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

Dovecote Nursing Home

<table>
<thead>
<tr>
<th>Hugar Road, High Spen, Rowlands Gill, NE39 2BQ</th>
<th>Tel: 01207544441</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Inspection: 29 May 2014</td>
<td>Date of Publication: June 2014</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Staffing</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✔ Met this standard</td>
</tr>
<tr>
<td>Records</td>
<td>✗ Action needed</td>
</tr>
</tbody>
</table>
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>European Care (UK) Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Manager</td>
<td>Ms Julie Deborah Bond</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>Dovecote Care Home is registered to provide nursing care to a maximum of sixty one older people. The ground floor provides nursing and personal care and the first floor is for people with dementia. The home is purpose built and the bathrooms are equipped for people with a disability. Each bedroom has an ensuite toilet. There is passenger lift access to the first floor.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Care home service with nursing</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Accommodation for persons who require nursing or personal care</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and screening procedures</td>
</tr>
<tr>
<td></td>
<td>Treatment of disease, disorder or injury</td>
</tr>
</tbody>
</table>
## 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'.

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>What we have told the provider to do</td>
<td>6</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgements for each standard inspected:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>7</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>9</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>10</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>12</td>
</tr>
<tr>
<td>Staffing</td>
<td>14</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>15</td>
</tr>
<tr>
<td>Records</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information primarily for the provider:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Action we have told the provider to take</td>
<td>19</td>
</tr>
</tbody>
</table>

| About CQC Inspections                                          | 20   |
| How we define our judgements                                  | 21   |
| Glossary of terms we use in this report                       | 23   |
| Contact us                                                    | 25   |
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 29 May 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 talked with other authorities.

What people told us and what we found

This inspection began out of hours at 6:00am in the morning.

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 the summary of what we found.

Is the service safe?

An assessment of people’s care and support needs was carried out before people started to use the service. This was to ensure staff had the skills and had received the training in order to safely meet the person’s support requirements.

Risk assessments were in place. People were supported and encouraged to maintain their independence and this was balanced with the risk to the person. Audits were carried out to look at accidents and incidents and the necessary action was taken to keep people safe.

Information was available to show that the service worked with other agencies to help ensure people’s health needs were met and to prevent admissions to hospital wherever possible.

We saw there were enough staff on duty at the time of inspection to meet the current care and support needs of people.

Is the service effective?
People commented how helpful and friendly the staff were. Records showed relatives were involved in the six monthly care reviews of people who used the service. This was to make sure the service kept them up to date with what was happening with their relative’s care.

Staff were observed to be patient and supportive as they worked with people.

More detailed record keeping was needed to show the service was meeting people’s needs effectively.

Is the service caring?

Most people spoken with talked well of the level of care provided by staff. Staff were helpful and offered people information and support about their care. We observed staff interacted well with people and it was evident that staff had developed a good understanding of people's communication needs and how best to communicate with them.

Is the service responsive?

Information was collected by the service with regard to the person's ability and level of independence before they moved into the service. Various assessments were completed by the manager of the service with the person and/or their family to help make sure staff could meet their needs. Regular reviews were carried out with the person who used the service and their representative to make sure plans of care were kept up to date. This helped ensure staff provided the correct amount of care and support.

Referrals for specialist advice were made when staff needed guidance to ensure the health needs of people were met.

People's individual needs were taken into account and they, or their representative if they were not able, were involved in decision making with regard to their care. They were kept informed and given some information to help them understand the care and choices available to them.

Meetings took place with staff and people who used the service and their relatives to discuss the running of the service and to try to ensure the service was responsive in meeting the changing needs of people. For example staff meeting minutes showed staff and people who used the service were concerned about staff deployment within the home at meal times. This was an issue still being addressed at the time of inspection.

Is the service well-led?

We found there was a focus from management on the provision of individual care and support to people who used the service. Staff were knowledgeable about the support needs of people, however people's care and support needs were not accurately reflected in the care records.

We saw people had the opportunity to comment on the quality of the service and that they felt able to speak to the manager and staff about any issues.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. While no applications had needed to be submitted, proper policies and procedures were in place.
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 28 June 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 |

<table>
<thead>
<tr>
<th>Respecting and involving people who use services</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run</td>
<td></td>
</tr>
</tbody>
</table>

**Our judgement**

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

**Reasons for our judgement**

We carried out this early morning inspection at 6:00am as concerns had been reported that people were being assisted to get up early from 5:30am, before they wanted to. At the time of inspection we did not find evidence that this was happening. People we spoke with said they were asked about their wishes, such as when to get up and go to bed. We saw three people were up by 6:30am on the ground floor and they said they liked to be up at this time as they had always been “early risers.” We saw on the unit for people who lived with dementia, one person was already up and another person was being assisted to dress and they told us “they wanted to get up.”

People told us they were asked what they wanted to eat, wanted to wear and offered a choice of activities. Staff told us they would show two plates of food to help a person who lived with dementia choose what they wanted to eat. They would show them two choices of clothes and get them to point to their preference to help them be involved in what they may wish to wear. One person we spoke with said they weren't dressed as they liked to have a bath after breakfast. This meant people were encouraged to be involved in making decisions about their care and treatment.

We saw a bulletin board that provided information for people who lived in the home and their relatives. It listed forthcoming social events and a variety of activities. Activities included: bingo, arts and crafts, board games, sewing, knitting, music, reminiscence, movie afternoons, pamper sessions and hairdressing. This meant people who lived in the home were given information to keep them informed and help them in their decision making.

We saw there was some visual stimulation to help maintain the involvement and orientation of people who lived with dementia. We saw corridors on the dementia care unit were themed and provided areas of interest for people as they walked around. The provider may find it useful to note however the areas were looking worn and decorations and items that helped people to remember and be mentally stimulated were no longer available. There was no activities board or calendar available or orientation board with
pictures and visual cues to help remind people. We saw there was some appropriate signage on doors to remind people where they were and to help maintain the independence of people with dementia.

We saw the service user guide which was given to people before they started to use the service. We were told it could be made accessible, in a format so people might understand it more easily if they did not use the written word, or if people's first language wasn't English. It stated that staff would encourage people to remain involved in decision making in their daily life. They would be helped to maintain their independence and individuality. It informed people they would have freedom of choice and their privacy and dignity would be respected at all times. This meant people who used the service and their relatives were given appropriate information about the care and support available to them.

Staff told us that when they started work for the organisation they received training with regard to the rights of older people and people with dementia. The training included basic care principles in providing care and support to people. This meant people's diversity, values and human rights were respected.
Consent to care and treatment

Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We were told that on a person's admission an assessment would be carried out with regard to their psychological state. Depending upon the outcome, information would then be collected about arrangements for care. The manager described to us the formal process to follow if they had any concerns about a person's mental capacity to make informed decisions about their care. They were clear on the responsibility to act in accordance with legal requirements. We were told if there were any concerns with regard to a person's mental capacity to make decisions, a referral was made to the mental health team, who carried out a psychological assessment to check a person's mental cognition. This meant if there were any concerns over people's capacity to make decisions, a formal process would be followed to determine what was in the person's best interests.

We checked that the Deprivation of Liberty Safeguards were only used when it was considered to be in the person's best interest. These are safeguards put in place by the Mental Capacity Act 2005 to protect people in care homes from having their liberty restricted without lawful reason. We found that no-one in the home was currently subject to any such restrictions. However, the manager was aware of a recent court judgement that will extend the scope of these safeguards, and we were told the provider was actively considering the implications of this judgement for staff practice and training.

The manager told us staff would involve the next of kin if it was assessed the person did not have capacity to consent to care and treatment. Staff also followed the advanced directives of people who had made arrangements such as a living will. This contained instructions for use when they were no longer able to give their consent. This meant where people did not have capacity to consent, the provider acted in accordance with legal requirements.

During our inspection we observed that staff asked people for their consent before they carried out care. We saw staff asked people if they wanted any assistance and support. We also saw staff were patient and allowed people time to consider their options and respected their wishes. We spoke with six members of staff, who told us they tried not to be intrusive and only provided support and care for people as they needed it.
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 looked at seven people's care records. We saw the service received pre-admission information for people who were referred. This information was provided by the social worker, relative or community mental health team. It assessed the person’s ability and level of independence before they were admitted. We saw various assessments were completed by the manager of the service before the person was admitted. The areas assessed included information about communication, mobilising, skin integrity, personal care, oral hygiene, dressing, eating and drinking, continence, sleeping and resting, breathing, memory and cognition and mood. We were told the information was provided by the person, or their relative, depending upon the outcome of a person's psychological assessment. This meant information was available to help ensure staff provided individual care to people.

We saw assessments such as Waterlow, for skin integrity, weight, blood pressure, nutrition and moving and handling were also reviewed monthly and the required action was taken, for example if a person was losing weight. This meant information was kept up to date to ensure people’s needs were still being met.

Where people with dementia were unable to make certain decisions themselves the manager ensured that the person's family were involved or an independent advocate was brought in to help with decision making. For example, the manager told us about situations where people with dementia needed support to make decisions about their end of life care needs and preferences.

We saw from care records that family members were kept up to date with their relative’s care and wellbeing. They had the opportunity to attend and contribute to the six monthly reviews of their relative's care.

We carried out an observation of care delivery to help us understand people's experiences of the care they received. During our observations we saw staff communicated sensitively with individuals and acknowledged their needs. We observed the interaction and noted the kind and caring way staff supported people, especially people who lived with dementia. Staff allowed sufficient time for people to respond. It was evident that staff had developed a good understanding of people’s communication needs and how best to communicate
with them. We observed staff bent down to be at the same level as the person as they spoke with them. This meant staff were able to provide individual care to people who were unable to communicate and make their needs known verbally.

Staff we spoke with were clear about the importance of maintaining and respecting people’s dignity and privacy. They had received training about privacy and dignity as part of their induction. We observed staff treating people with dignity and respect. For example staff spoke discreetly and quietly to people unless it was a group conversation. This meant the privacy and dignity of people was respected.
Cooperating with other providers

| People should get safe and coordinated care when they move between different services |

**Our judgement**

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

**Reasons for our judgement**

Records showed that before a person was admitted to the service relevant information was received from other agencies. The information included assessments and care plans which were used as a basis for the initial care and support plan for the person. We saw that information received from other agencies was incorporated into people's care records.

We were told information was transferred from the service with people when they were admitted to hospital. The document accompanied a person to hospital and when they were discharged. The transfer/discharge form included information about the person's contact details, health, medicines, allergies and the person's specific care needs. This information was to ensure that staff were given all the appropriate information and to support the person when they were admitted to hospital or discharged from the service. The provider may find it useful to note the information did not include details to explain about the person and things of importance to them, when the person was no longer able to tell people themselves. We were told information was received when a person was being discharged from hospital. The staff of the service were usually involved in discussions about the person's discharge to ensure the service could still meet the person's needs. This meant information was provided to ensure the care and treatment needs of people could be met when they were discharged from hospital.

The care records we looked at showed the health needs of each person were documented. This included information on the medicines used and important health conditions. Information was also available in their files with the contact details of other people involved in their care, such as the GP, social worker, physiotherapist, community mental health team and psycho-geriatrician (a doctor who specialises in older people's mental health). We saw evidence of visits by health professionals and referrals for specialist advice where staff needed guidance to ensure the needs of people were met.

We were told if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice combined with the staff's knowledge of the
person helped reduce the anxiety and distress of the person because the cause of distress was discovered.

Staff told us the district nurse from the GP practices used by the service, visited the home as required, for any people who were not assessed as having permanent nursing care needs. For example, if dressings needed changing or if there were any issues with skin tissue viability. The district nurse would also check on the well-being of people and if necessary, take blood or urine samples to check for infections. We were told this would be if a person’s behaviour had changed to determine if it was linked to any infection.

We saw people received chiropodist appointments and optician appointments regularly. We were told private chiropody was available at the home to supplement the NHS chiropodist service. This meant the health needs of people were met.
Staffing

<table>
<thead>
<tr>
<th>Staffing</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>There should be enough members of staff to keep people safe and meet their health and welfare needs</td>
<td></td>
</tr>
</tbody>
</table>

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

At the time of this inspection there were 51 people who lived in the home and this included one person who was in hospital. We were told by the manager staffing levels were based upon occupancy and the needs of people. Current staff levels were:

Ground floor which accommodated 26 people:
One senior support worker and four support workers 8:00am-8:00pm

Top floor which accommodated 25 people with dementia or cognitive impairment:
One nurse 7:45am-8:00pm
One senior support worker and four support workers 8:00am-8:00pm

To cover two floors 8:00pm-8:00am:
One nurse, one senior support worker and four support workers.

This did not include the manager and ancillary staff who were also employed for duties such as catering, cleaning, maintenance, administrative work and carrying out social activities with people. Rosters showed one domestic person was on duty each day from 8:00am-4:00pm. The provider may find it useful to note as occupancy levels have increased and there are more bedrooms in use ancillary hours for domestic work may need to be reviewed. This is to ensure an adequate standard of hygiene and cleanliness around the building.

People we spoke with said staff were kind and attentive. One person commented; "Staff are good." Another said; "Staff work long hours but do their best." And; "On the go all the time." Other comments included; "Friendly staff." And, "The staff are all very caring."

We observed staff were polite, patient and treated people in a respectful way. The atmosphere around the home was calm and relaxed.
### Assessing and monitoring the quality of service provision

| 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 in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

#### Reasons for our judgement

We saw the provider had systems in place to identify, assess and manage risks to health, safety and welfare of people using services and others. We were told a manager from head office visited every two months to audit different aspects of care, such as health and safety, dignity and privacy at each visit.

We were told by the manager targets were set and had to be achieved monthly by the management team in the home. These included monthly audits of the kitchen, laundry and medication. We saw records were audited monthly and included care documentation, nutrition, safeguarding, falls and mobility, skin integrity, infection control, risk assessments, staff files, staff training and staff supervisions. Monthly audits were also carried out for health and safety and maintenance of the environment. We saw a dining experience audit had been introduced to check people's dining experience. We were told a weekly financial audit was also carried out. This meant some systems were in place to ensure the safety and comfort of people who used the service.

We saw accidents and incidents that were reported were audited monthly. We were told the falls analysis would trigger a referral to a falls clinic, if a person had fallen a number of times. This was to investigate why a person may be falling.

We saw records that showed meetings were held with staff every month, these included general staff meetings for all staff and management meetings. We saw areas of discussion included the deployment of staff to endeavour to ensure the care needs of people living in the service were met in a timely way. The provider may find it useful to note staff meeting minutes did not show that effective deployment of staff was in place. We saw there was on-going discussion about meal times. For example the timings of meals and the length of time people had to wait for breakfast, 10:00am in some cases or the length of time it took for people to leave the dining room. We also noted one of the staff meetings had been cancelled due to staff failure to attend. This meant although staff were involved in decision making within the home, decision making was not always effective.

The manager told us that resident and relative meetings were also held monthly. Records showed people were consulted and made aware and consulted about activities and
outings, choice of food and individual care and support needs. We were told questionnaires were also sent out to people using the service and their relatives to get their views of the home. The results were analysed by the manager. This meant that people who lived in the home were asked their views and involved in the running of the home.
Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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 seven care records and saw they were kept securely in office areas. We saw the record keeping was inconsistent and did not contain all the appropriate information. This meant people were at risk of unsafe care or inappropriate treatment. The records also did not reflect the person centred care provided by staff.

Some of the records we looked at showed a social assessment called "This is Me" was available. We were told it was completed with the person or their family before the person was admitted. We did not see it completed in all the records and information that was available was not detailed. There was little information with regard to a person's life history, such as key events in their life, births, deaths, work history, spirituality and hobbies and interests. This meant information was not readily available to help staff have some understanding of the interests and areas of importance to a person when they were no longer able to communicate it themselves.

We were told the organisation was in the process of changing the support/care plan documentation. We did not see all the relevant assessment information for each person had been transferred to individual support plans to help ensure the health and social care needs of people were met. We saw support plans that were in place were evaluated monthly. They covered a range of areas which included physical health, mental health and social needs but the information was not consistent in each person's case to ensure their safety and welfare. Some support plans were not broken down to show the interventions carried out by staff to provide individual care to the person. For example, one stated; "To maintain the privacy and dignity of the person when providing personal care " but it did not say how this was to be achieved. Staff we spoke with however could describe the action they took to support the person. This meant written information was not always available to help ensure staff provided individual care and support to the person.

We saw there was no information available to record the person's or their families wishes with regard to their care when they were physically ill and reaching the end of their life, for example, to record their spiritual wishes or burial requirements. All support plans looked at
recorded respecting people's dignity but they did not state how staff were to do this. This meant people's end of life support plans were not individual and personal.

We saw food and fluid charts were used to record a person's nutrition and hydration. The charts we looked at were not completed in enough detail as they did not accurately show the quantity of food taken by the person. Some recordings were subjective and stated what the person had eaten without stating the amount. For example; "... has taken a good meal." This meant where records were used for example where there was a concern with regard to weight loss the records were not an accurate recording.

We did not see evidence of support plans for all people who displayed behaviour that was difficult to work with. For example one person became agitated as they believed they were living in their own home and could not understand why so many other people were around. Some staff were observed to placate the person but no written information was available to help ensure staff provided consistent care and support to the person, and to help reduce the person's distress and anxiety.

Records we looked at did not show all care plans, risk assessments and other care documentation such as records which required consent were signed by the service user, relative or their representative. An up to date signature was not available for all people with regard to consent to photography, sharing of information with third parties and the use of bedrails where people lacked mental capacity or to demonstrate their involvement and agreement to care plan information. This meant not all of the documentation ensured people's rights and best interests were safeguarded by the provider's record keeping systems.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Records</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.</td>
</tr>
<tr>
<td></td>
<td>Regulation 20(1)(a)</td>
</tr>
</tbody>
</table>

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 28 June 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:

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

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.