Inspection Report

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

Cordwainers

Chase Lane, Off Chase Road, Lindford, GU35 0RW

Tel: 01420472459

Date of Inspections: 01 May 2014
29 April 2014

Date of Publication: May 2014

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Solor Care Group Limited
Registered Manager	Ms Jacquetta Woolford
Overview of the service	Cordwainers provides residential care and support for eight people who may have physical and learning disabilities. The home is situated in Lindford near Bordon, Hampshire.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	6
More information about the provider	6
Our judgements for each standard inspected:	
Consent to care and treatment	7
Care and welfare of people who use services	9
Management of medicines	11
Supporting workers	13
Assessing and monitoring the quality of service provision	15
Information primarily for the provider:	
Action we have told the provider to take	17
About CQC Inspections	19
How we define our judgements	20
Glossary of terms we use in this report	22
Contact us	24

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 29 April 2014 and 1 May 2014, 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 carers and / or family members, talked with staff and talked with commissioners of services.

What people told us and what we found

At our last inspection in September 2013 we judged the service was not compliant with the essential standard relating to consent, because mental capacity assessments and best interest decision making had not been carried out in relation to medical interventions. When we visited in April 2014 we followed up on areas of non-compliance and reviewed other essential standards relevant to people's care.

For this inspection, we spoke with the registered manager and operations director, three staff members, a care manager and four relatives. The first part of the inspection was a visit to the home. The second part of the inspection involved telephoning relatives, staff and a care manager from adult social services to ask for their views of the service. We did this because people using the service had complex needs and those who would have been able to describe their experiences of care were out of the home during our visit. During the site visit we sampled the records of five people using the service and observed interactions between people and staff.

We set out to answer our five questions; Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

Below is a summary of what we found. If you wish to see the evidence supporting our summary please read the full report.

Is the service safe?
Relatives and the care manager from adult social services said they were confident that people using the service were treated with respect and dignity by the staff. We observed good interactions between staff and people using the service and staff understood how to protect people from abuse.

All staff we spoke with understood that people had the right to make their own decisions about their care. Not all had completed recent training in the Mental Capacity Act 2005 and

were unsure about how to assess people's capacity. Although the provider had carried out mental capacity assessments relating to medical procedures there was not a robust system in place for assessing people's capacity for making other decisions about their care. This meant it was not clear how the provider judged that people needed supported 'in their best interests' or concluded that some people did not have the capacity to make specific decisions. This meant there was a risk that people were not being supported in line with the legislation relating to consent, and we judged the service was not compliant with this essential standard. Procedures in relation to the Deprivation of Liberty Safeguards were about to be reviewed in the light of recent changes to the legislation.

There was a system in place to make sure the manager and staff learnt from events such as accidents, incidents and investigations. This reduced risks to people and helped the service to continually improve.

Procedures for the safe management of medicines were not always followed which meant people were at risk of not receiving their prescribed medications. We judged the service was not compliant with the essential standard relating to medicines management.

Is the service effective?
People's health and care needs were assessed with their involvement and that of their representatives. People's specific mobility and communication needs were assessed and people's care was informed by appropriate professional advice from healthcare professionals.

The premises had been sensitively adapted to meet the needs of people with physical impairments whilst retaining a homely environment.

Staff had completed their mandatory training however they had not received regular supervision. This meant that staff were not given sufficient opportunity to discuss any issues relating to their roles or review their specific training and support needs.

Is the service caring?
People were supported by kind and attentive staff and relatives said the staff were excellent. We saw that care workers understood how best to support and encourage people and we observed people appeared happy and relaxed. Relatives were positive about the care provided, and we heard comments such as "[Their relative] couldn't be at a better place," "It's a very loving and caring home" and "It's friendly and welcoming".

People's preferences, interests and needs had been recorded and care was provided in accordance with people's wishes. Staff were able to recognise and explain how people liked to be supported.

Is the service responsive?

People had access to a range of activities including a specialist day centre as well as local pubs and the cinema. However, we were told that sometimes additional activities and day trips had been cancelled because there were not enough staff available to drive the specially adapted minibus.

Relatives we spoke with said if they had concerns they raised them with the manager directly. They also told us that they observed that staff responded to people's needs promptly to ensure they were comfortable and content. We found the service had received no formal complaints in the past year, and the service had received a range of

compliments.

The service sought medical advice or assistance in a timely way and staff were aware of people's medical needs.

Is the service well led?

The service had recently introduced a quality assurance system, which meant that records and systems were self-assessed by the manager and then scrutinised by others. However, when we visited, the provider had not notified the Care Quality Commission that the registered manager was leaving, and plans had not been communicated about how the home would be managed thereafter.

The provider had not recently sought people's views of the service, and there was no record of actions being taken in response to the last survey. Relatives were concerned that the manager was about to leave and they had not been advised of future management arrangements. This meant there was a lack of confidence about the continued management of the home and the potential risk to people's welfare.

Staff said they worked well as a team, but they too were unsure about future management arrangements. This indicated that systems were not in place to take account of people's views or those of relatives and staff to identify, communicate and implement improvements.

We have asked the provider to tell us what they are going to do to meet the requirements of the law in relation to quality assurance and risk management.

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 11 June 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.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Although action had been taken to assess capacity in relation to some specific medical interventions, we found that the provider had not assessed people's capacity to make other significant decisions in accordance with legal requirements.

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

Reasons for our judgement

When we visited in September 2013 we judged that the service was not compliant with this essential standard. We judged the provider had not acted in accordance with legal requirements when people did not have the capacity to consent and issued a compliance action requiring the service to improve. The provider's action plan stated that mental capacity assessments and best interest decision making procedures would be undertaken in relation to medical procedures and for any other significant decisions required. It also said that in–house training would be delivered by the manager in relation to the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA 2005) and Deprivation of Liberty Safeguards (DoLS) provide a legal framework for acting and making decisions on behalf of people living in care homes who lack mental capacity to make decisions for themselves. The MCA 2005 and DOLS ensure that people in care homes are looked after in a way that does not inappropriately restrict their freedom.

For this inspection, we spoke with the registered manager and operations director, three staff members, a care manager from Adult Social Services and four relatives. We looked at the support guidance for three people using the service and observed interactions when staff were supporting people.

Before people received any care, staff ensured they had consented and acted in accordance with their wishes. People using the service had different communication abilities and staff could describe how people individually communicated their agreement or refusal to assistance. Relatives told us that staff recognised people's preferences and were always caring, compassionate and patient. One relative said, "I am so pleased [their

relative] is in a place I can trust". All the relatives we spoke with said they would know if people living at the service felt unsafe or were obliged to receive care they did not want. They all confirmed they were confident that the views of people using the service were respected.

The care staff we spoke with all understood that people had a right to make their own decisions about their life at the home. We observed that people were offered choices and their views were respected. The registered manager provided an example of how they had responded when one person refused an inoculation. They explained the implications had been discussed with them and with the GP and their refusal had been respected. For another person, when they refused a blood test, an alternative diagnostic technique was used instead which they accepted. This meant the provider acted in accordance with people's wishes.

The provider had used the Hampshire County Council's mental capacity toolkit to assess one person's capacity to make a decision relating to a particular medical intervention. It was determined that the individual had capacity to make that decision, and the provider had developed a care plan to support them to understand the procedure and help them prepare for it.

For another person, we found their care plan included a Best Interest decision document, stating they did not have capacity to decide whether to apply the lap strap in their wheelchair. There was no mental capacity assessment however that showed how their lack of capacity had been determined to inform the Best Interest decision. From reviewing three people's care plans, we found that their mental capacity had not been assessed in relation to other, significant aspects of their care, for example in relation to medication or finances.

There had been no applications to the local authority to authorise a DOLS for anyone living at this service. The operations director confirmed that the provider had booked for her to attend specific training on this topic, in response to an update to the legislation following a recent Supreme Court judgement. Not all staff had received training in MCA 2005 and DOLS since the last inspection, although the provider's action plan had stated this would be provided. Training in this topic had been completed by three members of staff. Training in these topics was not mandated by the provider.

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

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

During our visit we found that people's needs were assessed and care was planned and delivered in line with their care plan. Support guidance was documented to help staff provide people's care in line with their specific needs and preferences. For example, there were plans describing how to support people with their personal care, and what aspects people could carry out independently. Similarly, there was guidance on the assistance people needed with their meals and mobility. We saw that people's care needs had been reviewed although the provider may find it useful to note that some reviews had been undertaken over four months previously. This meant there was a risk that people's care needs had changed and were not correctly reflected in their plan of care. When we spoke with staff however we found they had a good understanding of people's specific care needs and how they wished to be supported. Relatives said people were involved in reviews of their care, and family members were invited. One relative said reviews took place "Two to three times a year with the manager and key-worker. They are very useful."

Risks associated with daily living, for example for going out in the service's minibus or for using mobility equipment such as wheelchairs had been identified and plans were in place to minimise these risks. For one person we saw there was specific guidance to ensure they spent time relaxing out of their wheelchair to minimise risks to their health from sitting for long periods in the chair.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. For example, people's health needs were supported by regular visits from the provider's physiotherapy team and from routine appointments with the optician and dentist. People had been referred to the speech and language therapists when concerns had been identified with their swallowing and resulting guidance was followed. When people's health deteriorated, there was evidence that clinical advice was sought. This was confirmed by relatives and documented. We saw that guidance from health professionals had been implemented. One person had recently returned from hospital and their health records summarised the changes to their medication prescribed by the hospital consultant.

During our visit we observed that people were active outside the home for much of the

day. Some people attended the provider's day centre where they took part in cookery and others went out for lunch in the local town. Relatives told us they had been concerned about the lack of access to activities outside the home. The manager and staff said staff had been recruited who could drive the minibus, and arrangements could be made with staff from neighbouring homes to ensure transport was available for people to access daytime activities outside the home. The provider may find it useful to note that some relatives also commented that activities at the home were limited, and there was a risk people could become bored.

Staff maintained daily records of the care they provided for people. These showed that people were supported to have their teeth brushed, described their meals and activities. Relatives we spoke with were positive about the care provided. They commented, for example, "I couldn't be more pleased, the quality of care is excellent" and "[The person using the service] is happy, I couldn't fault it and [their] medical needs are met". We were also told "It's a loving and caring home, we find nothing wrong with the place," "[People] are clean and well presented" and "it's like home here, not institutionalised".

Systems were in place for the safe management of people's monies. This was confirmed by the relatives we spoke with, and we observed that care was taken to account for any expenditure accurately

There were arrangements in place to deal with foreseeable emergencies. People's files contained information to give to hospital staff should they require emergency admission, which summarised their specific needs and preferences. Arrangements were in place to evacuate people in an emergency and the home maintained an emergency pack, with important details about people using the service, emergency equipment and useful contact numbers.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines. This was because the provider's arrangements for administering medicines and monitoring their usage and storage were not robust.

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 visit we looked at the medicine records for five people using the service and talked with the registered manager and other staff about the procedures for managing medications. We also looked at how medicines were stored.

We found that appropriate arrangements were in place for obtaining medicines for people using the service. The service had a lead member of staff for managing medicines and liaising with the pharmacy. We were told that any changes to the monthly delivery cycle could be accommodated, with new prescriptions delivered within a 24 hour period.

From reviewing people's files, we saw that the administration of medication support guidelines included information about how people preferred to have their medication. However, there was no information in people's support guidelines detailing their specific medication and what it was for. This meant information was not available to help staff talk to people about what their medication was for. It was also difficult to monitor the impact of any changes to people's medication over time.

The service's medicine administration charts were prepared showing photographs of the person for whom the medication chart related to and their allergies. When we reviewed these charts we found some errors. For example, one person's chart had been signed to show their 12.00 medications had been administered when the actual time was only 11.20. For another person, they had not received one of their medicines required at 09.00. We also found the wrong administration sheet was in use for this person. The sheet is use was meant for the previous month's delivery cycle and the dates had been changed at the top of the page by pen. We found the correct sheet had been filed away in error. We advised the registered manager that appropriate arrangements were not in place in relation to the recording of medicine, and this was investigated immediately.

We observed that a container of drink-thickening powder, prescribed for one person to aid swallowing, was on the drinks trolley. This was used to thicken both the drink of the person

it was prescribed for, and also another person's drink. This meant medicines were not given to people appropriately in line with their prescriptions.

The weekly stock monitoring system was not effective. The monitoring record showed the quantities of medicines supplied, but did not include the existing stock levels carried over from the previous delivery, which meant it was not possible to track the usage of the medicines. Stock checks of one particular medicine delivered by skin patches, administered every third day, were not carried out safely. These medicines were prescribed and administered to two people and kept in a locked cupboard, not the medicines cabinet. For one person, the weekly audits had not been undertaken since 2 April 2014 for this medicine, and there had been a gap in weekly checks between 3 March 2014 and 20 March 2014. There had been no stock audit set up for the other person prescribed this medicine. This meant there was a lack of consistency and accuracy in the medicines auditing system. There was a risk that people could be given the wrong medicines and this would not be identified.

When people went out for the day, the staff took any medicines they required in dedicated, lockable containers. The service had a system for staff to sign when the medicines were taken out and returned. This required that two staff members sign to show the medicine has been returned. However, the log book showed that the second staff signature had been omitted on various occasions.

For those people with a diagnosis of epilepsy, we saw that there were support guidelines in place for the treatment of seizures. People had not been prescribed pre-filled syringes for this, and the registered manager was intending to request this change.

Medicines were stored in a locked medicines cabinet in the service's treatment room. Medicines that required refrigeration were stored in a locked box within the domestic fridge. The service had a system for monitoring the temperature of medicines storage. However we found that the fridge temperature was not being measured by an accurate thermometer and the records were not completed correctly. This meant there was a risk medicines were being stored at inappropriate temperatures, outside the range recommended by the manufacturer.

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 received consistent support and training to deliver care and treatment safely and to an appropriate standard.

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

Reasons for our judgement

When we visited we looked at training records for staff and records of supervisions and appraisals. We also spoke with staff, the registered manager and relatives of people using the service.

During our visit, we observed that people were relaxed with staff and enjoyed their company. Staff communicated effectively with people and demonstrated a good knowledge of their care needs, interests and emotions. One relative commented, "The staff are lovely; it's like an extended family here."

From looking at records, we found that staff had completed their mandatory training. This included training in safeguarding vulnerable adults, infection control, non-violent crisis intervention, and moving and handling. Mandatory training did not include training in the Mental Capacity Act 2005 (MCA 2005). The provider's action plan to the Care Quality Commission, following the previous inspection in September 2013, had stated that staff would receive training in this topic. The registered manager had requested classroom training in this topic and confirmation of dates was still awaited. At the time of this inspection, only three staff had received update training in the MCA 2005.

Staff we spoke with confirmed that they were up to date with their mandatory training, and that they were required to pass competency tests of any e-learning courses, in order to show the training had been completed. Although staff had completed training in medicines management we found that in practice, the procedures were not robust. This indicated there were gaps in their understanding of procedures which had not been identified.

Staff supervisions had slipped. The most recent supervisions had been held in January 2014, when the senior care worker and registered manager had carried out supervisions with 60% of staff. The registered manager said she had not carried out staff appraisals since her appointment in summer 2013, and appraisals had not been booked as she was leaving at the end of April 2014. This meant staff were not given sufficient opportunity to

discuss any issues relating to their roles or review their specific training and support needs.

When we spoke with staff they were positive about the teamwork and support they had received from colleagues and the registered manager. They were concerned however that the registered manager was leaving shortly and they were not aware of the management arrangements that would be in place to provide them with adequate ongoing management support. Relatives were also complimentary about the skills and commitment of the staff, but were concerned that care staff would not receive the necessary leadership and support in their roles without a permanent manager.

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 not established an effective system to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. This had a moderate impact on people using the service.

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

Reasons for our judgement

When we visited we found the provider's arrangements for assessing and monitoring the quality of the service were not sufficiently robust. For example, we found the medicines management auditing system was not effective and this meant people could be at risk of not receiving their correct medication. The service had however been inspected by the pharmacist in March 2014 and the areas of concern we identified had not been identified at that audit.

We found that the provider had not recently sought the views of people who use the service, their representatives or staff. There was not an effective system for ensuring staff received regular supervisions. When we spoke with relatives they were very positive about the care provided by the staff and valued the service greatly. However, they also said they were concerned about reduced opportunities for people to go on trips. They could not recall being asked for their views on the service, and the registered manager was not familiar with actions required from the previous survey. We found the provider had not actively sought people's views to identify possible areas for improvements and implement changes.

We had reported to the provider in September 2013 that arrangements for obtaining people's consent in accordance with the Mental Capacity Act 2005 were not suitable. From this inspection, we found that effective arrangements had not been fully implemented to ensure people's capacity to make decisions was assessed and documented in line with legislation. This meant the provider had not taken full regard of the Care Quality Commission report to implement systems for assessing and documenting people's mental capacity.

The operations director showed us the provider's new approach to monitoring the quality of the service, which included self- assessment by the service and spot checks. This had recently been introduced and involved a self-assessment covering the key essential

standards of quality and safety. Areas of improvement had been identified from the self-assessment, for further action. For example the self-assessment scored 33% for the essential standard relating to outcome 16. This showed that systems for monitoring quality and assessing risk had been introduced, but were not yet embedded in practice.

We saw systems for reviewing some aspects of health and safety were in place. For example, there were routine weekly and monthly checks of facilities and equipment. The premises had been sensitively adapted to meet the needs of people with physical impairments whilst retaining a homely environment. The home was in a good state of repair and relatives told us that they found it clean and well organised. They were complimentary about the leadership with the home, and we saw many compliments in the visitor's book at reception.

We were however concerned that the registered manager was leaving at the end of the month and that revised management arrangements had not been communicated to staff, relatives and the Care Quality Commission (the Commission) in a timely way. We were not assured that the new quality management systems would be developed effectively without clear leadership.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The registered person must have suitable arrangements in place for obtaining and acting in accordance with consent of service users in relation the care and treatment provided for them. Regulation 18
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of making of appropriate arrangements for the obtaining, recording , handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13
Regulated activity	Regulation
Accommodation for	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations**

This section is primarily information for the provider

persons who require nursing or personal care	**2010** **Supporting workers**
	How the regulation was not being met: The registered person must have suitable arrangements in place to ensure people employed to carry out the regulated activity are appropriately supported to deliver care safely and to an appropriate standard, by receiving appropriate training, professional development, supervision and appraisal. Regulation 23(1)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided. This is by having regard to the views of people using the service, relatives and staff and by having regard to reports prepared by the Commission relating to compliance. Regulation 10 (1)(a)(2)(b)(v)(e)

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 11 June 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

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.