Inspection Report

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

Tudor Rose Rest Home

671 Chester Road, Erdington, Birmingham, B23 5TH

Tel: 01213848922

Date of Inspections: 15 May 2014
08 May 2014

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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	✖ Action needed
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Careplex
Registered Manager	Mrs Jackie Barrett
Overview of the service	Tudor Rose Rest Home is registered to provide accommodation and personal care for up to 27 older people. The home is not registered to provide nursing care.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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

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 8 May 2014 and 15 May 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We talked with commissioners of services.

What people told us and what we found

This inspection was conducted over a two day period. One inspector carried out this inspection on the first day and two inspectors inspected the home on the second day. The focus of the inspection was to answer five key questions; is the service safe, effective, caring, responsive and well-led?

As part of this inspection we spoke with the five people who use the service, a relative, the deputy manager, the registered provider, a business consultant employed by the provider and three care staff.

We also reviewed records relating to the management of the home which included, six care plans, daily care records, accident /incident records, complaints records, audits, safeguarding files, staff records and notification records.

Below is a summary of what we found. The summary describes what people using the service, their relatives and the staff told us, what we observed and the records we looked at.

Is the service safe?

All of the people and their relatives spoken with told us that they felt that the care provided was safe. A person that lived at the home told us, "The staff are alright, they are caring for me." A relative told us, "I have no major concerns about the care at the moment."

Systems were not in place to make sure that managers and the staff team learnt from events such as accidents and incidents, complaints and concerns. This was because managers were not always aware of incidents that had occurred in the home. Therefore the appropriate actions were not always taken.

Safeguarding procedures were in place, but staff did not always report and act on

incidents that were classified as safeguarding.

There were sufficient staff to meet the needs of people that currently lived at the home.

Records were not maintained to show that people's needs were appropriately considered.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care homes. While no applications have needed to be submitted recently. Staff currently managing the home has not been trained to understand when an application should be made, and how to submit one.

Is the service effective?

All of the people and their relatives spoken with told us that they were receiving the care that they needed.

Care plans that we saw lacked detail and contained conflicting information about people's care.

Improved systems were in place to ensure staff had the supervision, training and personal development plans that they needed.

Is the service caring?

All of the people and their relatives spoken with told us that they felt that the service was caring. A person that lived at the home told us, "I don't find anybody unpleasant." Another person told us, I like it here and the people are all pleasant."

During the two days that we inspected the home we saw good interactions with people that lived at the home and staff.

Is the service responsive?

All the people and their relatives that we spoke with told us that they had no complaints about the care provided. A relative told us, I made a complaint a long time ago and they dealt with it. I think they would address complaints."

We saw that the provider had introduced new activities and community involvement for people, so that their social needs were met.

Records looked at did not contain a pre-admission assessment and an audit trail was not available to show if an assessment had been undertaken prior to admission or that care needs were being reviewed.

Procedures were in place to ensure that people's lifestyle and preferences were recorded, but these were not completed on the records that we saw.

Is the service well led?

Whilst people and relatives spoken with had no concerns about the service they received. We found that effective systems were not in place to monitor the quality of the service. This has led to shortfalls in a number of the regulations that we assessed.

The registered manager was absent from the home for an indefinite period of time. The deputy manager was designated to be in charge of the home and we have been kept informed of the changes by the provider.

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 24 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

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 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

There were 25 people living at the home at the time of our inspection. We observed that the home had a homely atmosphere and we saw that staff interacted well with the people that lived there. We spoke with five people living there all of them told us that they liked living in the home. One person told us, "They are treating me good and I am settled and get on with them. It's good now." Another person said, "The staff are alright, they are caring for me." A relative told us, "I have no major concerns about the care at the moment." This meant that people were happy living at the home and had no concerns about their care.

Since we last inspected the home we saw that the provider had improved activities within the home. One person we spoke with told us, "We go out sometimes in the local area." We saw the activities coordinator helping someone to put their coat on to go out for the afternoon on the first day that we visited the home. We visited the home on a second day and someone told us they were going out for coffee in the afternoon. We saw records which showed when people were involved in activities. We were told that improved activities included gardening, cooking, making snacks and drinks and maintaining or regaining skills with one to one hobby sessions. The home was also encouraging and supporting people to use the iPads and access video technology with their relatives. This meant that people were involved in meaningful activities that supported their involvement in the local community.

We saw that people were dressed in clothing appropriate to their gender and the weather. We saw that everyone looked well groomed so that their dignity was maintained.

Before we inspected the home we received a concern which indicated that the needs of one person were not being met. We did not find evidence to indicate that this person's needs were not being met. This was because the provider told us and records showed

that the district nurses visited three times during March 2014 to order pressure relieving equipment and to check pressure areas. The provider said they had also purchased moving and handling equipment to help in moving and handling the person appropriately. However, all staff spoken with told us that the person's needs were too great for them to manage due to their increasing dependency and the deterioration of their condition. A member of staff told us and records showed that the GP had visited and advised nursing care. At the time of our inspection a full reassessment of the person's nursing needs had not been undertaken, so staff would not know the level of nursing input that would be required. Whilst we respect that district nurses were visiting to support this person's care. The care plan that we saw did not include the frequency of visits that were necessary to ensure that the person received the necessary nursing support and what action staff should take.

We looked at the care records of six people that lived at the home. We saw that a new process had been introduced for planning people's care. However, whilst the process itself was intended for staff to adopt a person centred approach to how people's care was planned. The process was not used effectively to plan people's care. For example the care plans were not detailed in a person centred way. All the records that we saw showed conflicting information about people's needs. One person's care plan that we looked at did not identify the person had any difficulties with their mobility. However, we saw from the daily records that staff struggled with the person on 3 May, as they couldn't walk. We could find no other mention of why this person's mobility had changed or when this change occurred. The assessment that we saw stated that the person was mobile and needs support from one care worker. Given that this person had varying degree of mobility we did not see a moving and handling assessment for this person. This indicated that the person's mobility needs had not been properly assessed.

Another record that we looked at showed and staff said that there were increased behavioural issues of a person that had impacted on other people living in the home. However, we saw that this person had not had a review of their mental health needs to determine the cause of these behaviours. Incident records that we looked at showed that another person also had behaviours that challenged the service. Issues relating to this person's behaviours were also highlighted to us by staff and we saw that action was taken to contact an appropriate health care professional. We saw that only one of these people had an adequate behavioural plan in place to support their behaviours. This meant that not everyone was adequately supported to manage their behaviours.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

All of the people that we spoke with said they felt safe living at the home. One person told us. A relative that we spoke with told us, "I feel dad is safe there."

All staff spoken with said they would report any issues of concern to the managers for investigation. They knew about external agencies that they could contact in order to keep people safe. We saw that the provider had introduced a safeguarding pledge. A person that lived at the home was designated as safeguarding advocate and they were supported by a member of staff who was the safeguarding monitoring person. We saw that both the safeguarding advocate and the member of staff monitored the procedures that were in the home for safeguarding people. This included, staff recruitment, staff training and knowledge of safeguarding. We looked at a sample of care staff recruitment records and we saw that all had received the relevant checks to ensure they were safe to work with people that lived at the home. This meant that the provider had good processes in place to help in keeping people safe.

However, we found that the procedures did not always work in practice. For example before we undertook our inspection we received concerns about an incident that happened at the home, which would be classified as safeguarding. All staff that we spoke with during the inspection were aware of the incident. We checked the incident record and we saw that there was a record of the incident. However, we saw no evidence that any action had been taken following this incident. The provider told us that he was not aware of this particular incident. In addition to this the incident record also showed that a safeguarding incident between people that lived at the home occurred the day before our visit. Again we saw that no action had been taken. The incident had not been referred to the local safeguarding team and both the deputy manager and the provider were not aware that the incident had occurred. This meant that staff were not recognising incidents that should be reported as safeguarding matters.

The provider did advise us of another incident involving the same people. One incident

had been investigated and deemed not to be safeguarding. We were told that a safeguarding alert was made for another incident between people that lived at the home. However, we were not notified of this at the time. We also checked with the local safeguarding authority and they had no record that this alert was made to them. This showed that the provider was not ensuring that safeguarding alerts were made when required to do so. In addition they were not keeping us informed about safeguarding matters as required by the regulations.

Following our first visit to the home on 8 May 2014 the provider told us that they would make a safeguarding alert to the local safeguarding team for the incident that took place the day before our visit. We visited the home again on 15 May 2014 and although the provider retrospectively sent us a notification about the incident we saw no record of this alert having been made to the local safeguarding team. This meant that the provider was not following the local guidance to ensure that people were safeguarded from harm.

Records that we looked at showed that safeguarding incidents that had occurred between people. There was no capacity assessment to assess whether these people were able to make informed decisions about these issues. We saw that the provider had discussed these incidents with relatives. However, there were no plans in place to support the people who had experienced these actions to minimise the risk of this happening again. This meant that the provider had not given sufficient consideration to the wellbeing of people. We made a safeguarding alert to the local safeguarding authority following this inspection. We spoke with the local safeguarding team. They advised us that records provided to them by the home showed that two other safeguarding incidents had occurred and safeguarding alerts had not been made regarding these incidents. These incidents had happened since we inspected the home and highlighted to the provider the serious nature of these incidents. This meant that staff were consistently failing to report safeguarding incidents and therefore people were not safeguarded from harm.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough staff available to meet the current needs of people that lived in the home.

Reasons for our judgement

Prior to our inspection we received a concern that people were having to get up at four o'clock in the morning due to the staffing levels within the home. On the first day of our inspection the deputy manager told us that the usual staffing levels were three care workers, a manager and two domestic staff during the days. At night there were two care workers on duty. All staff spoken with confirmed this to be the usual staffing levels. We looked at a sample of staff rotas and we saw that the staffing levels were as described by the manager. We were told that with the exception of one person all of the people that lived at the home had low level care needs. We spoke with a relative who told us that they thought staffing numbers could improve.

All staff that we spoke with told us that people start to get up at five o'clock in the morning and that usually by eight o'clock all the people that lived at the home were up for the day. Although staff told us that some people liked to get up early. The general view of staff spoken with was that night staff felt pressured into getting people up by eight o'clock. A person living at the home told us, "I get up quite early, but it's natural for me to get up early." This indicated that some people liked to get up early in the morning.

All staff spoken with told us that one person living at the home required two people to support them. This person lived on the first floor of the home. They told us that when they were attending to this person during the night there were no staff available on the ground floor to ensure that the other people were safe. Staff told us that they had asked the provider for an extra member of staff, but this had been decided on at the time of our inspection.

On the second day of our inspection we found that there were only two care workers plus a senior care worker, who was acting as deputy manager at the time. This meant that the staffing level on that day did not reflect the usual staffing levels. After we arrived at the home another senior care worker who was expected to be on duty later on, was asked to come on duty early to increase the staffing numbers. This indicated that there was flexibility to increase the staffing numbers as required.

Records that we looked at showed that a number of incidents had occurred between people using the service, these were not being analysed so the provider would not be able

to determine if staffing numbers were impacted on the when these incidents occurred.

All staff spoken with told us that one person living at the home required two people to support them. This person lived on the first floor of the home. They told us that when they were attending to this person during the night there were no staff available on the ground floor to ensure that the other people were safe. Was there any evidence of anything happening to adversely affect people Staff told us that they had asked the provider for an extra member of staff, but this had been decided at the time of our inspection. The provider may wish consider how best to ensure that staffing levels at the home was calculated, giving the layout of the home and the numbers of people that lived there.

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

During the inspection we spoke with two care staff, the deputy manager and two senior care workers. All staff spoken with told us about improved procedures for supervision, staff meetings and staff appraisal that had been put in place recently. They told us that meetings took place on a more regular basis and that their supervision sessions were more in-depth. This meant that systems were in place to ensure that staff had the support they needed to do their job.

The provider may wish to take note that staff spoken with had mixed views as to whether or not they felt supported in their role. Comments were made about the recent changes in the home and that this had an impact on how staff were currently feeling.

We looked at the records of three care staff and we saw that they all contained evidence of training, supervising and appraisal. There was a training plan in place showing what training had been planned for staff during the year. We saw that some staff had recently attended challenging behaviour training and manual handling training. All staff spoken with said that they received training, this included dementia awareness, medication food hygiene and safeguarding. We observed that most people that lived at the home had low level care needs and we saw that staff were able to meet those needs. This indicated that staff had the opportunity to receive the training they needed to do their job.

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 received. The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service.

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

All the people that we spoke with told us that they were happy with the care they received at the home. One person told us, "I am quite comfortable. They are treating me kind for the most part." A relative told us, I know the management do as much as they can, but I think there is room for improvement."

We saw that people and their relatives had completed surveys during February and March 2014, but they had not been analysed at the time of our inspection.

We saw that complaints recorded in a book, which showed what action had been taken. However, they were not being analysed for trends or themes , so the provider could take action to minimise the risk of reoccurrence.

We saw that there were some systems in place for auditing care plans, medication, and bedrooms. However, we identified a number of inconsistencies in the care plans, which indicated that the audits were not effective. In addition an audit trail which showed when people's care needs had been reviewed was not available. This meant that we could not determine when and if people's care was being reviewed and monitored.

After our last inspection on 19 June 2013 the provider notified us that the registered manager would be absent from the home for an indefinite period of time. We were notified by the provider that the deputy manager would manage the home in her absence. This meant that the provider kept us informed about the management arrangements in the home.

Records looked at showed that some incidents that occurred between people using the service had not been acted upon. Both the provider and the deputy manager said they were not aware of these incidents. This meant that the provider did not have effective

communication systems within the home.

Accidents and incidents were not monitored and analysed, so that the management would have an overview of these occurrences and ensured staff learnt from these. Where the provider had made safeguarding alerts to the local safeguarding authority prior to our inspection they had not notified us in line with the regulations.

With the absence of the registered manager the home does not have an adequate structure to ensure the home was managed effectively, therefore the home was not well led.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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 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

During the inspection we looked at the care records of six people three of which we looked at in detail. The records contained conflicting information about people needs. For example one record we looked stated that a person was unable to understand information and said yes to everything. Yet the mental capacity document assessment said no the person didn't lack capacity. However, we couldn't see how this conclusion had been drawn as the assessment had not been completed. Another record contained a copy of a court of protection order; again their capacity assessment document stated that they did not lack capacity. Again the assessment to make this judgement had not been completed. This meant that records did not demonstrate that people's rights were being safeguarded.

None of the care plans that we looked at had been signed by the person or a representative. One person's care record showed that they needed to be weighed monthly. We saw that they were last weighed 10 March 2014. This person's record also showed that they had a visit from the GP on 25 April 2014; they were put on antibiotics due to a water infection. The doctor recommended increased fluid intake. There were no records to show how this person's fluid intake was monitored. This meant that adequate records were not maintained to ensure safe care for this person.

Another person's care plan showed the assessed needs on the skin mark person centred plan, was to check pressure areas and apply cream after every pad change. We checked the daily care records for April and May 2014. The records did not show when or if cream had been applied.

On all the records looked at we could not see that original assessment for the person. We asked to see the audit trail for one person's record, so we could determine at what point their needs had changed. We were told that some records had been achieved but staff could not locate the records that we wanted to see. This meant that records were not kept in a way to ensure that they were easily accessible.

All the records that we looked at showed incomplete assessment documents and sections

of the person centred plans that contained no information at all. Care plans that we saw stated the objective of the plan was "To know." This would make it difficult for staff to monitor care was delivered in accordance with the objectives of the care plan.

We looked at the records of people that had been involved with incidents with other people that lived at the home. We saw that their experiences were not recorded in their care records and there was no record of any support being offered. This meant that the records did not identify that they had gone through a traumatic experience.

We inspected the home over two days, we asked to see safeguarding alerts that the provider told us they had made. However, these were not available in the home for us to see. Staff were unable to locate incident reports and investigation reports during the inspection. After the inspection these were emailed to us by the provider. This meant that records relating to people's care were not available in the home.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care plans were not detailed in a person centred way. People's mobility needs were not clearly identified, so that they could be managed adequately. This is in line with regulation 9 (1) (b) (i) (ii).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Safeguarding incidents were not been reported and acted upon appropriately. This is in line with regulation 11 (1) (a) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or 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: Accidents and incidents were not always reported and analysed. Records relating to people's care were not always readily

This section is primarily information for the provider

	available in the home. Complaints and comments were not analysed. An audit trail was not available to show that people's care needs was monitored and reviewed regularly. This is in line with regulation 10 (1)(a)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Numerous inconsistencies and gaps were noted in people's care records. This is in line with regulation 20

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 24 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:

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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