Inspection Report

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

The Old Rectory

Spring Lane, Lexden, Colchester, CO3 4AN

Tel: 01206572871

Date of Inspection: 09 June 2014

Date of Publication: July 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
Cleanliness and infection control	✖ Action needed
Management of medicines	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Adiemus Care Limited
Registered Manager	Mrs Agnieszka Helena McDonald
Overview of the service	The Old Rectory is a care home that provides accommodation and personal care for up to 60 older people including care and support for people living with a diagnosed dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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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 9 June 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 talked with other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We carried out our inspection in response to information of concern received from the local authority and others about the care and support provided to people who used the service. As part of this inspection we spoke with 12 people who used the service, four Relatives, seven staff and the registered manager. 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?

We did not find that all areas of the service were safe.

We saw that infection control checks were not robust and effective. We found areas of the service that were poorly maintained and unhygienic. A compliance action has been set in relation to this and the provider must tell us how they plan to improve. There was insufficient domestic staff available to keep the service clean and free from the risk of cross infection.

The registered manager had a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). There were no DoLS currently in place. Staff had been provided with the training they needed which would ensure that

people were only deprived of their liberty when they needed to be so.

The staff team were skilled and experienced. However, we found concerns with regards to the staffing levels on Redwood unit which was designated to provide care and support for people living with an advanced dementia. Staffing levels were not consistently maintained and were at times insufficient to meet people's needs. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

We found medicines were stored safely for the protection of people who used the service. We were assured that appropriate and effective monitoring arrangements were in place to identify and resolve medication errors promptly.

Is the service effective?

People's care records showed that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

During our observations we saw that people on the Redwood unit were bored, and disengaged. We saw that there was little evidence that the service provided activities specifically designed to engage and stimulate people living with a dementia.

The provider had a quality assurance system in place and the records we examined showed that health and safety audits had been carried out. However, due to our concerns found during this inspection, it was not evident that these audits were effective in keeping people safe from the risk of infection and robust enough to ensure that their needs were met by enough qualified staff. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

Is the service caring?

Staff supported and interacted with people in a friendly and supportive manner. However, staff were seen to be rushed and stressed, which meant that we could not be assured that the people who used the service received appropriate care and support.

Is it responsive?

Where concerns about an individual's wellbeing had been identified, staff had taken appropriate action that ensured people were provided with the healthcare support they needed. This included seeking support and guidance from care professionals, including dieticians, doctors and community nurses.

We found that activities provided for people living with a dementia were limited and not always appropriate given some people's complex needs as a result of their living with a dementia.

Is the service well led?

The manager held 'residents' meetings and a weekly surgery where people could speak with them to discuss any concerns they may have about how the service was managed.

We saw there were insufficient numbers of trained staff available on a daily basis to meet people's needs. Action had been taken by the manager to recruit new staff. However, there was insufficient staff deployed to meet the needs of people living with a dementia on

Redwood unit.

Quality audits were not always robust in identifying shortfalls, for example in monitoring the cleanliness of the service. There were insufficient systems in place to control the risk of cross infection.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

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 always 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

Not everyone who lived in the service was able to communicate with us verbally due to their complex needs. We spoke with 12 people who used the service and who were able to express their views. One person told us, I pull the cord (call bell) and they are quick. They look after me." Another person told us, "I feel safe here. It is a good place."

We noted that there were a high number of people using the service who had been diagnosed with a dementia. The registered manager told us that there were no current applications in place under the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). We discussed the recent Department of Health guidance to health and social care organisations with regards to assessing the best interests of people who lacked mental capacity to make decisions about their everyday lives. This was to confirm their understanding of when a person who required constant monitoring resulted in a potential deprivation of their liberty. The registered manager explained the correct procedures they would follow which would ensure people's rights were protected. We were assured that the manager had the necessary knowledge to ensure that people were only deprived of their liberty when this had been assessed to be in their best interests by those qualified to do so.

Care plans were informed by risk assessments, for example moving and handling, falls and pressure ulcer risk assessment tools. This showed that care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We saw that everyone was weighed regularly to ensure that their risk of malnutrition was assessed. A malnutrition universal screening tool (MUST) was used to assess the risk of malnutrition, along with risk assessments which considered the risk of pressure ulcers developing, falls and moving and handling needs. This showed us that risks to people who

used the service had been identified and minimised, and records we examined confirmed what we had been told. We noted that for one person recently assessed by a dietician due to concerns regarding their weight loss, it had been recommended that this person be weighed a minimum of two weekly. Weight monitoring records viewed showed us that this had not been implemented and this person's weight continued to be monitored monthly. We discussed our findings with the manager.

The daily records detailed the care and support the person had received that day and their health and wellbeing. Some of the people who used the service needed additional nutritional supplements with their meals and these were detailed in their care plan.

The service had three units, one of which, the Redwood unit provided for the needs of people with an advanced dementia. During our inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their limited mental capacity. We completed the SOFI in the lounge/diner on Redwood unit, a unit designated for people diagnosed with a dementia. Throughout our inspection we observed how staff supported and interacted with people who used the service. We saw that staff in general were friendly and supportive. However, staff were seen to be rushed and stressed, which meant that we could not be assured that the people who used the service received appropriate care and support.

We observed one carer on Rectory unit whilst they were supporting one person in their bedroom to eat their meal. This carer demonstrated kind and compassionate care. They took time to explain the choice of food and drink available with patience allowing the person time to respond without rushing.

We noted that people's only entertainment and stimulation throughout the day was the television. Without anything to stimulate them, people mostly slept or just looked into space. The majority of people did not receive any social interaction from staff throughout the morning and afternoon other than task related activities. We spent time talking with the activity coordinator, who told us they worked 35 hours per week. They told us that there was no weekly plan of activities and that the majority of activities they carried out were on a one to one basis with people. This included taking people to the local shops, church attendance and producing people's life stories. When group activities took place these included coffee mornings and crafts. The manager told us that there was an allocated budget for activities which although limited did provide for occasional outside entertainers. There were no items available for people to rummage through which might aid reminiscence. There was limited access to meaningful activities to enable people to remain engaged and motivated. We were therefore not assured that people had their needs adequately assessed with activities provided appropriate for people living with a dementia. We discussed our findings with the manager.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not cared for in a clean, hygienic environment.

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 saw that the service did not have effective systems in place to reduce the risk and spread of infection.

With spoke with 12 people who used the service. One person told us, "I have a bath two to three times a week or whenever I want. They change my bed sheets roughly once a fortnight but if tea gets spilt they change the sheets more often." One person's relative we spoke with told us, "The staff do their best but they could improve on their cleaning."

The manager told us that the majority of the staff, including domestic and kitchen staff, had completed infection control and food hygiene training.

We saw that there were hand-washing facilities and disposable paper towels in bathrooms and toilets, which minimised the risks of cross infection. We noted that staff wore aprons and gloves when assisting people in areas such as with their personal care and when handling food.

We saw records of cleaning schedules which consisted of a list of the rooms and bathrooms that domestic staff had signed when a room had been cleaned. However, there was no instruction of how the rooms should be cleaned that would ensure that they were clean and hygienic throughout.

When we looked around the service we found areas that were dirty and unhygienic. Several areas of the service had a strong, unpleasant odour. This meant that the cleaning of spills of substances that could cause an odour were not effectively cleaned.

With the registered manager present we examined six mattresses on Redwood unit by stripping the bedding, checking the cleanliness of the surface of the mattress and unzipping the cover to reveal the foam mattress inside. We found that the surface of four out of the six mattresses we checked was soiled which indicated that the surface of the mattress had not been washed or disinfected recently. When we opened the zips to reveal the inner mattresses, we found these to be stained and to have an offensive smell. When

asked, the registered manager told us that there was no schedule for cleaning and checking the mattresses inside and out and that it was not an area that they had audited other than bed change audits. We did not continue to check further mattresses, however, with no schedule of cleaning and checking mattresses in place, there was a high possibility that there were other soiled and unhygienic mattresses in the service.

The local authority's environmental health officer had visited the service recently and had rated the kitchen at five stars, which is the highest rating that could be awarded. However, when we looked at two satellite kitchens, where breakfast was prepared for people and other meals were served from, we saw that they were dirty and unhygienic. Drawers and cupboards were found to be unclean with food crumbs, sticky patches and debris in the drawers and on the window ledges. Clean cutlery was stored in these areas and had become contaminated. We saw that the inside of the microwave was dirty with food debris on the sides and the turning plate. When we moved microwaves we found the worktop underneath was stained with a sticky substance, food debris and crumbs. The counters in the satellite kitchens were generally dirty and the sealants had broken areas and tiles missing which would allow bacteria to penetrate and could not be cleaned and disinfected efficiently.

The fridge on Redwood unit was found to be unclean with milk which had become sour spilt in the bottom of the fridge. Sugar canisters were unclean with lumps of brown matter found in them.

En-suite toilets throughout the service were found to be stained as a result of lime scale build up. Limescale is a harbinger of bacteria and a source of cross infection. This meant that there was a potential risk of infection. We were therefore not assured that steps had been taken to ensure that people lived in a hygienically clean, safe environment free from the risk of cross infection.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Prior to our inspection we received information of concern regarding the management of people's medicines. Concerns related to the administration of medicines outside of the prescribed times as designated by the prescriber. For example, medicines due at 9pm given at 7pm.

We found that medicines were kept safely in lockable trolleys located in a lockable room that could only be accessed by senior staff responsible for the administration of medication. We found that there was a record of the temperature of the areas where medication was stored and these were within safe limits. We were therefore assured that medicines were stored in a way that maintained their quality.

People we spoke with told us, "My medication is given at the right time." Another, "There was a tablet on the floor for two weeks I picked it up and put it in the bin."

We looked at the care records and Medication Administration Records (MAR) and for five of the 45 people using the service on the day of our inspection. Care records contained a medication care plan with a medication profile which recorded medicines prescribed and guidance for staff in administration of these items. Each MAR contained a photograph of people. This helped staff ensure that they administered medication to the correct person. In general records for receipt were accurately completed. Records of medicines administered to people had been completed with no gaps.

We conducted an audit of medicines which considered medication records against the quantities of medicines available for administration. We were able to account for the majority of medicines we looked at with only one record where we found a numerical discrepancy of one item where we could not be assured that this person had received their medicines as prescribed.

Where people had been prescribed medicines on a 'when required' basis, for example, for pain relief we found that there was sufficient guidance for staff to follow in the circumstances when these medicines were to be used. We were therefore assured that guidance was in place for staff to ensure that medicines were administered when people

needed them.

We observed two senior staff preparing to administer controlled drugs. We noted that staff carried out a check of stock against the record of stock recorded within the controlled drugs register. However, we noted that one person's controlled drug Lorazepam, prescribed for treatment of anxiety to be administered at 9am was being prepared to be administered at midday. We discussed this with the two staff concerned who told us that the administration of this medicine had been forgotten from the morning round of medicines due to the shortage of senior staff available. We discussed our findings with the registered manager.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

We saw that there was not enough qualified, skilled and experienced care staff to meet people's needs.

One person we spoke with told us, "There is not enough staff after tea time. You don't see many staff after that time." Another person said, "I ring the bell and they are quick. I think there is enough staff but sometimes they need more as there are less of them. They could do with more staff in the daytime when people do not turn up for work and people are getting up or going to bed. Although I am quite happy here."

This service was registered for 60 people. At the time of our inspection 45 people were using the service. We were told that the allocation of staff for each of the three units, throughout the day and evening shifts were three staff which consisted of one senior carer and two carers for each unit. We found the staff team was skilled and experienced. However, we found staffing levels were not consistently maintained and were at times insufficient to meet people's needs. We found examples of low staffing numbers for 12 out of 28 days. On the day of our inspection two care staff were absent. Cover was found for one carer but not for the other. A senior carer stepped in to take on a carers role. This resulted in only two senior staff instead of three to cover medication administration. We also found examples of at least three occasions where the night shift was not staffed appropriately. We found that management had attempted to cover staff shortages with the use of agency staff.

The registered manager showed us a dependency level assessment tool used to assess the level of staffing needs for each of the three units within the service. This assessment had resulted in the allocation of two carers and one senior carer to each unit. As a result of our observations and discussions with staff and people who used the service we were not assured that there were sufficient numbers of staff allocated to Redwood unit. This unit was designated to meet the needs of people with complex needs as a result of their living with an advanced dementia.

We observed the midday meal on Redwood unit where we noted that staff were rushed

and stressed. Staff struggled to support several people at a time who required one to one support to eat their meals in the dining room as well as people who required support to eat their meals in their bedroom. We noted that staff would go from one person to another supporting several people at a time as well as seeing to other tasks such as dishing up meals and checking people had drinks. This indicated that there was insufficient numbers of care staff on duty. This meant that people's meals were interrupted and staff were not able to enhance their mealtime experience by spending uninterrupted time with each person.

On the day of our inspection we saw that some people spent long periods without being engaged in meaningful activities. There were no activities provided to people on Redwood unit. The staff we spoke with told us that they thought that there were not enough staff on duty to enable them to spend meaningful time with each person. One staff member said, "It is a struggle at mealtimes and we can't spend a lot of time with people."

Three domestic staff were on duty during our inspection, one told us that they were, "Kept busy." The manager told us that due to staff absence there had been only one domestic staff member on duty at the weekend. The poor quality of cleanliness and hygiene in the service indicated that there were insufficient trained staff available on a daily basis to ensure that the service was clean and hygienic at all times.

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

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 saw that people who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

The manager told us that they held regular residents meetings. They also told us they conducted a weekly surgery for two hours where people could access the manager to discuss any concerns they may have about how the service was managed. We saw notices located around the service which confirmed this provision. The manager told us that where concerns were identified action was taken to rectify any issues that were raised.

The manager told us that they carried out a range of management audits covering a wide range of areas which included reviewing people's care plans, complaints, medication monitoring, pressure ulcer and weight monitoring.

We saw reports which had been produced following the provider's compliance team visits to the service which had been carried out a monthly basis. These audits included discussions with people who used the service and checks to ensure that care and personnel files were up to date and had been reviewed regularly. The providers audit report for April 2014 identified concerns from one relative who said, "The home is in desperate need of some TLC and refurbishment. Mum's room is shabby, the carpets have seen better days and there is damage to the wall from the bed." We discussed this with the manager who showed us the room referred to and how this had recently been refurbished.

The provider's monthly audits included health and safety audits such as checks on fire safety, medication audits and the monitoring of cleanliness and infection control. However, as a result of our findings it was not evident that these audits were effective in identifying shortfalls with regards to the insufficient staffing levels on Redwood unit and the cleanliness of the service which resulted in the increased risk of cross infection. This showed us that the systems in place for auditing were not robust enough to protect people

from the risks associated with the unsafe exposure to healthcare associated infections and insufficient staffing levels to meet their needs.

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 planning and delivery of care and treatment did not meet people's individual needs. Regulation 9. (1)(b)(I))(ii)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: The registered person did not maintain appropriate standards of cleanliness and hygiene. There were ineffective systems in place to monitor the control of infection. Regulation 12. (1)(a)(b)(c)(2)(a)(b)(c)(I)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**

This section is primarily information for the provider

	How the regulation was not being met: IN order to safeguard the health, safety and welfare of people, the registered person had not taken steps to ensure that, at all times, there was sufficient numbers of suitably qualified, skilled and experienced persons employed to meet the needs of people who used the service at all times. Regulation 22
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: The registered person did not have an effective and robust system in place to identify and monitor the risks to people who used the service. This was in relation to the lack of sufficient, qualified staff and to ensure the cleanliness of the service with the associated risks of cross infection. Regulation 10 (1)(a)(b)

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 18 July 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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