Inspection Report

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

Genesis Care Home

197 Peter Street, Macclesfield, SK11 8ES

Tel: 01625421623

Date of Inspection: 18 September 2014

Date of Publication: November 2014

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

Care and welfare of people who use services	✖	Action needed
Safeguarding people who use services from abuse	✖	Enforcement action taken
Safety and suitability of premises	✖	Action needed
Staffing	✖	Enforcement action taken
Supporting workers	✖	Action needed
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Records	✖	Enforcement action taken

Details about this location

Registered Provider	Winnie Care (Macclesfield) Ltd
Registered Manager	Mrs Amanda Elizabeth Sargeant
Overview of the service	Genesis is a three-storey purpose built care home for people over 65 years of age. The home is owned by Winnie Care (Macclesfield) Ltd and is located in Macclesfield. It is close to the local shops and other community facilities. There are 42 single bedrooms all of which have en-suite facilities. Each floor has a lounge and dining area and access between floors is by a passenger lift or one of the staircases.
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

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 September 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and reviewed information given to us by the provider.

What people told us and what we found

We undertook a responsive inspection of Genesis Care Home on 18 September 2014 because we had received information of concern regarding poor safeguarding arrangements for people who lived in the home and low staffing levels (particularly at night) that were putting people at risk from harm.

During the inspection we spoke with seven members of staff. Some were on duty in the home and some we spoke with on the telephone. We also spoke with seven of the people who lived in the home and two of their relatives.

We considered all the evidence we had gathered under the outcomes we inspected. We used the information to answer the five 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?

Below is a summary of what we found. The summary is based on our observations during the inspection, speaking with people, the staff supporting them and from looking at records.

If you want to see the evidence supporting our summary please read the full report.

Is the service safe?

We had been told prior to our inspection that an incident had occurred where a person who lived in the home had behaved in an abusive manner. We were able to confirm that this had occurred and had not been dealt with in line with safeguarding procedures. We looked at the systems that had been put in place following this incident and were not

satisfied that people were being protected from potential harm or abuse. We contacted the local authority safeguarding unit to share our concerns and to ensure that appropriate steps were taken to protect the people who lived in the home.

Prior to our inspection we had received information of concern that told us that staffing levels were very low at the home and there were regular times when there were not enough staff on duty to meet the needs of the people who lived in the home.

We asked the deputy manager and they told us that the agreed staffing levels were six staff on the morning shift, four staff on the afternoon shift and three staff on the night shift. We looked at the rotas for the six weeks prior to the inspection and we saw that these staffing levels were often not maintained. We saw that there were regular night shifts that were covered by only two members of staff. We were aware that there were a small number of people living in the home who required two staff to support them with their personal care needs. This meant that if staff needed to support them during the night this left the rest of the building unattended. We asked if a dependency tool was used to monitor and evaluate the changing needs of people to ensure that staffing levels were maintained at adequate levels. We were told that there were no tools used and the staffing levels had been the same for years but were currently not maintained.

Is the service effective?

We asked about staff support and supervision sessions and were told that these did not take place. We looked at the supervision records for 11 staff and saw that only three of them had received one supervision this year and some had never had any supervision sessions. We saw that some appraisals had taken place but that most of these were over a year ago.

We asked about training and staff told us that training did not often take place due to staff shortages. We spoke with one of the senior care staff who was also the home's staff trainer. They told us that training was often cancelled due to time and staff constraints. They were constantly working on the rota which left no time for training.

Is the service caring?

During our inspection we spoke with seven people who lived in the home and two of their relatives. All of them spoke very highly about the staff and the care that they received but significant concerns were raised about staff shortages. People told us that the staff worked very hard to meet their needs. Comments we received included; "I have really good relationships with the staff but they work too hard and never get a minute to chat" and "The staff are very busy and very kind. They do so much for us and they are run ragged and it's not fair on them."

Throughout the day of our inspection we observed staff interacting with people who lived in the home. We saw warm, positive interactions. It was obvious that the staff had very close relationships with the people that they were caring for. We saw that people were treated with dignity and respect and were also having a laugh and a joke with the staff. One person who lived in the home said to us "I love it here. I've acquired a selection of daughters."

Is the service responsive?

Examination of care records showed that care plans had not always been updated to

reflect people's current personal and healthcare needs. For example, we saw one person in the home whom we had observed required significant support from staff to meet their personal care and mobility needs and to support them to eat and drink. We looked at their care records and saw that they had not been updated to meet their current needs and had not been evaluated since March 2014. We were concerned as their needs had changed considerably but the records did not reflect any of these changes.

Is the service well led?

During our inspection we were not able to access any audit information as the staff were not aware of where the information was stored. We spoke with the manager the following day and they emailed us the most up to date audits. We saw that the last care plan audits had been carried out in February 2013. We were concerned as the care plans were very poor and the lack of monitoring had contributed to this as regular audits would have highlighted the issues. There were no audits in place to monitor staff supervision or training. Regular monitoring of these would have identified the lack of both taking place for the staff.

We saw that no staff team meetings were taking place and the last meeting for people who lived in the home had been held in December 2013. The activities programme we saw said that a 'resident's forum' took place on a monthly basis but there were no records to evidence that these were taking 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 25 November 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

We have taken enforcement action against Genesis Care Home to protect the health, safety and welfare of people using this service.

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 and treatment was not planned and not delivered in a way that ensured people's safety and welfare.

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

Reasons for our judgement

During our inspection we spoke with seven people who lived in the home and two of their relatives. All of them spoke very highly about the staff and the care that they received. Significant concerns were raised about the staff shortages which we have reported in the 'Staffing' section of this report. People told us that the staff worked very hard to meet their needs. Comments we received included; "I have really good relationships with the staff but they work too hard and never get a minute to chat" and "The staff are very busy and very kind. They do so much for us and they are run ragged and it's not fair on them."

Throughout the day of our inspection we observed staff interacting with people who lived in the home. We saw warm, positive interactions. It was obvious that the staff had very close relationships with the people that they were caring for. We saw that people were treated with dignity and respect and were also having a laugh and a joke with the staff. One person who lived in the home said to us "I love it here. I've acquired a selection of daughters."

We asked about activities and were told that this was also the responsibility of the care staff. Staff told us that they did activities when they could but these were limited due to time constraints. We saw that there was a daily programme of activities but this mainly consisted of hairdressing and the 'Daily Sparkle' which was a newspaper that was handed out for people to read. We did not see any activities taking place during our inspection. We saw that the staff barely had any time to talk to people as they were trying to make sure that everyone's basic care needs were met.

We looked at four care plans for people who lived in the home and we had significant concerns about all of them. They did not reflect the current needs of the people they related to. We have explored this in more detail in the 'Records' section of this report.

We saw that the home had applied for a Deprivation of Liberty Safeguards (DoLS) authorisation to ensure that they could safely meet the needs of a person who lived in the home. This application had been granted and we saw that a risk assessment had been written with regards to the risks. However this risk assessment was not being followed and the person's behaviour presented a significant risk to the care and welfare of some of the people who lived in the home. We have explored this in more detail in the 'Safeguarding' section of this report.

We have reported our findings from this inspection to the local authority safeguarding unit and have asked them to investigate our concerns.

Safeguarding people who use services from abuse ✖ Enforcement action taken

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 major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We included this outcome because of information of concern that we became aware of during our inspection.

We had been told prior to our inspection that an incident had occurred where a person who lived in the home had behaved in an abusive manner. We were able to confirm that this had occurred and had not been dealt with in line with safeguarding procedures. The incident had been reported to the local authority as a 'care concern' and had not been notified to the Care Quality Commission. We looked at the systems that had been put in place following this incident and were not satisfied that people were being protected from potential harm or abuse. We contacted the local authority safeguarding unit to share our concerns and to ensure that appropriate steps were taken to protect the people who lived in the home.

During our inspection we were made aware of another incident that had not been reported appropriately to the local authority and had not been notified to the Care Quality Commission. We saw that health professionals' advice had been sought to support the people involved but the appropriate steps had not been followed to record how the person's behaviour was to be managed.

We spoke to staff about safeguarding procedures. They were unclear about how information of concern should be reported. We looked at the training records for five staff and saw that only one of them had received safeguarding training and this was over two years ago. There was no evidence to show that the other staff had received any training.

We asked if there were safeguarding and whistle blowing policies. The staff we spoke with did not know. The deputy manager said that there was one and showed us a safeguarding policy that was dated September 2005. We pointed out that this was very old and an

updated version was required.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

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 included this outcome because of information of concern that we became aware of during our inspection.

We spoke with staff and they shared their concerns that the building was not secure and that it was too easy to gain access to the building. Staff told us that they had raised their concerns with the manager but that nothing had been done.

We saw an entry in the communication book regarding concerns raised by the local police in August 2014. The police had attended the home and had managed to access the building without the staff's knowledge. The police had strongly recommended that the key pads on the doors were changed. However no action had been taken to rectify this.

Staff also shared their concerns about the access to the building from the fire escape ramp. They told us that visitors had accessed the building through this door and were in the building without the staff being aware. This was a risk to the safety of the staff, the people who lived in the home and to visitors. These concerns had been raised with the manager but no action had been taken.

The manager was not available on the day of our inspection. We spoke with them the following day and they told us that the staff had shared our concerns with them about the security of the building and they had contacted a locksmith to improve the security of the building as soon as possible.

Staffing ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Prior to our inspection we had received information of concern that told us that staffing levels were very low at the home and there were regular times when there were not enough staff on duty to meet the needs of the people who lived in the home.

We asked the deputy manager and they told us that the agreed staffing levels were six staff on the morning shift, four staff on the afternoon shift and three staff on the night shift. We looked at the rotas for the six weeks prior to the inspection and we saw that these staffing levels were often not maintained. We saw that there were regular night shifts that were covered by only two members of staff. We were aware that there were a small number of people living in the home who required two staff to support them with their personal care needs. This meant that if staff needed to support them during the night this left the rest of the building unattended. We asked if a dependency tool was used to monitor and evaluate the changing needs of people to ensure that staffing levels were maintained at adequate levels. We were told that there were no tools used and the staffing levels had been the same for years but were currently not maintained.

We spoke with seven people who lived in the home and six of them raised concerns with us about the lack of staff. The person who did not have concerns had only recently moved into the home. They told us that even though they were not concerned, they had been unable to have a bath on their agreed day and had waited an additional two days because of staff shortages. The people who had raised concerns made comments such as; "The staff are very overworked and we need more of them" and "It's like the Marie Celeste at night." All of the people we spoke with stressed to us that they thought that the staff were "wonderful" and "very hard working" but that they felt sorry for them as there was not enough of them.

During our inspection we spoke with seven staff. Some of these staff were on shift and others we spoke with on the telephone. All of them raised concerns about the poor staffing levels and the impact of this on the people who lived in the home and on themselves.

Discussion with staff and examination of the rotas confirmed that staff were working very long hours, up to fourteen hour days for days at a time. Some of the staff told us that they liked working extra hours but there was a limit to the number they could work. They also told us that they felt under constant pressure to work the hours because they had a duty to the people who lived in the home and to support each other.

We asked about relief staff and were told that there was one but this person had other commitments and could only work limited hours. We asked about agency staff and we were told that they were not allowed to use any so all additional hours had to be covered by the existing staff team.

Throughout our inspection we walked around all three floors of the building. We saw that floors were often left unattended as there were not enough staff to ensure that there was always a staff member on each floor. There were five staff on duty on the morning of our inspection instead of six. We also noted that the deputy manager was included in these five but that they spent the majority of their time in the office trying to get staff cover for other shifts, ordering medication and answering the telephone.

We saw that two days prior to our inspection, medication training had taken place. We asked how staff had attended this training and we were told that they had been taken off the morning shift to attend. This meant that three staff had been left to cover the needs of 39 people whilst the training took place.

We were also told that there was a problem with staff going off sick in the home, particularly on nights and that the evening staff were often anxious about this because they knew that they would have to stay on and work a night shift when this happened. We could see from the rotas that staff ringing in sick was a big problem particularly as there were no relief staff to call on.

We asked about on call arrangements and we were told that there were no formal arrangements and the staff would try to contact the manager or the deputy manager if they had a problem.

We spoke to the manager on the day after our inspection and we told them that the staffing levels were inadequate and immediate action needed to be taken to rectify this.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not supported to deliver care and treatment safely.

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 asked about staff meetings and we were told that these were rarely held. We asked to see the minutes of team meetings and we saw that the last team meeting was held in August 2013, over a year previously. Staff told us that they had been asking the manager to hold a staff meeting to discuss their concerns about the lack of staff but that none had been arranged.

We asked about supervision sessions and were told that these did not take place. We looked at the supervision records for 11 staff and saw that only three of them had received one supervision this year and some had never had any supervision sessions. We saw that some appraisals had taken place but that most of these were over a year ago.

We asked about training and staff told us that training did not often take place due to staff shortages. We spoke with one of the senior care staff who was also the home's staff trainer. They told us that training was often cancelled due to time and staff constraints. They were constantly working on the rota which left no time for training.

We looked at the training records for five staff and saw that most of the training completed was out of date. We had difficulty determining exactly what training had taken place as training records were stored in staff files and training files in two different offices. We saw a number of spread sheets that contained different information.

We asked staff if they felt supported in their jobs and they told us that they worked hard to support each other because there was no other support available.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

During our inspection we were not able to access any audit information as the staff were not aware of where the information was stored. We spoke with the manager the following day and they emailed us the most up to date audits. We saw that the last care plan audits had been carried out in February 2013. We were concerned as the care plans were very poor and the lack of monitoring had contributed to this as regular audits would have highlighted the issues.

The manager also sent us continence audits. These consisted of a monthly list of people who lived in the home and the continence products that they used. We could not see any purpose for these audits. We were not provided with any health and safety audits or infection control audits except for 'bare below the elbow' audits which had last been completed in June 2014.

There were no audits in place to monitor staff supervision or training. Regular monitoring of these would have identified the lack of both taking place for the staff.

We saw that no staff team meetings were taking place and the last meeting for people who lived in the home had been held in December 2013. The activities programme we saw said that a 'resident's forum' took place on a monthly basis but there were no records to evidence that these were taking place.

Records

✖ Enforcement action taken

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 major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We added in this outcome as we were concerned about the poor standard of records we observed during our inspection.

We looked at four care files for people who lived in the home and found poor monitoring and recording in all of them. For example we looked at one person's file and saw that there was a care plan for their pressure areas. The care plan identified them as being at high risk from pressure sores. This care plan had not been reviewed since October 2013 and prior to that in March 2012. This meant that this person was at risk from receiving inappropriate care as they were not being monitored at regular intervals. We also saw from the care records that this person sometimes behaved in a way that put other people at risk. Their risk assessment regarding this behaviour had not been reviewed since June 2014. We were aware from looking at other records that an incident had occurred in August 2014 but their care plan had not been updated to reflect this or inform staff how they needed to support the person.

We looked at the care records for another person and saw that their care plans were last reviewed in November 2013. This person had some health concerns and some behavioural issues that could impact on other people who lived in the home and these issues were not being monitored. We also noted that all of their care plans had been written in March 2011 and had not been rewritten or updated since. This person had last had an 'in house review' in September 2011. We spoke with staff and they told us that this person's needs had changed significantly and that their care plans did not reflect their current needs.

We saw one person in the home whom we had observed required significant support from staff to meet their personal care and mobility needs and to support them to eat and drink. We looked at their care records and saw that they had not been updated to meet their current needs and had not been evaluated since March 2014. We were concerned as their

needs had changed considerably but the records did not reflect any of these changes.

We looked at training records but found it difficult to interpret the information as records were stored in different places in the home and some contradicted others.

All of the policies and procedures that we saw were old and required updating. They were also stored in various different places in the home and when we asked staff they were unaware which records were the most up to date.

We spoke with staff regarding our concerns about the records. They all agreed that the records were poor. One staff member said; "My key persons' records are very poor. The only time I get to update them is on my break on a late shift."

We spoke with the manager on the day following our inspection and we told them that the records were inadequate and that people who lived in the home were at risk from receiving unsafe care and that immediate action needed to be taken to improve them.

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: The registered person had not taken proper steps to ensure that each service user is protected against the risks of receiving unsafe or inappropriate care or treatment.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The registered person had not ensured that service users and others were protected against the risks associated with unsafe premises.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met:

This section is primarily information for the provider

	The registered person did not have suitable arrangements in place to ensure that staff were appropriately supported to carry out their responsibilities.

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 25 November 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 31 December 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
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: The registered person had not made suitable arrangements to ensure that service users were protected against the risks of abuse.
We have served a warning notice to be met by 31 December 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The registered person had not taken appropriate steps to ensure that there were sufficient staff to meet the needs of the service

This section is primarily information for the provider

	users.
We have served a warning notice to be met by 31 December 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
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: The registered person was not protecting the service users and others against the risks of receiving unsafe care as there were not regularly assessing and monitoring the quality of the service provision.
We have served a warning notice to be met by 31 December 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
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: The registered person had not ensured that service users were protected from the risks of unsafe care as there was a lack of proper information about the needs of people who used the service.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk