored securely and suitable for the intended purpose.

7	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
7.00	The home is covered by public liability and indemnity insurance – this certificate is displayed in a quality frame in the reception area	x		Yes displayed			x	
7.01	Cleaning Schedules are in place and used daily for Bedrooms, Clinic Rooms, General Areas, Kitchen, and Lounge/Dining Rooms	x		Yes evidence seen			x	

7.02	A colour coded system is in place for aprons, cleaning products, mops, buckets and clothes. Mop heads are sent to the laundry each day to be washed. Goggles are available for use if required	x		Yes			x	
7.03	Is there a facilities management folder in place which contains evidence of all maintenance, servicing and repair certificates.	x		Yes			x	
7.04	Is equipment cleaned and/or decontaminated according to the manufacturer's instructions, cleaned/decontaminated after each use and between being used by/for different service users.		x	We did not see evidence that hoists where cleaned between use		x		
7.05	Faults / Defects are reported appropriately and is there a system in place which works well for the home to rectify faults and defects (test this by visual observations)?	x		Faults are reported daily			x	

7.06	The handyman undertakes daily visual checks of all areas of the home to ensure there have been no intruders, that areas are secure, escape routes are clear, room temperatures are above 21*C, the fire alarm is working etc. – these are recorded in the maintenance manual		x	Staff on duty are nominated to complete		x		
7.07	The handyman undertakes weekly tasks of flushing through unoccupied areas, rinsing the sluice machine, passenger lifts are safe to use, exterior lights are working correctly and the garden is maintained – these are recorded in the maintenance manual and fire log book		x	Staff are nominated to do this		x		
7.08	Health & Safety Posters are completed with contact details and displayed in the staff areas of the home	x		Evidence seen			x	
7.09	There is an active home H&S Committee comprising of staff from all departments and residents that meets quarterly. Minutes of the meeting are taken and an action plan is produced.		x	No		x		

7.10	The handyman undertakes monthly tasks of recording hot water from baths, showers and basins, cleaning of showerheads and window restraints – these are recorded in the maintenance manual	x		Staff are nominated to do this			x	
7.10	The handyman checks bedrails weekly to ensure safety and records	x		Checked monthly		x		
7.11	The handyman undertakes annual tasks of checking portable electrical appliances and fire compartmentalisation – these are recorded in the maintenance manual	x		Jan-16			x	
7.12	Where there are any cause for concern with the maintenance checks these have been discussed with the home manager	x		Yes mainrtrnance book			x	

7.13	The fire alarm is tested every 6 months and fire extinguishers are serviced by an external specialist company	x		Jan-16			x	
7.14	Plans of the home which identify fire zones, fire exits and firefighting equipment are displayed next to the fire panel	x					x	
7.15	An external specialist company undertakes an annual fire risk assessment – last risk assessment date: December 2013	x		floor plans in place			x	
7.16	The action plans from the fire risk assessment have been completed by the manager	x		By maintenance			x	

7.17	On discovering a fire notices are place around the home near exits to inform staff/residents/visitors of what to do in an emergency	x					x	
7.18	The handyman undertakes weekly tests of the fire alarm, aid call system and checks the fire extinguishers are in good condition – these are recorded in the fire safety log book	x		Yes in order			x	
7.19	The handyman undertakes monthly tests of the Emergency Lighting and undertakes a planned fire drill – these are recorded in the fire safety log book	x		yes in order			x	
7.20	Risk Assessments are undertaken for the following areas of work – Laundry, Kitchen, Domestic, Maintenance, General Areas and Staff – reviewed at least annually by the home manager – Date last reviewed: December 2013	x		Risk assessments in place			x	

7.21	Has an asbestos survey been carried out, if so give date.			We did not see any evidence		x		
7.22	Date of last nurse call system service (annual requirement)	x		Sep-15			x	
7.23	Date of last 5 year electrical hard wire test		x	no evidence		x		
7.24	Date of last emergency lighting service (annual requirement)	x		Mar-16			x	

7.25	Date of last Fire alarm service (6 monthly requirement)	x		Sep-16			x	
7.26	Date of last gas safety certificate (annual requirement)	x		Feb-16			x	
7.27	Date of gas boiler certificate (annual requirement)	x		Feb-16			x	
7.28	Date of last hoist service (3 monthly requirement)	x		Jun-16			x	

7.29	Date of last sling inspection (6 monthly requirement)	x		Individual slings monthly			x	
7.30	Date of last legionella test (minimum of annual requirement)	x		Jun-16			x	
7.31	Date of last lift service (3 monthly requirement)			Feb-16			x	
7.32	Date of last PAT test.	x		Jan-16			x	

7.33	Evidence of waste disposal certificates	x					x	
7.34	Date of last calibration test for weighing scales	x					x	
7.35	Are pressure/motion sensor pads regularly checked? is this recorded	x		Jun-16			x	
7,36	Is emergency evacuation equipment available if required.	x		Yes			x	

7.37	Has the provider: i. taken into account service user needs when premises are designed, built, renovated or adapted; ii. ensured that the size, layout and design of premises meets current legislation and guidance and is safe for the care and treatment being delivered; iii. ensured that service users can easily access premises, and, where this is not the case, reasonable adjustments are made in accordance with the Equalities Act 2010 and other relevant legislation and guidance;	x		Yes in order			x	
7.38	Where premises are being used to deliver care and treatment, but this was not the original intended purpose, have appropriate alterations been made and are these in line with current legislation and guidance.	x		Appears in order			x	
7.39	Care home providers must ensure that they meet the requirement of relevant legislation, including health and safety, fire, electrical, building maintenance, portable appliance testing, etc. to ensure that premises and equipment are properly used and maintained.	x		Appears in order			x	
7.40	Are Health and safety risk assessments of the premises (including grounds) and equipment carried out, and are they acted on in a timely manner if improvements are required.	x		Appears in order			x	

7.41	Is all equipment used in accordance with manufacturers' instructions and only used for the intended purpose and for the intended service user(s).	x		Appears in order			x	
7.42	Has the home anticipated the needs of service users to ensure easy access to relevant facilities and the local community.	x		Yes appears in order			x	
7.43	Are rrangements in place to ensure that ancillary services, such kitchens, laundry rooms, etc. (belonging to the provider), which are used for/by service users, are used and maintained in accordance with relevant legislation and guidance and that service users and staff using equipment are trained in its use or supervised if necessary.	x		Appears in order			x	
7.44	Are comprehensive maintenance and building audits completed on monthly basis, checked and signed by the manager	x		Maintenance complete monthly we were unable to view this documentation			x	
				Regulation 15 Total Scores	0	42	117	0

Standard 8:
Regulation 16: Receiving and acting on complaints
The intention of this regulation is to ensure that anyone can make a complaint about any aspect of care and treatment planned and/or provided, and to ensure that providers investigate complaints and take appropriate and timely action to rectify any failures identified by the compliant or investigation.

8	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
8.00	The provider should have suitable complaints policies and procedures in place to ensure that all complaints are investigated and that timely and appropriate action is taken in response to any failures identified by a complaint or the investigation of a complaint.	x		Yes in order			x	
8.02	Are all complaints received investigated , is necessary and proportionate action taken in response to any failure identified by the complaint or investigation.	x		Manager reviews complaints			x	
8.03	Is the manager able to provide a summary of complaints made under the complaints system, responses made to such complaints and any further correspondence with the complainants in relation to such complaints .	x		Yes in order			x	

8.04	Does the home promote an open culture in which anyone feels able to raise concerns and, where they feel that they need to, raise it further as a complaint.	x		Yes under new management open door policy			x	
8.05	Is information about raising concerns and making complaints accessible, and does the home provide support to enable people to raise concerns and make complaints.	x		Yes appears in order			x	
8.06	Is there a system in place for assessing, investigating and responding to complaints in a timely manner.	x		New process		x		
8.07	Is there evidence to demonstrate that changes have been made as a result of any failure identified by a complaint or related investigation.	x		Yes beginning to feed back to staff		x		
8.08	Does company policy support individuals to make complaints to any member of staff, either verbally or in writing, and are all staff aware of how to respond when they receive a complaint.	x		Whistleblowing policy Although we did not see this displayed		x		

8.09	Are there systems in place to ensure complainants are not discriminated against or victimised and, in particular, service users' care and treatment affected if a complaint is made by them or on their behalf.	x		Appears in order			x	
8.10	Providers act in accordance with Regulation 20: duty of candour in respect of complaints about care and treatment that has resulted in the occurrence of a notifiable safety incident.	x		yes policy displayed although some staff did not know the meaning		x		
Regulation 16 Total Scores					0	24	18	0

Standard 9:

Regulation 17: Good governance

The intention of this regulation is to ensure that providers operate systems and processes that enable all other regulatory requirements to be met, including ensuring that providers are able to meet all the requirements of the fundamental standards.

9	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
9.00	The home is registered with the Care Quality Commission (CQC) as being fit for purpose – this certificate is displayed in a quality frame in the reception area	x		Home registered with CQC with an inadequate rating		x		
9.01	Does the manager have oversight of planning, delivery and monitoring of all care and treatment, what action is taken to mitigate risks to the quality and safety of care and treatment, and what action is taken in response to issues raised by monitoring activities.	x		New processes in place		x		
9.02	Does the home have systems and processes to assess, monitor and improve the quality and safety of services provided, are these continually reviewed to ensure they remain fit for purpose, i.e.: a full suite of audits with associated action plans which are reviewed and updated on a regular basis	x		New process		x		

9.03	Does the manager ensure there is access to all necessary information and the information is properly analysed, is considered by a person with the appropriate skills and competence, is escalated if necessary, and is understood by those using it	x		New process		x		
9.04	Are there effective systems to support communications, throughout the organisation (and to others as appropriate) about the quality and safety of services.	x		Staff meetings recently implemented		x		
9.05	Is information and records in all formats managed in accordance with current legislation and guidance (i.e. The Data Protection Act 1998).	x		Yes appears appropriate		x		
9.06	Does the provider actively encourage feedback from service users (relevant persons) and others (such as staff, other relevant bodies) about the quality of care and overall experience of engaging with the provider; such feedback can be informal or formal, written or verbal.	x		New process being developed		x		
9.07	Is all feedback received from service users/relevant persons and others listened to, recorded and responded to (as appropriate), analysed and used to improve the quality and safety of services and experience of engaging with the provider.		x	Not yet but in the process		x		

9.08	Does the provider seek the views and act on recommendations and requirements made by external inspectorates such as fire, environmental health etc.		x	No but new process being developed		x		
9.09	Does the manager audit weightloss, press ulcers, fall, accidents and incidents, falls monthly and is appropriate action taken, is this rejected in care files.	x		Commenced a new process		x		
9.10	Care Plan Audits are undertaken each month (Minimum 10% of total occupied beds or 6 per month minimum) and an action plan is produced for any omissions, actioned and signed off by the manager when completed	x		New process in place		x		
				Regulation 17 Total Scores	**0**	**66**	**0**	**0**

Standard 10:
Regulation 18: Staffing
The intention of this regulation is to ensure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements.

10	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
10.00	Are there sufficient numbers of suitably qualified, competent, skilled and experienced persons employed to meet the needs of service users and the home.	x		Yes			x	
10.01	Does the home continually assess dependency of service user and match this to staff employed to meet the needs of service users at all times.	x		Dependency scores commenced		x		
10.02	Does the home provide an induction programme which prepares staff for their role. Are new staff supervised in their role until they can demonstrate required/acceptable levels of competence to function unsupervised.	x		Old style tick box system being reviewed		x		

10.03	Are the training, learning and development needs of individual staff members assessed and met at the start of employment and reviewed at appropriate intervals during the course of employment.		x	Under review new process		x		
10.04	Are staff supported to undertake training, learning and development to enable them to fulfil the requirements of their role.	x		Yes external trainer employed but quality compliance manager taking on this role		x		
10.04	Do staff receive appropriate ongoing or periodic supervision in their role to ensure their competence is maintained.		x	Very new process		x		
10.05	Is there a system in place to monitor training, learning and development, is appropriate and timely action taken where training requirements are not being met.	x		Matrix in place but new process		x		
10.06	Do staff receive regular appraisal of their performance in their role and any training, learning and development needs identified, planned for and supported.		x	No appraisils have been conducted new manager will undertake		x		
				Regulation 18 Total Scores	0	42	3	0

Standard 11:

Regulation 19: Fit and proper persons employed

The intention of this regulation is to ensure that providers only employ staff who are able to deliver care and treatment (appropriate to their role) that meets the regulatory requirements described in Part 3 (Requirements in relation to Regulated Activity) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

To comply with the regulation, persons employed for the purposes of carrying on a regulated activity must:

be of good character have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and

be capable, by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work for which they are employed.

All staff have the opportunity to undertake NVQ training & the home has a minimum of 85% of staff with an NVQ qualification

11	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
11.00	Does the home operate robust recruitment procedures, including undertaking any relevant checks required	x		Admin assisstant manager all recruitment process			x	
11.01	Where a qualification is required for a role – either by law or the provider – the provider must have means by which it can check that staff hold the appropriate qualification(s). Review the next 4 weeks rota – are all shifts satisfactorily covered or planned to be covered	x		Admin monitors			x	
11.02	Are there procedure for ongoing monitoring of staff to ensure they remain able to meet requirements		x	Through training but no competency assessments		x		

11.03	Are there appropriate arrangements to deal with staff that are no longer fit to carry out the duties required of them.	x		Yes capability and performance reviews and disciplinary		x		
11.04	Are there effective recruitment and selection procedures must be in place that comply with relevant legislation and guidance and enable information about candidates (set out in Schedule 3 of the regulations) to be confirmed prior to employment. These include (but are not limited to): proof of identify, eligibility to work in the UK, qualifications, registration with professional body (as	x		Appears in order			x	
11.05	Are staff supervision undertaken every 2 months and entered on to a supervision matrix		x	This is a new process there will be going forward a minimum of 6 in a twelve month period. The intrim manager has a matrix and all staff have either received 1:1 or group supervisions.		x		
11.06	During supervision staff are encouraged to discuss any concerns about risks to people, poor practice etc.		x	This is not formally discussed in their supervisions but they have recently received training		x		
11.07	Performance Appraisals are undertaken before the end of the 6 month probationary period to confirm permanent employment then annually thereafter		x	This is not completed		x		
11.08	Staff breaks are planned and staggered	x		The nurse in charge allocates and designates breaks.			x	

11.09	Staff only smoke in designated staff smoking area and use their mobile phones on official staff breaks	x		Yes seen in practice			x	
11.10	Staff meetings take place in the home at least monthly – minutes are recorded and displayed	x		Staff meeting are now being undertaken			x	
11.11	Staff Surveys are undertaken at least once a year		x	Being developed		x		
11.12	Individual Personal Development Plans are in place for all staff		x	No		x		
				Regulation 19 Total Scores	**0**	**42**	**18**	**0**

Standard 12:
Regulation 20: Duty of candour
To meet the requirements of this regulation, the provider must ensure an open and honest culture exists across and at all levels within its organisation.

12	Evidence of Compliance	Yes or NA	No	Comment/Evidence Seen/Feedback/Action Plan Requirements	Weighting			
				Score Per Weighting	8	6	3	5
12.00	In your view, does the manager act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. If you have concerns please clearly explain these concerns.	x		No concerns			x	
12.01	As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, does the provider: notify the relevant person that the incident has occurred provide reasonable support to the relevant person in relation to the incident, including when giving such notification.	x		Yes new process			x	
12.02	Do notifications include providing a truthful account of the incident, providing an explanation in writing about the enquiries and investigations that will be undertaken and offering an apology in writing. Does the provider maintain appropriate written records and offer reasonable support in relation to the incident.	x		Yes new process			x	

12.03	Does the home have policies and procedures in place to support the culture of openness and transparency required by the duty of candour, and are all staff aware of these and follow them. Do they include encouraging open and transparent reporting of errors and incidents.	x		Yes			x	
12.04	Has the manager made all reasonable efforts to ensure that staff operating at all levels within the organisation understand and operate within a culture of openness and transparency, this includes providing relevant training and support for staff.	x		Yes		x		
12.05	In cases where a relevant person informs the provider that something untoward has happened, does the provider treat the allegation seriously and immediately consider whether this is a notifiable safety incident and take appropriate action.	x		Yes			x	
12.06	When the manager becomes aware that staff have not acted in accordance with the requirements placed on them under the duty of candour, do they refer the individual(s) concerned to their relevant professional regulator/body, police other relevant body etc.	x		Yes			x	
12.07	Where the service user affected by an incident lacks capacity, or it is felt that it would be counterproductive to disclose information, are appropriate arrangements in place to support best interest decisions and relevant persons are notified.	x		New process		x		

12.08	Are various Confidential Surveys are sent out each month to identify levels of satisfaction and areas of concern about the service provided – issues raised are acted upon		x	No		x		
12.09	The Outcome of Satisfaction Surveys are displayed in the home together with information about any remedial action taken		x	No		x		
				Regulation 20 Total Scores	**0**	**24**	**18**	**0**

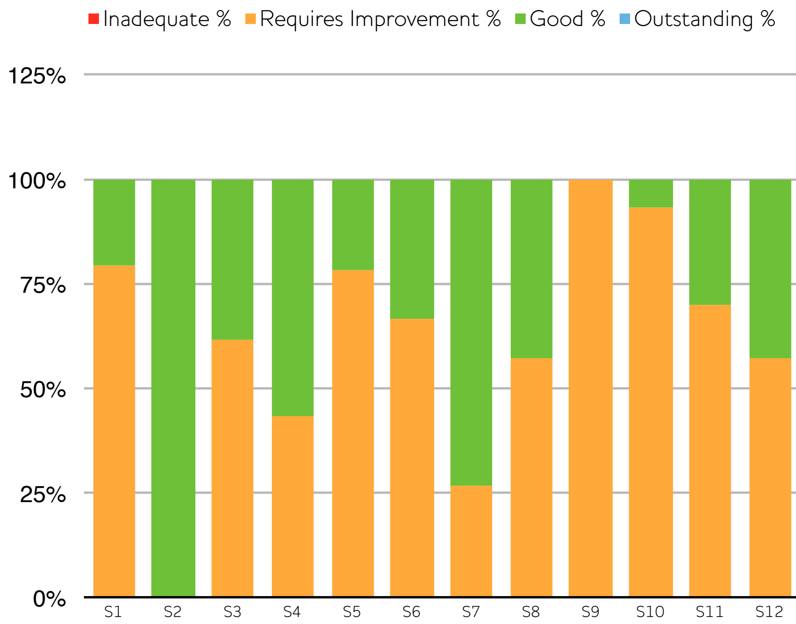
COMPLIANCE AUDIT TOOL (CAT) - CQC (England)

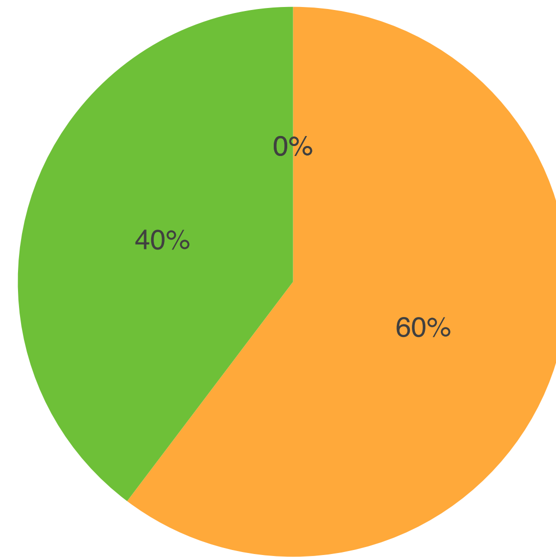
CAREPORT

Fundamental Standard	Inadequate	Requires Improvement	Good	Outstanding	Inadequate %	Requires Improvement %	Good %	Outstanding %	Total Score
1	0	126	33	0	0%	79%	21%	0%	159
2	0	0	21	0	0%	0%	100%	0%	21
3	0	24	15	0	0%	62%	38%	0%	39
4	0	84	111	0	0%	43%	57%	0%	195
5	0	96	27	0	0%	78%	22%	0%	123
6	0	36	18	0	0%	67%	33%	0%	54
7	0	42	117	0	0%	26%	74%	0%	159
8	0	24	18	0	0%	57%	43%	0%	42
9	0	66	0	0	0%	100%	0%	0%	66
10	0	42	3	0	0%	93%	7%	0%	45
11	0	42	18	0	0%	70%	30%	0%	60
12	0	24	18	0	0%	57%	43%	0%	42
WS HOME WEIGHTINGS	0	606	399	0	0%	60%	40%	0%	1005

COMPLIANCE AUDIT TOOL (CAT) - CQC (England)

CAREPORT





This care home is deemed to be..........following this audit.
Inadequate/Requires Improvement/good/outstanding

Assessors Notes	
Please itemise your points and keep to one point per note	
Point	**Note**