Inspection Report

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

Weymouth Community Hospital

3 Melcombe Avenue, Weymouth, DT4 7TB

Date of Inspection: 17 December 2012

Date of Publication: March 2013

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

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✗ Action needed
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Action needed
Cleanliness and infection control	✗ Action needed
Safety and suitability of premises	✗ Action needed
Requirements relating to workers	✗ Action needed
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	Dorset Healthcare University NHS Foundation Trust
Overview of the service	Chalbury ward, Weymouth Community Hospital is part of Dorset Healthcare University NHS Foundation Trust.
Type of services	Acute services without overnight beds / listed acute services with or without overnight beds Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 17 December 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who represent the interests of people who use services, talked with people who use the service, talked with carers and / or family members and talked with staff. We talked with stakeholders.

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

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

We used the SOFI (Short Observational Framework for Inspection) tool to help us see what people's experiences were. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time and whether they have positive experiences. This includes looking at the support that is given to them by the staff.

Patients told us that staff ensured their privacy was maintained during personal care. One patient told us that staff always knocked before they entered the room. They also told us that staff supported them with the things they found hard to do for themselves. We observed staff assisting patient's and found that the interactions were empathetic and caring. Visiting relatives told us how much they had appreciated the efforts made by staff, one person commented how much calmer their relative was.

We found that the ward was experiencing long term staff sickness of key staff and had a period when there was no manager. The trust had taken steps to ensure that there was an acting manager to provide leadership and support to the staff group.

Patient's care needs were not always assessed and risks were not always acknowledged in patient's individual care records putting them at risk of harm. The records used by the ward did not have complete or accurate information.

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 26 March 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

Respecting and involving people who use services ✓ Met this standard

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 meeting this standard.

Patients privacy, dignity and independence were respected.

Reasons for our judgement

Patient's privacy and dignity was respected. We used the SOFI (Short Observational Framework for Inspection) tool to help us see what patient's experiences were. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how patients spend their time and whether they have positive experiences. This includes looking at the support that is given to them by the staff.

We carried out a SOFI during the afternoon snack time and observed that patient's independence was promoted. We saw staff giving guidance and encouragement to patients during this period. The staff we spoke with were able to tell us about the patient's abilities and how they encouraged choice.

Patients were able to access all areas of the ward without any undue restrictions. They could go to their rooms to rest if they wished. We saw that staff asked permission to enter patient's bedrooms.

Patients told us they were involved in decisions relating to their care and support. We looked at four patient care records and saw that only two of the care records demonstrated agreement to care plans by way of a signature on the records. The trust may wish to note there should be evidence that patients or person's acting on their behalf are involved in their care and treatment.

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.

Patients capacity to consent to treatment was not always assessed neither was their consent always obtained prior to treatment beginning.

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

Patients capacity and consent had not always been ascertained and documented before treatment. We spoke with a patient who was detained under section 2 of the Mental Health Act . The patient showed us a copy of their statutory rights form. This form is a requirement of the detention to explain their rights to challenge decisions made regarding their care and treatment. The form had been completed incorrectly. It had no details of the hospital managers and made no reference to their nearest relative.

We looked at four patient care records. In two of the four care records there was no evidence of a signature or written conformation that they had consented to the treatment they received. We spoke with seven relatives who were visiting. They told us they were happy with the treatment and told us they had been involved with meetings relating to their relative's care but they were not clear if they had given consent to treatment.

In one of the four patient care records there was no evidence of a patients capacity assessment. All four records had evidence that best interest decisions had been made, but two of these had not been signed by the assessor or a person acting on behalf of the patient.

We looked at the information available to patients and their relatives to help them understand how to change any decision that had previously been made about their care and treatment. The notice board had only limited information and did not provide information into the care and treatment process. The information booklet about the ward was out of date and referred to a predecessor organisation. The acting ward manager told us that up to date information was being produced.

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.

Patients did not always experience care, treatment and support that met their 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

The patients who were able to speak to us told us it was nice to stay at the unit. They said the staff were kind to them and ensured that their needs were met. We spoke with seven relatives who were visiting during our inspection. They all told us how much they had appreciated the efforts made by staff. One person commented how much calmer their relative was another told us that they wished their relative could stay longer as there needs were being met well.

Patients told us that staff supported them with the things they found hard to do for themselves. One person told us that staff helped them dress in the clothes they chose as they were unsteady on their feet. Another person told us that staff helped them with their medication as they could forget to take them which made them unwell. We observed staff assisting patients when they could and found that the interactions were empathetic and caring.

Patients did not always experience care, treatment and support that met their needs. We looked at four patient care records which contained an assessment of need and plans to meet these assessed needs. Patient's health care needs were recorded but the records did not always evidence that staff had assisted patient to see a doctor as required. For example, one patient had been admitted three days before our visit but we could find no evidence that this person had been seen by a doctor to ensure they had no physical health needs. This was confirmed by the acting manger.

In one other patients care records there was no nutrition assessment and a note had been put on the file on 6 November 2012 to say it had been lost but a new assessment had not been conducted. In another patients care records the weight monitoring chart evidenced that the patient had lost 3.5kgs of weight in 15 days up to 15 December 2012. A review of the patients care needs had been carried out on but this did not recognise their weight loss. There was no action plan in place to address this patient's nutritional needs or weight loss.

The staff we spoke with were aware of patient needs in relation to general care and

welfare. They told us about the likes and dislikes of patients and how to manage challenging situations. Three of the staff we spoke with were unclear as to the therapeutic interventions that were in place.

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.

Patients who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse, the impact patient's behaviour was having on others and how to prevent further abuse from happening.

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

Patients were not always protected from the risk of abuse. The trust had policies in relation to reporting safeguarding concerns and whistle blowing. We spoke to five staff. The staff we spoke with were aware of the different types of abuse and how to report concerns. The acting manager told us that the unit was using agency staff to cover long term sickness. The trust had not established if agency staff had received training with regards to mental capacity, DOLS or safeguarding vulnerable adults.

Prior to our visit we had information of concern regarding a safeguarding issue on the ward. We checked with the local authority safeguarding team to see if any issues had been raised with them. The local authority team had not received a safeguarding alert from the trust and we had not been notified by the trust of a safeguarding issue at the ward.

During our visit the acting manager made us aware of two incidents at the beginning of November 2012, one where staff had required the assistance of the police when a patient had become violent on the ward. We looked the patient's care records and noted there was no risk assessment or guidance on control and restraint to support staff to manage this patient's aggressive behaviour. Triggers to the patient's behaviour were not noted which would have enabled staff to avoid known situations and protect others from the potential of harm. Whilst the patient's behaviour had been managed through the care management process the risk assessments in relation to their behaviour had not been updated to keep patients and staff safe. Neither of these incidents had been reported to the local authority or notified to us.

We observed that two patients had challenging behaviour during our visits. We observed that staff worked well with these patients to reassure them and help them calm down. We spoke with staff about how they knew what to do in these situations. They told us that it was through their experience of working with challenging behaviour. We asked if the care records provided guidance on how to support them in these situations. They told us that

the guidance was around reporting concerns not how to manage challenging behaviour and how to keep patients safe. All the staff we spoke with told us they had received training in challenging behaviour.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

Patients were not protected from the risk of infection because appropriate guidance had not been followed.

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 the communal areas and patients individual rooms and found they were kept clean.

Patients were not always protected from the risk of cross infection. We looked in the communal bathrooms and noted there were a range of toiletries. We noted that the toiletries were marked as being "unit" and did not belong to specific individuals. We spoke with one member of staff who told us that some patients did not have their own toiletries so these were supplied by the unit. The use of communal toiletries could be a source of cross infection.

We looked at the sluice facilities and contents of the sluice room. The sluice was dirty and there was staining on the top and down the outside of the macerator unit. Although the mops were colour coded to ensure that they were only used in specific areas for example, red ones to be used in the dinning area and blue ones in the toilets, the mops were stored together in such a way as the mop heads were touching each other undermining good infection control practices. Buckets that were marked with the label toilet were stored with a range of other buckets, and their use was not identified.

The trust had a copy of the Department of Health Code of Practice for health and social care on the prevention and control of infections and related guidance. The unit had undertaken an infection control audit in October 2012. Another audit was planned but there was no date as to when this would occur.

Staff took precautions to prevent cross infection. We observed that staff wore gloves when providing person care. We also saw that they wore different coloured aprons when providing care and when they were serving food or supporting people to eat

Safety and suitability of premises ✖ Action needed

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.

Patients who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises. The provider had not ensured that patients had care in an environment that was appropriately maintained.

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

The premises did not promote patients dignity and safety. We were shown around the unit and noted that many efforts had been made to provide a stimulating environment. One large communal area had a café theme which relatives told us gave them somewhere to socialise with their family members in an informal setting. Three smaller areas had been adapted to provide a small shop, a bar and a workshop where patients could fix things such as bicycles. Staff told us the workshop was used under supervision and we did not see patient's using this when we were at the unit.

The unit had been redecorated but there was evidence of paint spots on the floors in every area painted. We were shown a patient's room that had originally been designed for use by two but was only occupied by one. The second bed frame and mattress was in the room but it was unmade. The furniture for the second patient was broken and the chest of drawers was missing the drawer front. The room was not homely and did not provide a dignified space for the occupant. We observed that there were ligature points in the bathrooms and in two bedrooms. We asked the acting manager for risk assessment regarding this issue but none was available.

There were two areas, an activity room known as the beach and a toilet area that were unused. The beach area had a leaking roof and the toilet area required a new floor. The acting manger told us that there were plans to bring these areas back into use but there were no timescales attached to these plans. The beach area had been out of use since the leak had been reported on 25 November 2012

Patients had call bells in their rooms but they did not have any leads. Leads ensured that, should a patient fall or be out of reach of the wall socket, the call bells could still be accessed. We pointed this out to the acting manager who told us these were for the use of staff should they need assistance and not, as we had assumed, for the safety and well being of the occupant of the room. We asked staff how patients let them know they required assistance when in their rooms; staff told us they called out. This meant that

patients living on the ward had no other means of letting staff know they required assistance except for shouting for attention.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

Patients were not always cared for, or supported by, suitably qualified, skilled and experienced staff

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

Appropriate checks were not undertaken before staff began work and their suitability to work with adults with mental health issues was not always considered. We looked at six staff files, two staff in permanent employment, one member of the bank staff and three staff from an agency.

We were made aware by the acting manager that the unit was using agency and bank staff to cover long term sickness. The records held in relation to the agency staff did not evidence that they had experience to work with adults with a mental illness.

We looked at the records held at the unit in relation to permanent and bank staff. We found there was no evidence of their training prior to starting work to evidence that they had suitable qualifications, skills and experience. The records did not contain confirmation that checks had been undertaken with the Criminal Records Bureau. One person's application form did not contain a full employment history, two employment records did not have evidence of the person's identity. This meant that patients were at risk of harm as the staff member's fitness to work with vulnerable adults had not been appropriately checked

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.

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

Reasons for our judgement

Staff were supported to deliver care and treatment to an appropriate standard. We spoke with the acting manager about the leadership of the staff group. They told us that it had been acknowledged by the trust that leadership and support was an issue which had lead to their short term appointment until permanent arrangements could be put in place. They told us that staff had received an annual appraisal but supervision had recently lapsed. They told us that in order to provide support to staff, weekly meetings were being held with the staff group and the handover of information between staff at shift changes were now more detailed and gave staff an opportunity to discuss their concerns.

The acting manager also explained that due to the increased levels of adverse incidents on the unit they had concentrated on drawing up an action plan support staff. The plan in place was to address issues such as staff sickness levels by recruiting bank and agency staff that were familiar with the unit, to review staffing levels in line with dependency and to ensure opportunities to for staff to have refresher training in areas such as physical intervention.

We spoke with five staff on the two occasions we visited. They told us that up until recently they had felt unsupported but were pleased with the increase in staff meetings and the stability an acting manager was providing. They told us that they had received an appraisal and they were aware that one to one supervision would start when the new manager was in post from January 2013.

The staff training matrix demonstrated that staff had received training. The trust had split the requirements for training into distinct categories such as mandatory and core specific. Mandatory training covered areas such as fire safety, infection control and safeguarding, core specific training covered areas such as the Mental Capacity Act, risk and safety and the Deprivation of Liberty Safeguards. The training matrix also evidenced that there were opportunities for staff to develop their skills through attending level one and two training. These two levels relate to subjects such as medicines management and motivational interviewing. The acting manager told us that all bank staff were sponsored and as such were included in the training opportunities provided for permanent staff.

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 trust did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients on the ward.

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

The quality of the service was not being assessed and monitored. There had been an audit of the care records on the 12 December 2012 to ascertain if they were correct and that patients had been consulted about their care. The outcome and analysis of the audit was not yet available. A schedule of reviewing patient care records was not in place. There were no audits on environmental risks or an action plan. Areas such as the workshop that contained a range of tools that could be harmful were not risk assessed.

The acting manager told us that a medication audit had been carried out by the trust but the result of this audit was not yet available. They told us that the trust pharmacy department who had carried out the audit had not provided them with an evaluation of their findings.

We spoke with the acting manager who told us there had been a period when audits had not been completed prior to them taking up their position. Although there were a range of audits in relation to issues such as care record reviews and infection control that had previously been carried out, these audits had lapsed. The also told us that the governance of the unit was a priority and a plan was being put in place which would be addressed when the new manager took up their post in January 2013.

The acting manager told us that the main focus of their work in relation to quality assurance was the reduction of adverse incidents. The unit had had two safeguarding incidents that had been unreported. The acting manager had carried out a review of the environment and how it was being used by the patients. As a result of this review, an action plan had been drawn up for the unit that encouraged a more suitable mix of personalities and less opportunity for conflict.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients care records did not contain complete or accurate information and electronic records could not be accessed promptly when required.

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

The care records used on the ward were not kept up to date or fully completed. We looked at four patient care records. We found that the records were incomplete for example, there was evidence in two of the records that a personal history had been started but had not been completed. In the other two there was no personal history. A personal history enables staff to engage with patients, understand what is important to them and acknowledge the patient as an individual. In one patient care record the health care profile was not completed.

One patients care record did not contain information as required by the Mental Health Act 1983. The patient was detained under section 2 of the Mental Health Act 1983. We found that some of the documentation had been incorrectly completed by an approved mental health practitioner employed by the local authority. The trust had identified that an incorrect application form was used as parts of the form were missing. A second application had been made. However we found that parts of the form had been deleted which should have been used to identify the nearest relative.

The trust used a mix of paper and electronic records which were not always accessible. We asked the senior nurse on duty to access the computer records to look at some information that was not available in the paper records such as risk assessments. They did not have the right level of access to the computer system. We were not made aware of any other staff on duty who could access the system.

In two of the care records we found safeguarding alerts that should have been filed separately in accordance with the trust's policy on data protection

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Patients capacity to consent to treatment was not always assessed neither was their consent always obtained prior to treatment beginning. Regulation 18
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Patients did not always experience care, treatment and support that met their needs. Regulation 9 1(1)(a)(b)(i)(ii)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met:

This section is primarily information for the provider

	Patients who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse. Regulation 11(1)(a)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Patients were not protected from the risk of infection because appropriate guidance had not been followed. Regulation 12
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The trust had not taken adequate steps to provide care in an environment that is adequately maintained. Regulation 15(1)(c)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: Patients were not always cared for, or supported by, suitably qualified, skilled and experienced staff Regulation 21(a)(ii)(b)
Regulated activity	Regulation
Assessment or medical treatment for	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

persons detained under the Mental Health Act 1983	**Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The trust does not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients living on the ward. Regulation 10(1)(a)(b)
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Patients care records did not contain complete or accurate information and electronic records could not be accessed promptly when required. Regulation 20(1)(a)(2)(a)(c)

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 26 March 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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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