Inspection Report

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

The Croft Care Home

17 Snydale Road, Normanton, WF6 1NT

Tel: 01924223453

Date of Inspection: 14 August 2013

Date of Publication: September 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✖ Action needed
Safety and suitability of premises	✖ Enforcement action taken
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Croft Care Homes Limited
Registered Manager	Mr. Mark Hague
Overview of the service	The Croft Care Home is located in Normanton and provides accommodation for up to 29 people requiring personal care.
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'.

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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 14 August 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During our inspection of this service on 20 March 2013 we judged the provider was not compliant with Outcome 10 (Safety & Suitability of Premises), Outcome 16 (Assessing & Monitoring the Quality of Service Provision) and Outcome 21 (Records). Following that inspection the provider sent us an action plan telling us what they would do to achieve compliance. During this inspection we checked if improvements had been made.

We spoke with people who used the service, their relatives, staff and the registered manager. People we spoke with praised the staff and described them as; "very nice", "good" and "lovely".

There were no activities taking place during our visit. People told us they were bored and there was nothing to do. We saw some practices which we considered showed a lack of respect for people who used the service. For example in some en suite facilities people's toiletries were stored either on the floor or on top of the toilet cistern as there were no shelves or storage space.

People we spoke with who used the service said they were satisfied with the care they received and said they felt safe. We found improvements had been made to the care records which were now personalised and more detailed.

We found staff had limited knowledge and understanding about safeguarding, which we considered placed people who used the service at risk as abuse may not be identified or responded to appropriately. We found safeguarding policies and procedures needed updating.

We found maintenance issues were not always identified and addressed promptly. We

found some areas of the home were not clean and there were offensive odours.

We found there were systems in place to monitor and assess the quality of service.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 12 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against The Croft Care Home to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

We spoke with seven people who used the service and two relatives. The people we spoke with said they felt their privacy and dignity was respected and comments were generally positive. However, one person said they felt their privacy was only respected sometimes and only by certain staff members. We saw staff knocking on doors before entering people's rooms. We saw staff were discrete when speaking to people about personal care and ensured that people's privacy was maintained. However, we saw some practices which we considered showed a lack of respect for people who used the service. For example some people's beds had not been made properly, in some en suites people's toiletries were stored either on the floor or on top of the toilet cistern as there were no shelves or storage space.

We observed one or two people who used the service did not look well groomed. We saw their trousers and jumpers were stained and their finger nails were unclean. One relative told us they thought their relative's hygiene was not very good. They said their relative did not always look clean and they had to ask if they had had a bath. Two people told us they could have a bath when they wanted. However, another person said they were kept waiting for a bath and thought they had not had one for three to four weeks.

Staff we spoke with said people could have a bath or shower whenever they wanted. They said they asked people daily if they wanted a bath and recorded when baths had been given. We saw records which showed the majority of people had received one or two baths in the last fourteen days. However there were no baths recorded for one person. The care records we reviewed showed whether people preferred a bath or shower but did not say how often they would like one. The records did not show if people had been offered baths by staff on a daily basis. People's individual preferences regarding the frequency of showers or baths should be recorded and accommodated to ensure their personal hygiene needs are met.

People told us they were given choices such as when they got up and went to bed. Staff we spoke with said they gave people choices in all aspects of their lives from what clothes they wanted to wear, where they wanted to sit and what they would like to eat. We saw evidence of this during our visit. One person said: "Staff ask would you like this, would you like that".

We observed staff interactions with people were kind, caring and polite. We saw staff chatting with people and checking they were all right. People we spoke with made the following comments about staff: "some excellent", "staff all very nice – always respectful", "lovely" and "care staff alright, can't grumble". One person told us they felt some staff talked over them and sometimes they felt patronised.

The manager said there was no activity organiser employed at the home and it was the responsibility of the care staff to organise activities. When we visited there were no activities taking place and there was no activity programme. In the small lounge two people were watching television. In the main lounge people were either asleep or just sitting looking around. There was a television on which some people were watching. We felt there was a lack of stimulation for people and little to occupy them other than the television. When we asked people how they spent their day the following comments were made:

"Read the paper, do crosswords"
"Not a lot – just sit around – boring",
"Don't do anything",
"Sit in this chair",
"Would like to go out for walks – fed up"

We spoke with two visitors who both said they felt there could be more activities and said there was not a lot for their relatives to do. We discussed this with the manager who told us that activities had lapsed since March. This was confirmed by staff we spoke with who told us due to staff shortages they often did not have time to organise activities. They said that they tried to take people out to the local shops when staffing levels permitted. We saw records that showed an external person visited the home every month and provided group activities such as sing-a-longs and craft sessions. Staff told us a local minister visited the home every Sunday to provide holy communion and one person went out to a local church. In the care records we reviewed we saw detailed information about people's past lives and interests and hobbies they had enjoyed. However there was no evidence to show that this information had been used to inform a social programme to meet people's needs. We saw daily records were well recorded, however the content focused mainly on physical care needs and the meals people had during the day. There was little information to show how people had spent their days. For example the only activities recorded for one person were visits from their family and smoking. The manager told us they had audited the daily records on 8 August 2013 and identified the same issues and they were in the process of addressing these with staff.

Many of the people who used the service had dementia. We saw there were pictorial signs on toilet and bathroom doors and people's names on their bedroom doors. We saw in the dining room there were reminiscence posters and pictures of the local area as it was many years ago. There was also a notice asking relatives to bring in items for memorabilia boxes which the home were looking to introduce. However we found parts of the environment were stark and functional. For example all doors were the same colour and the corridors

were one colour with only a few pictures to provide any interest. There was no information provided to orientate people to the day, date or season. One clock we saw was set to the wrong time. People with dementia can be highly affected by their surrounding environment in either a positive or negative way. We would expect to see that the home had considered research and guidance on providing a suitable and stimulating environment for people with dementia.

We asked the manager how often residents meeting were held. He told us they were held every three months, however, he said there had not been a meeting since March 2013. The manager said one had been planned for 25 July but had been cancelled. A further meeting was scheduled for 19 September 2013.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

The manager told us he had introduced a keyworker system whereby each person was allocated two staff, a senior care assistant and a care assistant. Staff told us "keyworkers" liaised with families, were responsible for updating care plans and for keeping people's rooms tidy. We saw notices in people's rooms naming their keyworkers.

We reviewed three care plans and found overall improvements in the documentation, which was more personalised and detailed. (We have reviewed this in outcome 21).

The provider may find it useful to note that staff we spoke with were not aware of the Mental Capacity Act 2005 or Deprivation of Liberty Safeguards (DOLs). The manager confirmed staff had not received training in these topics. We considered it essential that staff had knowledge and understanding of this legislation as many of the people who used the service had dementia which may impact on a person's capacity to make some decisions.

People we spoke with who used the service said they were satisfied with the care they received and said they felt safe. One person said they felt staff knew them well and knew what they needed. Other comments included:

"Smashing, like being at home. Well treated, well fed and well looked after",
"Feel settled here, quite content",
"Staff ask if I'm comfortable and have what I need".

One relative said they felt the home kept them informed of any changes and felt their relative was given the care and assistance they needed.

We saw that staff were present in the lounges and regularly checked on people who were in the smoking room or small lounge. We saw that people were attended to promptly. Staff we spoke with showed a good understanding of people's needs and were able to describe the care and support they required.

We sat with people in the large lounge and dining room and observed lunch. The meal

was a choice of either bacon or sausage with mashed potatoes and green beans. We saw staff offered each person a choice. We saw two people were shown the meal to help them decide what they wanted. We saw that people who didn't like either option were given an alternative. We saw staff assisting people who needed help with their meals by sitting with them individually. We saw the evening meal was served at 4pm, which we considered to be early. We asked the manager about this and he told us the people who lived in the home chose to have their evening meal at this time. He said additional drinks and snacks were offered to everyone at 6pm and food and drink was available throughout the night if people were hungry. People we spoke with told us they had plenty to eat and drink, comments included:

"We're well fed and watered",
"Meals lovely",
"Food good ,enjoy every meal"

We found people received the care and support they required to meet their needs.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

We looked at how the home protects people from the risk of abuse. We looked at the provider's safeguarding policy, which outlined the different types of abuse. The policy was not dated but the front sheet to the policy file stated reviewed May 2011. The policy did not refer to the procedures for reporting abuse or identify specific staff roles and responsibilities. There were no contact details for the local safeguarding team or any reference to the regional safeguarding procedures. We asked the manager if he had a copy of the regional safeguarding procedures. He said he had seen them however he was unable to locate them during the inspection.

We spoke with four staff and found they had limited knowledge and understanding about safeguarding. Only one of the staff was able to describe the different types of abuse. Three of the staff we spoke with said they either had not received safeguarding training or thought they may have had some "in the past" but did not know when. They were not clear if they had seen the safeguarding policy and procedures or where they were kept. Staff told us if they suspected or saw any abuse they would report it to the manager or senior staff member. We asked the manager how often staff received safeguarding training. The manager was unsure and said he thought it was every three years.

We were aware there had been a delay in reporting a recent safeguarding incident, which occurred when the manager was not on duty. Staff had failed to report the incident to safeguarding and had left it for the manager to make the referral when they came back on duty. The delay in this instance did not cause any harm to people who used the service, however we were concerned that senior staff failed to follow correct safeguarding reporting procedures.

We found people who used the service were not fully protected from the risk of abuse because the provider had taken not reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Safety and suitability of premises

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We reviewed this outcome as at the previous inspection in March 2013 we identified concerns around the safety and suitability of the premises. These related to maintenance issues which had not been addressed by the home. Following the inspection the provider sent an action plan outlining the improvements that would be made to ensure compliance.

The manager told us he carried out weekly checks of the environment and reported any faults or repairs identified to the provider. We saw records of these checks and the last one had been recorded on 29 July 2013. The manager confirmed this was the last check he had done. The home also had a maintenance log where staff recorded any repairs. The manager said this was checked by the maintenance person when they visited the home which was usually twice a week.

We looked round the home and saw that many of the maintenance issues we identified at the previous inspection had been addressed. For example we saw that call bell leads were now present in some bedrooms. Where call bell leads were missing we saw risk assessments were recorded which explained why and detailed the checks in place to ensure people were safe.

However we were concerned other issues had not been addressed. For example at least eight rooms we visited (ensuites and toilets) either did not have a toilet roll holder or it was broken. In at least four bedrooms we found headboards were loose and two bedrooms had radiator guards which were broken. This meant that people who used the service were at risk of injury. One bedroom door had no handle on the outside of the door and three bedroom doors slammed shut which indicated the self-closing devices were either broken or needed adjusting. This meant people were at risk of being knocked over by the door slamming shut or could sustain an injury. The grab rail in one of the toilets was very loose and needed securing. This meant people who relied on the grab rail to lower and raise themselves from the toilet were put at risk of falling. The bath taps in the upstairs bathroom

were continually running and required attention. The handle to open the window in another bathroom was missing which meant the window was not secure. Staff told us the shower room could not be used as the shower was broken. They said they had not been able to use it for some time. Staff told us that none of the people who used the service wanted a shower. However we saw documented in one person's records they preferred to have a shower.

We found many of the en suite facilities were very basic containing only a toilet and wash hand basin. There was no shelving or storage space for people to store their toiletries, which we found were either piled on top of the toilet cistern or on the floor. There was no mirror and often no toilet roll or towel holders and no paper towels dispensers.

We found the standards of cleanliness were poor. We found offensive odours in at least ten bedrooms and one of the toilets. Three carpets we saw were stained and marked. We visited these rooms when we first arrived at the home at approximately 10am and again at 4pm when the cleaner had been round the home. Although the odour was not as strong when we went into the rooms in the afternoon it was still present despite the windows being open and the room having been cleaned. We found the cleaning was superficial and rooms were not thoroughly cleaned. For example we found windowsills and the surfaces of furniture were dirty and dusty. We saw cobwebs from some of the ceiling lights. We found one room with an electric fan that was heavily covered with dust and dirt.

The manager told us the cleaner had returned from leave the previous week following two weeks off. The manager said care staff had been allocated to cleaning duties during the cleaner's absence, although some days there had not been enough staff to undertake the cleaning.

We saw a hoist stored in one of the bathrooms. Staff told us they used this for one person in the home. The maintenance sticker on the hoist said it was due for a service in September 2010. We asked the manager for the maintenance certificate for the hoist. He was unable to provide this at the inspection. However he showed us a record of monthly safety checks staff had carried out on the hoist. This showed the hoist was last checked on 25 July 2013.

We found the provider was consistently failing to identify and address maintenance issues which means people who used the service were not protected against the risks of unsafe or unsuitable premises. We found people's privacy, dignity and autonomy was not protected by the premises as basic fixtures, fittings and storage space were not always provided to ensure a comfortable and suitable environment. The premises were not kept clean and free from preventable offensive odours.

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

We reviewed this outcome as at the previous inspection in March 2013 we had identified shortfalls in the systems in place to assess and monitor the quality of service people received. The provider sent an action plan which showed the action they would take to achieve compliance.

The manager started in post in December 2012 and was registered with the Commission. The manager informed us at this inspection he had resigned from his post and the provider was in the process of recruiting a new manager.

We found the manager had systems in place to assess and monitor the quality of the service people received. We saw evidence that complaints and accidents and incidents were audited monthly. We saw that manager had updated the environmental risk assessments and had reviewed and updated the care documentation system. We saw evidence of weekly environmental checks the manager had carried out.

We saw minutes of staff meetings held in April, June and July 2013 where staff were given information about the service and were able to raise any concerns they may have. We saw topics such as infection control, care planning and staffing had been discussed at these meetings.

Staff told us they felt supported by the manager and they felt they were able to raise any concerns they had and that they would be addressed.

We saw satisfaction surveys had been sent out to relatives in February. Those that had been returned had not been collated and no feedback had been provided to people who used the service or their relatives.

The action plan stated the Director of Care would carry out a monthly visit to the home to ensure that systems were working and were effective in assessing and monitoring the service people received. The manager confirmed the Director of Care visited the home regularly. We asked the manager for a copy of the report from the Director of Care's visits

to the home. He told us there were no reports currently, however he said the Director of Care intended to start producing reports of their visits. The provider may find it useful to note that these quality monitoring visits were not formally recorded. This made it difficult to determine what checks had been carried out and whether any actions identified as a result of the checks were followed up and resolved.

We found there were systems in place to gather and record information about the quality of service provided in the home. We found action had been taken to improve the service in response to some of these audits. For example the audit of care documentation had resulted in improvements to the care records. However the provider may find it useful to note there was not always information to show what action had been taken in response to information gathered through the quality monitoring processes.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

We reviewed this outcome as at the previous inspection in March 2013 we had identified shortfalls in the care records. The provider sent an action plan which showed the action they would take to achieve compliance.

We reviewed three people's care records. The manager told us he had reviewed all the care plans and implemented new documentation. He told us care plans had been allocated to senior staff who were responsible for reviewing them and keeping them up to date. The manager said the senior staff had received care planning training, including writing daily records, from another home manager who worked for the organisation. This was confirmed by staff we spoke with during the visit.

We saw care plans provided information of the care and support each person needed and were individualised. We saw evidence the care plans were reviewed monthly and there was input from other healthcare professionals, such as the district nurses, GP and optician. This meant people's health care needs were being met. The provider may find it useful to note that two of the people, whose records we reviewed, had dementia, yet there was no care plan for dementia or any reference to the person's mental capacity. Two people we spoke with said they had been involved in their care plans. The manager said that they planned to involve people and their relatives more in the care plans and showed us a letter that had been sent out to relatives inviting them to a care plan review.

The action plan sent by the provider stated that the Director of Care would spot audit 10% of the care plans each month to ensure they were meeting requirements. We saw no evidence to show this had been completed.

We saw risk assessments were recorded for areas such as nutrition, pressure areas, moving and handling and falls. These were generally well completed. However, some of the risk assessments were not dated or signed and one person's risk assessment had not been reviewed following a fall.

We saw food and fluid charts for one person were well completed. We saw evidence that the manager had audited the food and fluid charts in April and identified a number of

shortfalls. The manager told us these shortfalls had been addressed with individual staff members through supervision.

We found overall improvements had been made to the records.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The provider did not have suitable arrangements in place to ensure the dignity, privacy and independence of service users or provide appropriate opportunities, encouragement and support to promote service users' autonomy, independence and community involvement. Regulation 17(1)(a)(g)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: The registered person had not made suitable arrangements to ensure that service users were safeguarded against the risk of abuse, by taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and responding appropriately to any allegation of abuse. Regulation 11(1)(a)(b)

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 12 October 2013.

This section is primarily information for the provider

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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 07 October 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person had not ensured that service users were protected against the risks associated with unsafe or unsuitable premises by means of adequate maintenance. Regulation 15(1)(c)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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

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