Inspection Report

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

Hazelmere

Hambleton Way, Winsford, CW7 1TL

Tel: 01606862401

Date of Inspections: 16 September 2014
15 September 2014
05 September 2014

Date of Publication: October 2014

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
Safeguarding people who use services from abuse	✔ Met this standard
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Community Integrated Care
Registered Manager	Ms Pauline Woodward
Overview of the service	In this report the name of a registered manager appears who was not in post and not managing the regulatory activity at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at the time. Hazelmere is a purpose built establishment containing 106 apartments with domiciliary care if required. There is an extra care scheme which offers 24 hour on site care staff, a building manager and a community alarm service. It is designed to provide a service where older people can live independently in their own home. There are car parking facilities, a hairdresser, communal areas and a restaurant on site.
Type of services	Domiciliary care service Extra Care housing services
Regulated activity	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'.

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 5 September 2014, 15 September 2014 and 16 September 2014, talked with people who use the service and talked with staff. We reviewed information given to us by the provider, were accompanied by a pharmacist, talked with commissioners of services and talked with other authorities.

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

We considered our inspection findings to answer questions we always ask; Is the service Safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

This is a summary of what we found;

Is the service safe?

People were not always kept safe because they were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place to manage medicines. We found that the agency's medicines policy was not consistently followed. Support plans did not always reflect people's current medicines needs and there were occasional 'gaps' in medicines record keeping that did not support and evidence the safe administration of medicines.

Where risks to people's safety had been identified we saw that risk assessments had been drawn up. However, they had not been reviewed since the provider took over the running of Hazelmere in December 2013.

We found that staffing numbers were not adequate and several people who lived at Hazelmere raised concerns that they never received their care at the required time. Some people reported that their carers sometimes never turned up.

People who lived at Hazelmere told us they felt safe. Staff were knowledgeable of the types of abuse that could occur and new how to report it. The provider had adhered to

legal requirements and had informed and updated the commission with regards to any incidents of concern at Hazelmere.

Is the service effective?

The care provided was not always effective as sometimes staff did not arrive to deliver the care in people's apartments. People told us that they sometimes had to wait for long periods of time to be assisted and this had impacted on their welfare

Although staff had been provided with training in order to meet the needs of the people who used the service, we saw that no training had been provided to support people who had dementia.

Is the service caring?

The service was not always caring. Many people told us that they were not always supported by staff who knew them well. Although people said they were treated with kindness and respect, three people told us they felt rushed as they knew staff were short of time and needed to provide care for others.

The service did not always listen to or consult people about how they would like to receive their care. Three people told us they were not involved in the planning of their care. Two people were not aware they had a care plan.

Is the service responsive?

The service was not responsive to people's needs. People's care needs were not assessed regularly and this resulted in their care plans being out of date and not reflecting their current needs.

Some people told us they had raised concerns about different people supporting them in their homes. While some said the new manager responds to concerns quickly, others said they felt dismissed when they raised concerns.

Is the service well-led?

The service was not always well-led and changes had recently been made to the managerial structure at Hazelmere. In August 2014, the provider made us aware a new manager had been appointed and they would be applying for registration with the Commission.

It was clear that the concerns we found on this inspection had been picked up by the provider beforehand through their auditing systems. However, we asked people if they felt involved in assessing the service and if their views had been sought. Most people told us they did not feel involved. We saw that no formal processes were in place for obtaining people's views about the service.

Staff said the new management team were approachable and were confident that any concerns raised would be appropriately addressed by them. Staff said morale had recently improved and felt the service was improving after recent concerns.

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 04 November 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

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 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

Before this inspection we received concerns that people's health and welfare had been put at risk. People told us that due to staff shortages people were not receiving care at the allocated time and sometimes people were not receiving care at all.

During this inspection we spoke with 15 people who used the service and two relatives. We asked them for their views on the service that was provided at Hazelmere. Seven people told us that there were times when their carers never turned up and they were often late. Four of them said they never stayed for all of their allocated time. Two people told us that they required two carers to hoist them but on many occasions only one carer turned up. One person said this affected their confidence and as a result they did not allow only one carer to hoist them. Three people said they felt rushed as they knew the carers needed to be providing care for somebody else. One person said they do not receive domestic care although they still pay for it. Other comments from people included; "My regular carers are smashing and really respectful", "The carers always look in to check I am fine", "They are marvellous", "My carers are very good", "I was not given the chance for any input and no choices were given to me with regards to timing", "I never know when they are coming sometimes. It could be 9.30am or it could be as late as 3.30pm. The communication is poor", "They have been very late a couple of times but they do try to let us know", "Things have improved but it used to be terrible. The new manager has made some changes and it's marvellous now", "There are quite a few Monday's when they don't come" and "They are supposed to come and change my pads. I don't like being left and I don't want to be sat wet for a long period of time. I am frightened people will think I am lazy or smelly. I get soaked through my clothes when they don't come".

We looked at the care plans for six people who used the service. The care plans showed how the needs of the people who used the service were to be met, including any risks to

their well-being. The care plans covered areas such as physical, emotional, nutritional, mental health, social and domestic needs. Risk assessments were in place for each risk that was identified. However, all of the care plans we had looked at had not been reviewed since the provider took over the service in December 2013. This made it difficult to tell if they were an accurate reflection of people's current needs.

Information about the support people needed with medicines was recorded within their care plans when they first started to use the service. However, we found that this was not always kept up-to-date where people's medicines needs changed. For example, one person had chosen to self-administer a recently prescribed medicine, but this was not reflected within their support plan. Similarly, support plans did not always include an up-to-date list of their currently prescribed medication.

Most of the people spoken with confirmed that staff were quick acknowledge changes to their needs and the appropriate changes were made. However, one person told us that their carer tried to give the wrong tablets when their medication had changed. Two people spoken with were not aware that they had a care plan and three people told us they had not been involved in the planning of their care. All of this meant that people's health and wellbeing had been put at risk.

We saw that on each occasion when care had been delivered late, that a record was made of this. We noted that each person received late care on several occasions. On some of the occasions, care was delivered considerably later than the required time. This showed that people's health and wellbeing had put at risk.

There were activities available on site for people to attend if they wished too. We saw that there was a hairdresser on the premises and a restaurant. There were plenty of communal places for people to socialise if they wished too.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

All of the people we spoke with told us they felt safe when they were supported by their carer's. Two of them said they had concerns in the past but they had been appropriately dealt with by the provider. All of the people we spoke with said they had a pendant or a cord they could pull in the event of an emergency. Other comments from them included; "They are really good when they take me shopping by making sure I have receipts and am charged rightly".

We spoke with five members of the staff team including the manager. They knew what action to take if they recognised signs of abuse and were aware of the whistle blowing process should they have any concerns. Discussions with staff demonstrated they were knowledgeable about the different types of abuse that could occur. Staff confirmed that training had been completed in relation to safeguarding people from the risk of abuse. The staff we spoke with said they had very good relationships with the new management team and felt they could approach them with any concerns and felt they would be appropriately dealt with.

The provider had adhered to legal requirements and had informed and updated the commission with regards to any incidents of concern at Hazelmere.

We saw that the service had an up to date copy of the local authority's safeguarding policies and procedures that reflected their own. Staff told us they knew where the policies were kept and had easy access to them.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

Two people we spoke with told us that changes to their medicines needs were not promptly addressed. This meant that people might not receive the support they need to take their medicines safely.

Medicines were administered by suitably trained support staff. Most people we spoke with felt that support workers provided them with the help they needed with managing their medicines. We saw that care was taken to ensure that any special label instructions such as 'before food' were followed when administering medicines. Assessments were in place where people were prescribed controlled drugs for pain-relief to ensure these were given at the right times.

However, some people we spoke with told us that they did not receive their medication correctly because calls were sometimes missed, or late. Additionally, one person told us that they did not always have their prescribed creams applied because they, "don't like strangers (agency staff)" applying them. We found that there were occasional 'gaps' in the medicines administration records that meant it was not possible to tell whether medicines had been administered correctly.

The service had a protocol for reporting medicines incidents but we found that this was inconsistently used. For example, failure to administer medicines due to a lack of stock was not always reported. This meant not all incidents were investigated to try and reduce the risk of reoccurrence.

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 was not enough 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

Before this inspection we received several concerns reporting that there was not enough staff at Hazelmere and as a result people's needs were not being met in a timely manner. We spoke with the local authority who also told us they had concerns around staffing levels.

On this inspection we asked people who used the service whether they thought there were enough staff to meet their needs. All of them said there was not enough staff and calls were often missed or late as a result. Comments from them included; "They need more staff. If an emergency occurs then everyone else's care gets progressively later", "Staff shortages are a problem recently, although we are lead to believe they are getting more staff. Bank holidays and weekends never go smooth; the timetable doesn't work over these periods", "It's getting a bit better and the manager comes in and does the care if no one is available", "The girls are run ragged", "Lots of staff have left and have not been replaced", "I don't always get my full allocated time so I feel rushed" and "[My relative] is supposed to have their call at 9am but at weekends it could be 11am. It feels very unreliable".

Several people who used the service told us they wished to be supported by people who they knew well and had concerns that they never knew who was going to be providing care each day. People told us they were aware of an upcoming meeting so that all people who lived at Hazelmere could get to meet all of the carer's. One person told us; "When I raised concerns about not wanting a particular individual or different carers my opinions were dismissed". Another said; "I can understand if my carer is off sick or on holiday. I just want to know who is coming into my home". A couple of people provided positive responses. One said; "The new manager has sorted out the staff and it is much better". Another told us; "I asked for a different carer and the manager changed things quickly".

We spoke with four members of the care team. They told us that staffing levels had improved very recently but things had been a struggle due to sickness and holidays over the summer period. They said that because of this people's calls had been late or missed. Staff said that all people who used the service had a pendant to press if they needed

assistance and due to answering these calls, this would often delay the care to be provided to others.

We looked at the staff rota and saw it was planned ahead in advance. We saw there was six care staff allocated to work between the hours of 0700-1500 and four care staff between 1500-2200. Two staff were on duty throughout the night in case people required assistance in their apartments. Due to the concerns that people had raised, we found that staffing numbers were insufficient to meet people's care needs at Hazelmere.

We spoke with the manager and the regional manager about staffing levels during our visit. We were told that some staff members were to be offered permanent contracts and recruitment was on going to employ seven full time staff to the care team. We were told that the new staff would be used to answer the pendant calls so that other staff members would be able to provide care to other people who used the service at the allocated time. The regional manager told us that an administration assistant was also being recruited for so that the care team could concentrate on supporting people who lived at Hazelmere with less emphasis on paperwork.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not cared for by staff who were supported to deliver care safely and to an appropriate standard.

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

Reasons for our judgement

Before this inspection we received concerns that staff did not have the opportunity to review their roles and look at their personal development. On this inspection senior staff acknowledged this had been an issue and supervisions with staff members had started to take place. Three out of the four staff spoken with confirmed they had a recent supervision. The other staff member said they had not had one since the provider took over Hazelmere in December 2013.

Staff told us that they felt well supported in their roles by the new management team. Staff told us they had plenty of training opportunities with the new provider. We saw that some staff had gained National Vocational Qualifications (NVQ) levels 2 and 3 in social care. Comments from them included; "Things are improving slowly here" and "I feel I can approach the new manager. Things are getting better now".

Discussions with staff and examination of training records showed that training was current for the majority of staff in areas such as moving and handling, infection control, safeguarding, medication and fire safety. However, we saw that 12 members of the staff team had not had any first aid training. Should an emergency situation arise, people's health might be put at risk. In addition to this several staff members had not received any training with regards to dementia. This was important as the service provided care for some people who had dementia. This meant that not all staff were provided with the required skills and knowledge to support people with dementia.

We found there were good systems for communication between staff. Handover between each shift was documented in the 'communication book' so staff could see any concerns or changes that had been occurred in relation to people who used the service.

Three people who used the service told us they thought staff needed extra training in domestic tasks such as cooking and cleaning as this was a service they paid for. All three of them told us that such tasks were not completed to a satisfactory standard. Another person had a medical condition and was not sure whether staff were knowledgeable of

this. Examination of training records confirmed that staff had not received training to support people with this medical condition. This meant this person's safety welfare had been put at risk.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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 service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

In August 2014, the provider made us aware that the previous registered manager no longer held this position. We were told a manager had been appointed and would be applying to register with the Commission.

During this inspection we asked people who used the service if their views had regularly been sought about the service provided at Hazelmere. The responses we received were varied. Comments from people included; "No, not as yet but the new manager is very helpful", "No, I met the new manager once but she did not ask about the care I am getting or if I'm happy with it", "We were never asked for feedback by the old manager. Things are different now", "The new manager listens to all sides then makes decisions when she gets all the points straight" and "They don't listen to me. They want me to accept the changes they want and are not prepared to hear what I want".

We asked people what their opinion of the quality of service provided was. Comments from them included; "Satisfied", "Excellent", "Poor, going downhill", "Quite good but CIC (provider) is not as good as our previous provider", "Currently about I am about 90% happy but this will change if the care staff constantly change and the clients don't get to know the care staff" and "If I don't continue to get regular carers I'll look to move elsewhere".

People told us they had recent made complaints around staff shortages and not having carers they knew well. Some people said they didn't feel things would improve until staff shortages had been resolved.

We spoke with the regional manager who told us that satisfaction questionnaires had not

yet been sent to people who used the service since the provider took over Hazelmere in December 2013. This showed that people's views had not been sought on a formal basis. We were told they were due to be sent out to people in order to gain their viewpoint on the service. Staff told us they had been sent a questionnaire so their views could be obtained. However, we saw no analysis or evidence of the staff survey results to show how any concerns or comments had been dealt with.

The regional manager was able to demonstrate that they identified some of the concerns we had found during this inspection through regular audits that had taken place at higher management level. We saw that clear processes were in place to show how this poor practice was investigated. Action plans had been put in place to address the concerns identified prior to this inspection. We saw that care plan reviews had begun to take place with the involvement of people who used the service after none had been carried out since the provider took over at Hazelmere. The new manager was able to provide a matrix to show what care plans had been reviewed under this new monitoring system to ensure people received care that reflected their needs. Systems were also in place for the recording and monitoring of accidents/incidents in people's homes.

Senior staff completed regular checks of the medicines record keeping and any concerns were discussed directly with the staff involved. However, these concerns were not centrally recorded in order that they could be audited to given an overall measure of medicines handling at the service.

We looked at the minutes of the last staff meeting that was held in March 2014. Staff told us that they have had 'flash' meetings since then but these are not recorded. Staff told us they were able to raise to views to the manager and felt listened to.

Staff told us they had not received spot checks to monitor the quality of care they provided since the new provider took over. This meant the provider did not have a system in place to assess whether staff were competent to carry out their roles effectively. Without such a system in place, the health, safety and welfare of people who used the service had been compromised.

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
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regular assessments were not carried out with regards to the needs of people who used the service. Care and was not planned in a way to ensure people's safety and welfare and did not meet the individual needs of people who used the service. Regulation 9 (1) (a) (b) (i) (ii)
Regulated activity	Regulation
Personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider's medicines policies were not consistently followed. Regulation 13
Regulated activity	Regulation
Personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**

This section is primarily information for the provider

	How the regulation was not being met: The provider did not ensure that there was sufficient numbers of staff on duty to safeguard the health, safety and welfare of service users. Regulation 22.
Regulated activity	Regulation
Personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The registered person did not have suitable arrangements in place to ensure that people were supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23(1)(a)
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have an effective system to regularly assess and monitor the quality of service provided. Systems were in place to identify, monitor, assess and manage risks to the health, safety and welfare of people who use the service and others. The provider did not have a system in place to regularly seek the views of people who used the service or those acting on their behalf. Regulation 10(1)(a)(b) and (2)(d)(i)

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 04 November 2014.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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