Inspection Report

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

Haddon Court Nursing Home

High Street, Beighton, Sheffield, S20 1HE

Tel: 01142511318

Date of Inspection: 23 June 2014

Date of Publication: July 2014

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✗ Action needed
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Amocura Limited
Registered Manager	Mrs Judith Margaret Nicholas
Overview of the service	Haddon Court is a nursing home registered for up to 83 people situated within Beighton Village, approximately five miles from the city centre of Sheffield. The home is within easy access of the local community, which has a selection of shops and churches. Haddon Court is a large purpose built three-storey care home. It provides nursing and personal care for older people who have a physical disability, nursing needs or have dementia.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services. We reviewed information sent to us by other authorities and reviewed information sent to us by local groups of people in the community or voluntary sector.

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 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

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at this time.

At the time of this inspection Haddon Court was providing care and support to 49 people, some of whom had a diagnosis of dementia. We spoke with 12 people living at the home, and three visiting relatives to obtain their views of the support provided. We also spoke with the home manager, the company director and seven members of staff.

We considered all the evidence against the outcomes we inspected to help answer our five key questions; is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

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

Is the service safe?

People who used the service told us they felt safe. Comments from people included, "I like it here. It's a pleasure to be here," "Staff are very nice. There are no arguments" and

"Nobody upsets me."

Systems were in place to make sure that managers and staff learned from events such as accidents and incidents, whistleblowing and investigations. This reduced the risks to people and helped the service to continually improve.

We found risk assessments had been undertaken to identify any potential risk and the actions required to manage the risk. This meant that people were not put at unnecessary risk but also had access to choice and remained in control of decisions about their lives.

The home had policies and procedures in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. One application had been submitted which confirmed to us that relevant staff had been trained to understand when an application should be made and how to submit one. This meant that people would be safeguarded.

We found 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 asked the provider to send us a report setting out the action they will take to meet this standard. We will check to make sure that this action is taken.

Is the service effective?

One relative told us the home had made contact with them in the early hours suggesting they might like to come as their family member was unwell. They said, "Our [family member] has been looked after very well. They were admitted to the home with their spouse and until this period they had been given adjoining rooms. Their spouse has Alzheimer's so is not entirely aware of situation but arrangements are being made to bring the couple together today."

During our visit, we found people were provided with the support they needed. However we observed people often had to wait as staff were very busy. We found staff knew people well and were aware of their individual preferences. We found staff treated people in a kind manner.

Care files we checked confirmed that initial assessments had been carried out by the staff at the home before people moved into the home. This was to ensure the home was able to effectively meet the needs of the people. Specialist mobility and equipment needs had been identified in care plans where required. People and their relatives said they had been involved in writing them and they reflected their current needs. Visitors confirmed they were able to see people in private and that visiting times were flexible.

Staff were provided with training to ensure they had the skills to meet people's needs. Managers' were accessible to staff for advice and support. Staff were provided with formal individual supervision and appraisals at an appropriate frequency to ensure they were adequately supported and their performance was appraised.

Is the service caring?

People who used the service and their relatives said staff treated people respectfully. Relatives told us, "Staff do a good job. I wouldn't do their job for anything" and "Everyone is respectful and our [family member] has been treated with dignity."

Other comments made to us by people who used the service were, "They [staff] tell me what to do," "They're always picking on you. They [staff] tell you what to do all the time and I don't like it," "I get up at 6.15 and nobody comes near me. If I go and ask for a cup of tea, they say 'in half an hour' and then they don't get me one." One person said that when her relative had visited recently, staff had been laughing about their last name and its pronunciation.

During our observation we saw friendly interactions between staff and people who used the service and there was kindness in staff's tone of voice when speaking with people. Staff addressed people by their preferred names and people seemed comfortable in the presence of staff. Interactions between staff and people who used the service were relaxed and unrushed.

We found staff skills in recognising and respecting the diversity and human rights of people who use the service varied significantly. Some staff were able to tell us how important it was for people, other staff were less understanding of the concepts of privacy, dignity and independence.

Is the service responsive?

Staff and a relative told us the care and support provided was flexible to the person's needs and adjustments could be made where required. Staff said they informed the manager if they felt any change in needs was required and the support was reviewed. For example, one person was requiring palliative care and this was being provided.

On the day of the inspection the activity worker was asked to work as a carer because a member of staff was sent home ill. When we looked at the record of activities provided we found there had been a significant number of days over the last month where the activity worker had worked as a carer to cover staff shortage. This meant very little activity had been provided for people.

People knew how to make a complaint if they were unhappy. Five people who used the service said, "Everything here has improved in the last six months." One person also said, "Management is more easy going."

Is the service well-led?

The service worked well with other agencies and services to make sure people received their care in a joined up way.

All people spoken with said they weren't aware of any 'residents meetings'. One person said, "That would be a good idea." Another person who used the service told us the manager came to see them twice a week and this gave them the opportunity to raise any concerns they may have.

On the notice board we saw a 'relatives meeting' was planned for the end of the week. Staff told us relative meetings took place every 'few months' and we saw the minutes recorded at the last meeting in March 2014.

Staff had regular meetings with the manager and were kept updated about any information they needed to know about the service. This helped to maintain consistency in the running of the service and to ensure staff were aware of relevant information.

The service carried out a yearly 'Quality Assurance Survey'. Feedback was sought by way of customer satisfaction surveys sent to people who used the service, their relatives and friends, staff and healthcare professionals. This showed people had the opportunity to put their views across.

The service had a quality assurance system. Monthly and weekly audits were completed regarding such things as medication, care plans, the environment, staffing and infection control. We found there was not always an action plan with a timescale of the action required to ensure improvement. This meant there was a risk that intervention and improvements may not be made within a reasonable timescale.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

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.

People's privacy, dignity and independence were respected.

Reasons for our judgement

We spoke with 12 people who lived at the home and three visiting relatives. All people who used the service and their relatives said that staff treated people respectfully. Relatives told us, "Staff do a good job. I wouldn't do their job for anything" and "Everyone is respectful and our [family member] has been treated with dignity."

Other comments made to us by people who used the service were, "They [staff] tell me what to do," "They're always picking on you. They [staff] tell you what to do all the time and I don't like it," "I get up at 6.15 and nobody comes near me. If I go and ask for a cup of tea, they say 'in half an hour' and then they don't get me one." One person said that when her relative had visited recently, staff had been laughing about their last name and its pronunciation. This meant that staff did not always recognise and respect the diversity and human rights of people who used the service.

At this visit we arrived at the home at 8:45am and spent a period of time sitting with a group of people in the dining room on the ground floor. We were able to observe people's experiences of living in the home and their interactions with each other and the staff.

During our observation we saw friendly interactions between staff and people who used the service and there was kindness in staff's tone of voice when speaking with people. We saw peoples' needs were being met. Staff addressed people by their preferred names and people seemed comfortable in the presence of staff. Interactions between staff and people who used the service were relaxed and unrushed.

One person was upset and asked us if we thought their hair "looked a mess." Staff said the person had been showered and their hair washed. We observed the person's hair was not styled and needed some attention. Staff told the person they would brush their hair when they had finished breakfast. Throughout breakfast the person continued to worry about their hair "looking a mess." This meant this person did not have their dignity respected.

We observed a person who used the service sitting separately from others in the lounge

area. Two members of staff came and went without acknowledging the person in any way. One member of staff came into the lounge and sat in the same area. They did not speak to the person at first but then told us they were escorting the person to a hospital appointment. At that point they started chatting to the person about their appointment.

We observed some staff listening to people and supporting them to make decisions about their care and support. Much of the interaction we observed between staff and people was kind and thoughtful. We saw staff communicating with people patiently and respectfully. It was very evident that some staff were skilled in involving and actively listening to people.

We spoke with seven staff members who explained how they offered choices to people. During our observations, we saw staff asking people what they wanted to eat and drink. One staff member spoke about how they explained things to people and said, "We give people alternatives and then give them time to let them decide things for themselves." Another staff member gave examples of how they ensured people could make their own decisions, "I ask people what they would like to wear, if they would like a bath, if they want to do an activity."

The provider may find it useful to note that staff skills in recognising and respecting the diversity and human rights of people who use the service varied significantly. Some staff were able to tell us how important it was for people, other staff were less understanding of the concepts of privacy, dignity and independence.

Staff told us that the issue of privacy, dignity and choice was discussed at all training events. A member of staff had signed up to become a 'dignity champion'. Each month the 'dignity champion' completed an audit of their observations regarding dignity and respect. We saw the audit had not identified any issues even though it had been completed over many months.

The provider may find it useful to note the dignity champion had not attended any additional training or meetings in order to improve their skills in supporting other staff to ensure the dignity, privacy and independence of people who used the service.

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

We spoke with 12 people to ask about their views of living at the home. Comments included, "I like it here. It's a pleasure to be here," "Staff are very nice. There are no arguments," "Not too bad. Nobody upsets me," "It's awful. People don't understand me. I feel unwell and can't talk to anybody. I sit here because I feel unwell and I know they can see me. If I'm in my room, they wouldn't come. I tell them I'm not feeling well and they just say that I'll feel better soon," "When they come to cream my legs they don't wash their hands and they don't wash my legs first. I say, why haven't you washed my legs first? Then they will wash my legs but I have to ask first" and "I only get a shower twice a week because they're too busy. I asked for a shower but was told they were too busy and short staffed. I was so upset that I phoned my daughter to tell her I couldn't have a shower. I don't want to aggravate the staff but when I complained (about the shower) I was told that they are short staffed and there are only two of us looking after eighteen people. That's not my problem."

We spoke with three relatives. One person's relatives told us the home had made contact with them in the early hours suggesting they might like to come as their family member was unwell. They said, "Our [family member] has been looked after very well. They were admitted to the home with their spouse and until this period they had been given adjoining rooms. Their spouse has Alzheimer's so is not entirely aware of the situation but arrangements are being made to bring the couple together today."

When we asked a relative if they had been involved in their family member's care planning they said, "I visit nearly every day and staff always talk to me and tell me exactly how my relative is. When my relative isn't well, I'm informed straight away."

Relatives who were visiting the home told us they visited frequently and there were "no obstacles" in the way of visiting whenever they wished.

During our visit, we found people were provided with the support they needed. However we observed people often had to wait as staff were very busy. We found staff knew people well and were aware of their individual preferences. We saw people approach staff and engage in conversation, or ask for something and staff responding as soon as they were able. We found staff treated people in a kind manner.

We observed one person had dressings on both lower legs. There was leakage through the dressing on the left leg and the leg was malodorous. The person told us the dressings were changed daily. Staff spoken with said the district nurses came to change the dressings. We checked back later in the day and the soiled dressings had been removed, the person's legs were elevated and they were asleep and appeared comfortable.

We examined five people's care files. All the care files contained information about the person's biography, physical, medical and personal support needs. They also included people's likes, dislikes and preferences. All the care files had a range of individual risk assessments. There were clear links between the risk assessments and the care plans. All the care plans were reviewed at least each month, but more frequently if people's needs changed.

There was evidence in the care files that a range of healthcare professionals were involved in supporting staff to meet the needs of people as required. The care files recorded information provided by relatives which was reflected in the care plans as appropriate.

We observed one person in a lounge who had a problem with a productive cough and she had phlegm on her hands and clothing. This went unnoticed by one care worker who was sat doing paperwork opposite the person. A second care worker came in and put a bib on the person and wiped the person with paper towels.

We saw one person had extensive bruising to both arms. There were bruises on the person's outer arms and more significant bruising on their inner arms. The person told us, "I don't know how I got them. I think it's when they [staff] try to help me to stand up and my feet were slipping."

We looked at the person's care plan. We found risk assessments in place regarding falls and skin integrity. The care plan stated the person sometimes needed assistance to stand. The daily records recorded the person's skin was fragile and bruised but there was no information about how the bruising had occurred. An accident form had been completed which also stated that the cause of the bruising was unknown. This meant care, treatment and support were not reviewed and changed if found to be ineffective in order to maintain the person's welfare.

The provider may find it useful to note that some observations showed that people's needs were not always fully identified and responded to in a timely way.

The homes activity coordinator worked Monday to Friday for four hours each day. On the day of the inspection the activity worker was asked to work as a carer because a member of staff was sent home ill. When we looked at the record of activities provided we found there had been a significant number of days over the last month where the activity worker had worked as a carer to cover staff shortage. This meant very little activity had been provided for people.

On the day of the inspection we saw one staff member putting a CD on in a communal area and having a dance with a person who used the service. One person told us they had been "making cards" earlier in the day. Otherwise there were no activities provided. We did not see any items such as playing cards, jigsaws, dominoes or reading material on show and available for people to use. TVs were on in the corners of lounges but were fixed quite high on the wall and possibly not easy for people to see

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 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

We looked at the storage of medicines, three people's medicine administration records (MAR) charts in detail, including their care plans and some other additional MAR charts and documents.

We observed two nurses during the evening medicines round. They administered medicines and this was done patiently with regard to people's dignity and personal choice. Both nurses were fully aware of ensuring any sedative medicines were administered when people were in bed and they had safely followed the homes policy in that practice. However, we saw keys were consistently left in the lock of one drug trolley and the other drug trolley had a open container fixed to it containing several inhalers.

We saw some medicine cupboards were open and left unsecure without keys available to securely lock them, which did not follow the homes policy in practice for safely storing medicines This demonstrated that the procedures used were not always safe and did not follow best practice.

Nurses did not always follow the homes policy in practice for ordering prescriptions, recording keeping, and filing of MAR charts including drug audit checks of medicines stored in the home. We noted unfiled MAR charts and several prescriptions and medicines loosely left untidy in one of the clinic rooms.

We observed that some people living in the service also had a preferred name although this was not recorded on the MAR chart. This meant that there was an unnecessary risk of wrongly administering medicines to another person living in the service.

We noted that some people living in the service had allergies and this was not recorded on their MAR charts to alert staff as well as the local pharmacist supplying medicines to the home. This meant that there was an unnecessary risk of medicines dispensed or administered which may have detrimental effects to people living in the service.

We found that the quantities of medicines carried forward to a new recording period were not always completed and so it was difficult to account for all medicines and nutritional supplements.

We found some medicines had been delivered by the supplying pharmacy but the delivery packs were left unopened. This meant that we were not always assured that people were given their medicines and 'creams' as prescribed in a timely manner.

We noted the temperature readings in all the clinic rooms' were well above the maximum temperature range to store medicines. Medicines may not be effective as they were not appropriately stored as directed by the manufacturers.

We found some people living in the service were self-administering tablets, 'creams' and inhalers, and these were not securely kept in their rooms. Although there were some recorded risk assessments in place, care workers had not monitored the storage arrangements properly. This meant there was a risk that medicines were not always safely handled.

We found that where people were given medicines on a 'when required' basis for example, for pain relief or to control a person's challenging behaviour , there was insufficient details and guidance for staff on the circumstances these medicines were to be used. This meant people may not have been given medicines to meet their needs to ensure safe and consistent use.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with four members of staff that had worked at the home for a number of years and one newly recruited staff member. The new member of staff explained to us the 'new starter induction' that was completed when staff were new to their job role. This involved mandatory training sessions on moving and handling, safeguarding, food hygiene, infection control, personal care and policies and procedures. These were booked in for staff to complete during their first two weeks of employment. Over the following 12 weeks staff completed the Skills for Care Common Induction Standards. If this was completed then they were made permanent staff members. If it wasn't completed then their probationary period was extended.

Staff told us that following the induction period staff were booked in, on a rolling yearly plan, to complete updated and refresher training in all mandatory subjects. Staff that wanted to further their career could also be enrolled onto a diploma course.

New members of staff worked supernumerary alongside a competent member of staff until they and the home manager were confident that they were suitably skilled and trained to work on their own. This usually lasted for two weeks but could be extended if the new starter had any concerns about starting to care and support people on their own.

The home manager had a 'Training Matrix' which showed the training all staff had undertaken. We saw some staff were due refresher training in such things as moving and handling and fire safety. The home manager confirmed to us that staff were booked in for training sessions over the coming months. Staff we spoke with confirmed this to us.

Staff we spoke with said they had received formal one to one supervision from a line manager. The home manager said formal supervisions had been provided every six to eight weeks. Staff told us they completed a form detailing what they wanted to discuss at their supervision session. Staff told us they were given an opportunity to discuss and comment about any issues or concerns and request any further training.

We saw evidence that all staff had received a yearly appraisal. Staff that we spoke with said they had found this useful and beneficial.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The home manager had worked for the provider as the area manager for a number of years. They were currently in the process of registering with CQC as the homes registered manager. Several people we spoke with told us they thought the new manager was "very good."

We looked at a sample of the service's policies and procedures, for example the health and safety policy. We found the policies and procedures to be detailed, clearly written and easy to understand. The policies and procedures had been reviewed and updated as necessary.

The home manager explained the systems in place to assess and monitor the quality of service provision. They confirmed that the internal auditing of the service covered many areas, for example, infection control, environment, medication, food hygiene and care plans. We saw evidence of the systems in place to demonstrate this.

The provider may find it useful to note where audits had been completed it was not always clear if any action had been taken to rectify issues found during the audit. For example, we saw a food hygiene audit carried out in May 2014. It listed a number of areas that required improvement. It was not clear if the actions had been completed and if so when and by whom. We also found 27 care plan audits that had been undertaken by a registered manager from a sister home. The audits showed the actions that needed to be completed to make sure information in care plans was up to date and current. The home manager confirmed to us that the actions required had been completed but confirmation of this could not be found.

The provider may also find it useful to note on the audits seen there was not always an action plan with a timescale of the action required to ensure improvement. This meant there was a risk that intervention and improvements may not be made within a reasonable timescale.

A complaints procedure was in place so that people could voice any concerns. We saw information about how and who to complain to on display around the home.

All people spoken with said they weren't aware of any 'residents meetings'. One person said, "That would be a good idea." Another person who used the service told us the manager came to see them twice a week and this gave them the opportunity to raise any concerns they may have. Five people who used the service told us that everything at Haddon Court had improved in the last six months. One person also said, "Management is more easy going."

On the notice board we saw a 'relatives meeting' was planned for the end of the week. Staff told us relative meetings took place every 'few months' and we saw the minutes recorded at the last meeting in March 2014.

Staff told us that staff meetings were held frequently. Following the meetings staff were provided with a copy of the minutes of the meeting. This made sure that all staff were made aware of any discussions that had taken place and any actions they needed to take.

A 'Customer Satisfaction Survey' was completed in September 2013. Questionnaires had been sent out to people using the service, their relatives and advocates asking their opinions about such things as the environment, social activities, food and personal care and support. The survey showed that overall; the proportion of people who were very satisfied or quite satisfied was over 70%. A report detailing the findings of the 'Customer Satisfaction Survey' had been completed. The report incorporated an action plan detailing what changes would be made following listening to people's views.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 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 did not have appropriate arrangements in place to manage medicines. Regulation 13.

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 23 July 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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