Inspection Report

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

Friston House

414 City Way, Rochester, ME1 2BQ

Tel: 01634403556

Date of Inspection: 17 October 2013

Date of Publication: November 2013

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

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✓ Met this standard
Safety, availability and suitability of equipment	✓ Met this standard
Staffing	✖ Action needed
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Barchester Healthcare Homes Limited
Registered Manager	Mrs. Linda Donovan
Overview of the service	Friston House provides accommodation, residential and nursing care for up to 81 older people. The home comprises three units. The main building has two floors and accommodates people with residential needs with early onset dementia on the ground floor; and people with nursing needs on the first floor. There is a separate "Memory Lane Unit" for people who have dementia care and nursing needs. The home has garden and courtyard areas available for all of the people living in the home.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 17 October 2013, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with staff and reviewed information given to us by the provider.

What people told us and what we found

There were three units in the home. One of which cared for people with dementia which meant that we were not able to ask them about their experiences. We spoke with people who lived on the other units and observed the care provided on the dementia 'Memory Lane' unit.

There was a calm relaxed atmosphere on the residential and first floor nursing unit. People we spoke with were complimentary of staff and thought they were kind and caring.

Our observations, discussions with staff, visitors and people who used the service demonstrated that staff were very busy. We saw that this impacted on the care they provided particularly on the Memory Lane unit.

Not everyone who lived in the home received consistency of care and support that met their needs as not all staff read the care plans. Communication at handover between shifts did not always give the staff the information they needed to ensure they were aware of peoples changing needs.

People were provided with a choice of nutritious meals and snacks. The chef understood the importance of fortifying meals. We saw that staff on the Memory Lane unit, however lacked understanding in this area.

We saw that there was sufficient equipment to meet people's needs.

Staff received training and support appropriate to their role.

There was an effective system to regularly assess and monitor the quality of service that people received.

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 03 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

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

People's needs were assessed and care and treatment was planned but not delivered in line with their individual care plan.

We spent time on all three units looking at care plans and records maintained to monitor care given. We also spoke with people who lived in the home, visitors and staff and observed the support provided.

On the residential unit people we spoke with were happy with the care provided. We saw that people asked staff questions and they were answered in a patient and caring manner. We saw people making bead necklaces and joining in to do a jigsaw. People were chatting to each other and there was a calm and relaxed atmosphere. The care plans we looked at were clear and gave consistent information about people's needs. Each care plan was supported by a risk assessment which showed staff how to care for people safely. They stated what people could and could not manage to do for themselves, identified individual likes and dislikes and there was evidence that people's life histories had been discussed with them. This meant that staff had enough information about each person so that they would be able to understand and meet their individual needs.

We saw that most people who lived on the upstairs nursing unit remained in bed for reasons of ill health. People we spoke with all told us that they were happy with the care provided. They said that staff were kind and caring. When we spoke with staff they told us that they read the care plans and felt that they gave them the information they needed to support people. The plans we looked at covered the different care and nursing aspects of peoples care and were supported by risk assessments. This meant that staff were given the information they needed to promote consistent care.

We looked at how tissue viability was monitored on the upstairs nursing unit. We were told that there was only one person on this unit who had a pressure sore which needed dressing. We saw that there were records about the care needed and updated assessments about any changes in wound management. This meant that people's skin care was monitored and they were protected from the risk of harm.

We observed the care provided on the Memory Lane unit. We met with one person in their room. We noted that their catheter bag was full. We asked a member of staff to check this for us. They found that the valve on the 'leg bag' had not been opened to allow drainage into the night bag. She told us that she thought that night staff had forgotten to open the valve. We also noted that they had a pillow over their legs and staff told us that this pillow should be under their legs to relieve pressure areas. This meant that care was not delivered to meet this persons needs safely.

We looked at the care plan for this person who had been identified as having two pressure sores. The care plan stated that this person should be repositioned very two hours during the day and every four hours during the night. We saw that one of the pressure sores was not identified on a body map and that this was undated which meant staff may not know when any new pressure sores were identified. The repositioning charts showed that staff were not turning this person in line with their care plan which meant that their skin integrity was not being maintained safely. A member of staff said, "I didn't know about the repositioning instructions and it hadn't been mentioned at handover". Two other members of staff told us that they didn't have time to read the care plans, although a new member of staff confirmed that they were reading the care plans. This meant that consistency of care was not being provided in order to meet people's individual needs.

We saw that there was one person who was frequently distressed and calling out. We noted that staff walked past their room without looking in and checking to see if there was anything they needed. We spent time in the lounge and observed staff support. We saw that the activities coordinator was working with a group of people at a table in the corner of the lounge. There were games and singing along to music. People who joined in these activities appeared happy and engaged with what they were doing. We saw, however, that there were other people in the lounge who did not join in the activities. There was one lady who was not happy and was calling out and swearing. Staff did not spend any time reassuring this person. We saw that care staff only came into the room when they were brought someone else to sit in the room either in a chair or their wheelchairs. We saw that staff didn't always tell people when they were going to move them and observed staff moving wheelchairs from behind without telling the person what they were going to do. This meant that staff did not take people's wellbeing into account.

We saw on two units the handover between staff shifts did not always make sure full information was communicated between staff in order to promote consistency of care. On the upstairs nursing unit a visitor told us that there had been some issues with the care their relative received. They told us that they had spoken with the manager and this had been resolved for one shift, but said, "When there was a changeover of staff the same mistakes were repeated". We were also told by a member of staff that there were no formal procedures for handing over information between shifts. On the Memory Lane unit staff told us that they had not been given information at handover. This meant that staff may not always be made aware of people's changing needs.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People were supported to be able to eat and drink sufficient amounts to meet their needs and were provided with a choice of suitable and nutritious food and drink.

We looked at how people were supported with their meals and observed their experiences at lunchtime. We spoke with the chef, staff who were supporting people with their meals and people who lived in the home.

People we spoke we were complimentary about the meals. Comments included, "The meals are always nice", and "I enjoy what they serve you here". The chef told us that some people had complained that the soup was too salty but stated, "We have resolved that now". This meant that people generally enjoyed their meals and any concerns raised about the meals were listened to.

We looked at care plans and records for monitoring people's nutritional and hydration needs. We saw that each person had a care plan that identified their nutritional needs. The records we looked at showed people were weighed on a regular basis and referrals had been made to appropriate healthcare professionals such as the dietician and speech and language therapist. Where appropriate people were provided with food supplements such as 'ensure' to help meet their nutritional needs. This meant that people's nutritional needs were identified and taken into account when maintaining their diets.

We saw that food and fluid charts were maintained so that staff could monitor what people's intake was. The records we viewed, however, were not all completed in a way that monitored peoples nutrition and hydration needs safely. Records on the first floor nursing unit were difficult to locate and had not always been completed; for example staff did not always record what people had to eat or how much they had eaten. Records on the Memory Lane unit did not show that people had been given sufficient drinks. For example one person had been recorded as having a drink at 13.00 hours on one day and there was no further record of drinks being given on the chart in their room until the following morning. Records kept elsewhere showed they had been given a drink in between those times. This meant that monitoring of people's intake was not promoted by consistency of record keeping.

We observed the lunchtime meals on the different units and found that people's

experiences were different depending on which unit they were living on. On two of the units we saw that people received support that was appropriate to their needs. For example on the first floor nursing unit we saw that most people remained in bed. We observed staff giving out meals and saw that they checked with each person what they would like to eat from the menu. Staff told us how they supported people with their meals and were able to describe the different help people needed. On the ground floor unit people used the dining room and we saw that the atmosphere was relaxed and people received the help they needed. This meant that people were given the support they needed to eat their meals.

However on the Memory Lane unit we saw that people's experiences were different. We observed that staff started to move people to the dining room thirty five minutes before the meal was served. This meant that some people had to wait a long time before their meal was served. We saw that space was limited and when the chef brought the hot trolley through to serve the meals we noted that they accidently bumped into someone's chair due to the difficulty of manoeuvring the trolley through the dining area. We observed that people were not offered choices in a way they could understand. For example there were no pictorial menus available and although the manager told us that people should be shown a choice of the meals when they were served, a member of staff told us that this did not happen. This meant that people who lived on this unit were not supported in a manner that met their needs.

We spoke with the chef and they showed us that they were familiar with different dietary needs. There were records maintained in the kitchen that listed people's individual needs. The chef was able to tell us about different dietary needs such as diabetic or high fibre diets. They told us how they fortified foods such as adding full fat milk, cream or butter to increase people's calorie intake. This meant that meals were arranged in accordance with people's needs.

We found, though, that when we spoke with staff on the Memory Lane unit that they were not aware of fortifying people's food which was served on the unit. For example we saw that one person had been assessed as being at risk of malnutrition and needed their food intake increased and required their meals to be fortified. Advice had been sought from the dietician because of significant weight loss. Staff told us they had given this person two weetabix for breakfast that morning. They had not offered any other foods such as scrambled egg which was prepared by the chef and had not fortified this person's breakfast in any way. The chef explained that they provided a range of snacks that were sent to the units each day so that people would have a choice of healthy and nutritious snacks in-between meals. This included a range of sandwiches, fresh fruit, biscuits and yoghurts. Staff however on the Memory Lane Unit told us that fresh fruit was served from the kitchen in the afternoons but they did not think, "There was anything suitable for people who were on soft diets", although them manager and chef had both confirmed that nutritious 'smoothies' were provided.

The provider may find it useful to note that staff on the Memory Lane unit did not always understand the nutritional support that people needed. This meant that people may not always benefit from meals that were nutritionally balanced in accordance with their needs.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

People were protected from unsafe or unsuitable equipment because the provider had ensured there was enough equipment to protect people who used the service.

We looked around the home at the equipment which was in use.

Equipment included lifts to the upper floor, aids and adaptations around the home to assist people to move about.

We saw that each unit had sufficient hoists so that people could be moved safely. We were told that people had their own slings so that there was suitable equipment that met individual needs. The care plans we looked at stated what equipment people needed to assist them with any movement and handling needs such as hoists or slide sheets for example.

Hospital style beds were provided. We saw that beds had rails attached and there were agreements in care plans to show that people consented to having the bedrails up. Where people chose not have the bedrails we saw that this was recorded in the care plan. This meant that people could make a choice as to whether they wanted bedrails.

Where people were at risk of pressure sores due to their tissue viability we were told that they were provided with air flow mattresses. The nurse in charge of the upstairs nursing unit explained how the mattresses were maintained so that they were kept at the correct pressure to meet individual people's needs.

People had their own wheelchairs or specially adapted recliner chairs so that they were able to sit in chairs that met their needs.

We saw that there were adaptations in the bathrooms to help people in out and of the baths safely.

All the equipment we looked at was clean. The quality assurance processes showed us that equipment was serviced and maintained in accordance with the manufacturer's guidelines and any relevant registration. This meant that equipment was maintained safely.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

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

The home was set out over two floors and three units. The home was overseen by a manager who was supported by a deputy manager and individual lead nurses or team leader on each of the units.

Staff were allocated to individual units. This was so that they were familiar with people's needs and the aim was to promote consistency of care. On the Memory Lane unit there were 31 beds. Staffing was allocated so that there were two nurses and seven care staff in the morning, one nurse and six care staff in the afternoon. Between 8.00 am and 8.00 pm, one member of staff was allocated to provide one-to-one support. At night there was one nurse and two care staff at night. The upstairs nursing unit had 34 beds. Staffing levels consisted of two nurses and six care staff in the mornings, one nurse and five care staff in the afternoon and one nurse and two care staff at night. The residential unit had 15 beds and was supported by three care staff during the day and two at night. The manager told us that the staffing levels remained the same at the weekend.

The manager told us at the time of our visit that they had one vacancy for a trained nurse. She explained that they used a supply of bank staff to cover any additional shifts.

We looked at the rotas for a two week period for the end of September and beginning of October. We saw, however, that the rotas did not always reflect the stated staffing levels. We noted that the residential unit rotas always stated that the correct allocated number of staff were on duty. However we saw the rotas for the other two units were not as clear and indicated that there were some shifts that had not been covered. For example on the Memory Lane unit we saw that one day had identified five staff on duty in the afternoon, not six staff as designated. On another day we saw that there were six staff in the morning and not seven. On the upstairs nursing unit we saw there were days when staff had been recorded as being off sick, but there were no staff names entered as replacement cover. This meant that staff rotas did not show if the home was appropriately staffed.

We spoke with staff on all three units. Staff on the residential unit told us that they felt they had the time to support people and assist them with all their needs. Staff on the upstairs nursing unit told us how that they were very busy. They said, "We are always busy in the mornings and it can take a long time to get people ready for the day and sometimes we don't finish until 11.30 am". We asked staff how they managed this and they told us that people needed regular turns to prevent pressure sores and also regular safety checks. Staff told us, "When we check people we make sure that they are comfortable and clean. If someone needs a pad changing we will make sure that is done. We have set people to get up but we always check who might need help first and it changes every day". We spoke with relatives who were visiting the upstairs nursing unit. They told us that they thought staff were very busy. Two visitors told us that sometimes it was very difficult to find staff and that staff were often too busy to spend time with people". People who lived on the unit told us that staff were very kind but, "Didn't have time to talk". We also noted that when a call bell sounded, staff were often too busy to respond immediately. We observed that there was one person who was sat in a lounge area during the time of our visit and we noted that they received very little interaction from staff. Overall this meant that, although we found staff on this unit understood how to make sure peoples were met, they were often too busy to respond in a timely manner.

When we spoke with staff on the Memory Lane unit they told us that, "There are not enough of us to be able to get everyone up, most people need 2 people to wash and dress them." "We do not have time to get everybody up before 12.00" and, "Staff work long days so they have to go off for their breaks which leaves us short." "Sometimes you can't find anyone on the floor to take over from you." We saw that one person was not washed, dressed and brought to the lounge until 12:10 pm on the day of our visit. This showed us that staff felt under pressure and that they were unable to meet people's needs in a timely manner.

We saw that staff spent very little time in the lounge engaging people in conversation during the morning, they were too busy getting people washed and dressed. Staff said, "We don't have time to spend talking to people, the only time we have is when we are doing personal care." We noted that when some staff entered the lounge area they did not talk to people other than to say, "Alright X" as they walked past. We saw that some care staff spent some time in the lounge at the end of the morning of our visit but they were writing up people's daily notes. We had to bring staff's attention to three occasions where we saw people were at risk of either falling from their chair or their privacy and dignity was not respected. This was because staff were too busy elsewhere on the unit.

We spoke with the manager and area manager about how staffing levels were allocated to each unit. They told us that people's support needs were analysed individually when they moved into the home. We asked to see these records but they had not been completed. There had been no unit by unit or whole home analysis of people's needs on which staffing levels were decided which took account of people's on-going changing needs. This resulted in staff being unable to respond to people and fully meet their care needs.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Staff received appropriate professional development. Staff were able, from time to time, to obtain further relevant qualifications.

We looked at the induction pack and induction training records for the home. We saw that staff were given workbooks to complete in areas of support such as effective communication, promotion of good skin care, safeguarding, continence care and completing documentation. Staff training records showed that all staff had completed their induction. We spoke with a member of staff who had recently started work at Friston House. They told us that they had completed induction training that had included watching training videos, orientation with the training officer and shadowing more experienced staff on duty. They told us that they were asked if they felt they were ready to start work on shift before they were allocated on to the duty roster. They said, "I felt well prepared to start working on the unit". This demonstrated that new members of staff were given the training and support they needed before they started working with people who lived in the home.

We looked at the on-going training records for staff who worked in the home. The majority of training was completed on line with some courses delivered by the home's trainer. We saw the training records showed that the majority of staff had completed the organisation's legislative and mandatory training courses in areas such as safeguarding vulnerable adults, health and safety, infection control and movement and handling. Where there were gaps in the training the manager was aware of these. We spoke with staff about the training and support they received. Staff told us that they were supported with their training needs and attended regular training. One member of staff told us that they were completing a National Vocational Qualification (NVQ) at level 3. Staff told us that they received good support and attended staff meetings. This meant that staff felt they were given the support and training they needed to fulfil their roles.

We asked about specialist training in areas such as dementia care and were told that staff could complete a dementia awareness course on line. The provider may find it useful to note that not all staff confirmed that they had completed training in dementia care, and two members of staff told us that they would find this useful.

We spoke with visitors and people who lived in the home. They told us that staff were kind and caring and felt that they generally carried out their roles to the best of their abilities.

We saw testimonies from people whose relatives had used the service and comments included, "Thanks for all the care and love given", "Staff were outstanding" and another person commended staff on their professionalism.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We saw that a variety of methods were used to monitor the quality of the service people received. These included regular audits of all aspects of the service; direct day to day contact between the management team and people who lived in the home; observation of care and treatment, supervision of staff; regular residents and relatives meetings; staff meetings and monthly provider audits.

We looked at the last three monthly provider reports. These were carried out by the regional operations director who audited different aspects of the home each month. The manager was responsible for implementing actions and conducting a full audit of the home every quarter. We looked at the last two manager audits. We found that areas that needed improvement had been identified and action plans were implemented by the manager. This showed that the management team had taken steps to ensure that systems were effective in monitoring the quality of the service.

We discussed the shortfalls we had identified in the service during this visit. The manager told us that they were already aware of areas where improvement was needed in staffing levels and day to day management of the dementia unit to ensure that people received a good service. The manager told us about actions they were taking to address these issues.

We looked at risk management systems in the home. Records showed that all installations and equipment were serviced regularly. Regular fire safety checks were carried out, including checking fire safety equipment. A fire safety risk assessment had been carried out, the manager confirmed that this had been carried out by a suitably qualified person and approved by the Kent Fire and Rescue Service. Fire safety procedures were displayed in the home and fire drills had been carried out from time to time. Each person had a personal emergency evacuation plan in place to make sure staff knew how to support them to evacuate the building safely in the event of fire. These systems ensured that

people were provided with a safe service.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

The provider arranged for an external company to send out quality review surveys to people who used the service, their relatives and health and social care professionals every year to make sure they were happy with the service. The forms used provided an opportunity for people to express their views about the quality of the service. The responses were collated and the outcome was sent to the home to provide information about how well the service was doing in all aspects of the service. The survey for this year was underway at the time of our visit so the results were not available for 2013.

Relatives who we spoke with told us they were generally happy with the service. Comments, "I'm very happy with the home". "It's very good here, very pleasant, a very pleasant environment". The manager's office was close to the reception area of the home. We saw that people felt comfortable speaking with the manager, care and nursing staff and were free to express their view and opinions. There was an open door policy in place to make sure that the manager was accessible. We saw that relatives felt free to come to the office and talk with the manager about any concerns. This meant that people were encouraged to express their views and provided with opportunity to have direct and regular contact with the management team.

Staff who we spoke with told us they received support from the management to carry out their role. Regular staff meetings were held to make sure that staff received the information they needed and had opportunity to discuss any issues and make suggestions about how the service could be improved. We looked at minutes of staff meetings and saw that the manager raised issues and told staff where improvements were needed. Staff who we spoke with told us that they could raise any concerns and were listened to by the management of the home. This showed that staff were given guidance and supported to carry out their roles.

The provider took account of complaints and comments to improve the service.

There was a complaints procedure displayed in the entrance hall of the home so that people who lived in the home and their relatives or other visitors knew who to talk to if they were unhappy about the service. This contained information about how to make a complaint and contact details for other agencies they could talk to if they were unhappy with the service. We looked at the complaints log. This showed that complaints were recorded, investigated and responded to in a timely manner. This meant that people were given the information they needed should they wish to make a complaint about the service.

The provider may find it useful to note that we spoke with one visitor who told us that they had had some concerns about the way care was provided to their relative. They told us that they had brought it to the attention of the nurses, but felt their concerns weren't acted upon. They said that once they had escalated their concerns to the manager then appropriate action was taken. This meant that relatives did not always feel that they were listened to by the nurses on the unit.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care that was inappropriate or unsafe by means of the planning and delivery of care and where appropriate treatment in such a way to meet the service users individual needs and ensure the welfare and safety of the service user. [Regulation 9 (1)(b)(i)(ii)]
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: In order to safeguard the health, safety and welfare of service users the registered person had not taken appropriate steps to ensure that at all times there were sufficient numbers of staff employed for the purposes of carrying on the regulated activity.

This section is primarily information for the provider

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 03 December 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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