Inspection Report

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

Holbeche House Care Home

Wolverhampton Road, Wall Heath, Kingswinford, DY6 7DA

Tel: 01384288924

Date of Inspection: 20 August 2014

Date of Publication: October 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	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	Four Seasons (Bamford) Limited
Overview of the service	Holbeche House care home can provide accommodation for up to 49 people who require nursing or personal care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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 20 August 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 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.

What people told us and what we found

We carried out this inspection in response to a number of concerns that we had received about the care and treatment that people received. Some allegations raised centred on concerns over a number of staff leaving the provider's employ and the impact this had on the care delivered to people. It was stated that people were at risk due to a lack of consistency in the way care was provided.

We checked to see that people's health and well-being was being promoted by the care home.

Below is a summary of what we found. The summary is based on our observations during the inspection, discussions with four people using the service, two visitors, six members of staff, and the acting manager and area manager. We also looked at five records relating to people's care and other records related to the running of the service.

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

Is the service safe?

People told us they felt safe at the home although we heard some concerns about the availability of staff. One person told us staff responded in a reasonably time. Another told us, "Sometimes there are not enough girls, they work very hard". A relative told us, "There are not enough staff" and, "Changes need to be made" but was encouraged by the response of the new manager in providing reassurance as to what they were doing about the views of relatives.

The manager and staff told us that a number of staff had left the home recently and this

had impacted on the ability of staff to provide effective and consistent care. The manager told us what steps they had taken to minimise the impact of reducing staffing levels, for example agency staff that were employed were as far as possible the same staff. They also told us that they were actively recruiting new staff. From our observations and looking at the staff rotas we saw that the provider was working to maintain staffing levels so that people's needs were met and they were safe.

Procedures for dealing with emergencies were in place and staff were able to describe these to us. People's records did not always describe how their safety should be promoted. For example ensuring monitoring systems were in place to alert staff when someone maybe at increased risk of falls.

The manager and staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). This is legislation that makes provision relating to persons who lack capacity, and how decisions should be made in their best interests when they do so. At the time of our inspection the manager had made some applications and they, and senior staff were able to describe the circumstances when an application should be made and knew how to submit one.

Is the service effective?

People all had an individual care plan which set out their care needs. People's relatives told us they had not been involved in the assessment of the health and care needs for people they represented and had not contributed to developing their care plan. People told us that the care and support they received was as they wanted it to be. We saw that assessments included people's specific health care needs although we did see that information in some care plans was not always accurate. Staff we spoke with did understand how to meet people's needs appropriately.

People told us that staff ensured they saw external healthcare professionals as needed to promote their healthcare.

We saw that staff knew people's individual care needs and wishes although planning for people's individual needs was not always accurate.

Is the service caring?

We saw on the day of the inspection that people were supported by kind and attentive staff. We saw that care workers showed patience and gave encouragement when supporting people.

Staff we spoke with were aware of people's preferences, interests, aspirations and diverse needs. Our observations of the care provided showed that people's individual wishes for care and support were taken into account and respected. People we spoke we told us that, "The girls are nice" and, "The people that look after me are alright". We did hear concerns from relatives about some people's care that the manager was to investigate.

Is the service responsive?

People told us, that they were satisfied with their day to day routines although we saw limited activities on the day of our inspection. The manager and staff told us this was an area that needed improvement. A relative commented that, "They do dancing, singing, used to do baking and have fun days such as the Black Country day".

People knew how to make a complaint if they were unhappy. Some relatives told us that concerns they had raised had not been responded to. This meant that some relatives felt their complaints were not taken seriously.

We did see that the manager was putting forums in place to gain the views of people and their relatives. We heard that the manager had changed residents and relative's meetings to an evening time so as to assist their attendance. Staff we spoke with also told us they felt the manager was listening to them one telling us the manager, "Listens to our views".

We have asked the provider to tell us what improvements that will make in relation to responding to people's complaints.

Is the service well-led?

The home had a system to assure the quality service they provided. The way the service was run had been regularly reviewed. We saw this had helped the new manager, who had been in post a short while, to identify areas that required improvement and tell us how they intended to put right any shortfalls they had found.

Information from the analysis of accidents and incidents had not always been used to identify changes and improvements to minimise the risk of them happening again.

People's personal care records, and other records kept in the home, were not always accurate and complete.

We have asked the provider to tell us what improvements that will make in relation to improving people's personal care records.

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 17 October 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 ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was delivered in a way that was intended to ensure people's safety and welfare but people or their representatives were not always involved in planning their care.

Reasons for our judgement

We carried out this inspection in response to concerns that we had received about how care and treatment was delivered to people. We looked to see how care was planned so that people's safety and welfare was promoted.

We observed the care that staff provided in both units in the home. We saw that staff responded well to people, and acknowledged people, as a matter of routine. We saw staff in the dementia unit were responsive to people when helping them with their midday meal, for example taking time to feed people, allowing independence when people were able to feed themselves and responding to people when requested, or when they noticed someone did not eat. We did note one occasion where a person was looking to attract the attention of staff, although did not verbally call out. As staff were busy with serving meals they did not note this which led to the person having some difficulties with personal hygiene. At this point we saw staff responded quickly. The manager and staff told us they are looking to introduce dementia care mapping, for which they were currently receiving training, which will help identify when staff need to be aware of people's behaviours and possible outcomes through observation.

We saw some people helped to stand or transfer on a number of occasions and saw that this was done safely with staff explaining what they were doing so the person was aware of what was happening. We spoke with some people about the care they received. One person told us, "Well looked after", another saying "Staff always there if I want some help".

We spoke with some relatives and one told us that the standard of care at the home had been a cause of concern to them over the last five months due to staffing issues. They told us, "Basic care and nursing of the home went down". They did say that the new manager had acknowledged that there was improvement needed and they were hopeful they would make the necessary changes. Another relative told us that the care a person received was better at Holbeche than their previous care home telling us, "Staff can cope better here,

always friendly, very understanding here". We were aware that the manager had received some complaints about the standard of care at the home and they acknowledged that they had identified there was need for some improvement. They told us they were working towards this, starting with the 'basics'. This was reflected by comments staff made one saying, "Things are getting better" and another, "We come together more as a team now team leader checking out things". This was indicative that the manager had identified areas where care delivery could improve and was working with staff to promote the meeting of people's needs.

The provider may find it useful to note that neither of the relatives we spoke with, who were representatives for people living at the home, had seen the person's care plan. One relative said, "Not seen care plan, and not involved in drawing up the care plan". People we spoke with were not aware of their care plans either. This meant that people or their representatives were not involved in planning their care when their care plans were written.

We were made aware of concerns prior to our visits about the care of people who had diabetes. We looked at care plans and records for two people that had diabetes that was managed through insulin injections. We discussed the management of people's diabetes with nurses and they showed a good understanding of how this health need should be managed safely, and in accordance with advice given by the appropriate external health professionals. We saw from records that people's blood sugars were monitored and appropriate action taken in accordance with what was found, for example glucose drinks were given if blood sugars were low as suggested by the diabetic management team. Nurses told us that changes to the site of the insulin injections people had had been changed again as per advice from the diabetic team. The sites of these injections were alternated and this was documented on care records that we saw. Staff we spoke with were aware of what they should look out for in regard to symptoms that indicated people with diabetics were unwell due to this health condition. A number of staff also confirmed that they were due to receive training in the management of diabetes in the near future. This meant that staff knew how to recognise risks to people's health when they had diabetes.

We looked at care plans for people who had fragile skin and were at risk of skin breakdown. These detailed the actions that staff should take to prevent skin breakdown and the equipment that was needed to aid this. We looked in people's bedrooms and found the appropriate equipment was available and records of repositioning showed this was carried out in accordance with the person's care plan. We spoke with staff who understood what they needed to do to promote the health of people with fragile skin. This meant that people with fragile skin received appropriate care to prevent further risks to their health.

We saw in one person's care plan that it stated they should have a crushable medication in jam. We discussed this with some nurses and were told that they gave the medication with water not as detailed in the care plan. The provider may find it useful to note that this was not recognised as a covert medication in discussion with nurses. We did not see a confirmation from the person's doctor that it should be given in this way although it was recognised that there would be a risk to the person's health if they did not take it, and we saw that the prescription had been changed to a crushable form by the doctor to aid administration. The nurses were verbally able to explain how the administration of this medication was in the person's best interests but we found there was a lack of clarity in the person's care plan as to how this was recorded.

We saw from looking at people's records that staff ensured people saw external health professionals as necessary to promote and review their health needs. Comments we heard from relatives also confirmed that people saw health care professionals when needed and one highlighted that staff were aware of a person's allergies to a specific medication when this was incorrectly prescribed. This meant that people's healthcare needs were reviewed as needed by external healthcare professionals.

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.

The provider was working towards ensuring that there was always enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We received concerns before our inspection that stated staffing levels at the home were not sufficient to meet people's needs. It was alleged that due to the number of staff submitting their notice since a new manager had been appointed there was a risk to people that lived at the home. It was stated that the night shift was covered mainly by agency staff and there was a reliance on agency carers. It was stated that cover on the day shifts would also be problematic for the same reasons.

We also received concerns about staffing levels from relatives prior to our inspection with examples given as to how this impacted on people's quality of life, this including not being able to go to the toilet when requested and having no choice about routines. We saw a copy of the residents and relatives meeting on 17 July 2014. Comments made by relatives included, 'My mom had to wait 20 minutes to be taken to the toilet', 'I come in to feed my dad as the girls are so busy'. The manager discussed this issue with people telling them there was enough staff but there were issues around staff practising better time management.

We looked to see if there was enough qualified, skilled and experienced staff to meet people's needs. On arrival we discussed the allegations with the manager who said that there were some issues in respect of number of staff leaving or having left the provider's employment. They said that they were now using a number of agency staff which included nurses whilst they recruited new staff. They told us that every effort was made to use the same agency staff to help with the consistency of care. We looked at the staffing rotas and records of the bookings the manager had made with the agency and this confirmed what they had told us. They acknowledged that the situation was not ideal but they told us they were recruiting staff but there were delays with carrying out checks to ensure they were safe to work with vulnerable people.

We spoke with people about how responsive the staff were to their requests for assistance and they told us that staff helped them when needed, although one person said they did not need much help. Another person told us, "Staff always there if I want some help". One relative told us, "Not enough staff, quite often 20 minutes before the staff will turn up". They told us, "Since new manager has come has seen impressed on staff that they should

be there (in lounge) but couple of times found that not the case". They said that the manager had been carrying out checks on staffing in the communal areas. One staff member told us that, "Could do with more staff it's hard -anything can happen". This meant that there were still some concerns around their being sufficient staff available to people.

We spoke with staff who confirmed that staff turnover had impacted on the home but the majority felt this situation was now improving. They also said there were always some experienced members of staff on duty to work with agency staff who knew people that lived at the home, even though they may not be nurses. The manager and area manager told us they were monitoring the staffing situation closely and looking to ensure that staff consistency was improved and any vacancies filled. The manager told us that they had carried out a night check the week previous to our inspection to ensure standards were maintained at night. The majority of staff we spoke with confirmed that staffing levels had made providing effective care difficult at times but most felt that the situation was improving and staffing was increasing as new staff were employed. This meant that the provider had identified that staffing needed improving and was taking action to maintain staffing levels and fill staff vacancies.

We looked at the provider's staffing tool and compared this with the number of staff that we saw on duty in various parts of the building during the course of our inspection. We saw that the staff available reflected what the tool had identified as needed based on dependency levels. We looked at the home's staffing rota and the staffing levels shown, which included agency staff reflected those identified by the staffing tool. The manager and provider were clear that they may need to work with staff to look at effective deployment however and the provider may find it useful to note that auditing of people's individual dependency would be helpful in ensuring that the raw data used in the staffing tool is accurate. In addition the layout of the building would need to be considered as a factor in deciding appropriate staffing levels to ensure that the staffing levels identified are sufficient to meet people's needs and keep them safe.

We looked at staff training records and this showed us that there was a system for identifying where staff needed training and in what areas. We spoke with staff and they told us that there was training that they needed that had been identified and was programmed in. Staff confirmed that training was booked in areas such as medication, dementia care mapping and diabetes awareness. This meant that the provider had a system for identification of staff training needs and provision of training that reflected people's needs.

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

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

Our judgement

The provider was meeting this standard.

The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service.

Reasons for our judgement

We spoke with people and relatives about how the provider gained their views about the care and treatment they received and the service in general.

People who used the service, their representatives and staff had not always been asked for their views about their care and treatment. This was an issue that the manager told us about when we arrived at the home, and they said they wanted to improve the way they gained people's views. We saw that changes were being made to ensure that suitable forums were put in place so that people and their representatives were able to share their views. The manager told us relatives were previously poorly attended. A change of meeting time saw good attendance at the last meeting. There was comment from one relative that, 'They were always arranged for afternoons before and I work and so do a lot of us. I could never make them usually'. The manager told us that they were going to arrange meetings during the evenings in future to make them more accessible to relatives. Changes that the manager was looking to make were raised and discussed with relatives and their views sought.

We spoke with relatives about whether they were able to share their views and one told us, "Able to voice opinions. Survey, did have something to fill in quite a while ago", the other telling us they had an invite to the recent resident's/relative's meeting but had not completed a survey form. We saw the provider's last customer satisfaction survey was carried out in 2013. We noted some areas detailed in this survey showed the outcomes were lower than those the provider had as an overall benchmark. These areas reflected what the areas manager and manager told us they were prioritising for improvement, for example the dining experience, activities and staffing. This meant that the provider was seeking people's views and prioritising areas that required improvement.

We sampled a number of other audits that the home carried out and found these to be well documented, carried out on a regular basis and used to inform the planning and development of the service. This had enabled the manager to share areas they had identified for improvement that mirrored some of our findings from this inspection. Identification of such trends enabled the home to have identified where improvements in

the way that care was planned and delivered were needed.

We saw that the manager had commenced auditing care records to identify how these could be improved, and sight of some that had been completed recently showed they were more accurate and easier to understand. The area manager told us about a staffing tool that was being developed and how this was to be used to ensure staffing levels were appropriate to the dependency of people living at the home. They were aware that they need needed to ensure that the information as to people's dependency was accurate so that the staffing tool was able to generate a workable staffing ratio that ensured there were sufficient staff to meet people's needs. This showed that the providers systems should identify shortfalls in the service to the provider. This meant that risks related to the quality of the service were being actively identified and action plans were been put in place to progress improvement.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

Comments and complaints people made were not always responded to appropriately.

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

People were made aware of the complaints system although the format it was presented in could be more accessible. We saw that the provider's complaints procedure was available on notice board in the home although this was in smaller typed print. Different formats should assist people's access to the complaints procedure. We spoke with people who said they would speak to staff if they wanted to raise any concerns. One relative we spoke with said they had never been given a complaints procedure but any matters they said they were able to raise with staff and a matter they had raised, "Had been sorted out". Another relative told us that they had seen the provider's complaints procedure. We did see that the manager had discussed how to make a complaint at the last resident and relative's meeting, a record of this seen in the meeting minutes.

We heard from a relative that they had complained about an incident in July 2014. They had been told that the incident would be investigated by a nurse who subsequently left the provider's employ. They told us that there was no follow up to the complaint despite earlier verbal reassurances it would be looked into. We looked at the home's complaints record and found that the complaint was not recorded and the new manager had not been made aware of it having commenced work at the home after it was made. We saw that the home had received another complaint on the 12 August and when we asked the manager they told us no holding letter to acknowledge receipt of this had been sent. They told us this would be actioned and the complaint investigated. The manager said they would forward a copy of the response to this complaint to us for information. We spoke with the complainant after our inspection and they told us that they had received no response from the provider. This meant there were instances where people's complaints were not fully investigated and resolved, where possible, to their satisfaction with one relative telling us their concerns were not taken seriously.

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's care records were not consistently accurate and fit for purpose.

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

People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. The manager told us that care records did need improving and we saw that they had commenced auditing and updating some records on a planned basis. Staff we spoke with told us people's records were, "Too long winded, do need to update all of them" and, "I do read, but not easy to read".

We looked at care records for a number of people that lived at the home, this including assessments care plans, risk assessments and other records relating to people's care and treatment. We looked at one person's assessment and this identified that the person may present behaviours that may challenge staff. There was a lack of information about how these behaviours may present and no information about the triggers that may lead to these behaviours. We spoke with a nurse and care staff and they had some awareness of potential triggers for this person. The nurse showed us the behaviour plan for a more recent admission to the home and this was well recorded. This meant the lack of recorded guidance in some people's care plans may mean that newer or less experienced staff may not have the knowledge to provide the correct care for people.

We looked at a care plan for a person that was diabetic. We saw that the person was prescribed fortified supplement drinks which we saw recorded on their medication administration records. Their care plan did not however describe when these drinks should, or should not be given. Due to their content giving people these drinks had the potential to raise their blood sugars above safe levels. This meant they should only be given when the person's blood sugars were low. The nurse and staff we spoke with were aware of when to give this drink so the person's blood sugars would not be raised above safe levels but their care plan did not record this knowledge. We also saw that another person's diabetic insulin dose had been changed recently this recorded on the medication administration records. Information within the person's care plan still showed the previous dose, and not the changed one.

We noticed one person had a bruise on their face. We spoke with the person's relative

who told us that the person did not always sleep at night and this may lead to their having a reduced capacity for identifying hazards. This had led to them having some injuries recently. We looked at this person's care records and asked the nurse to find us records that would identify when this person had not slept and when, as a result they may be a greater risk of walking into things for example. The nurse was unable to show us a system of recording that was in use that would alert staff as to when the person should be under more regular observation.

We also looked at this person's incident reports and we found records that were not very clear as to events that had taken place. An example of this was a statement that the person had a, 'To do with another resident'. There was no detail as to what this meant. There was also a reference to a fall the person had in one record, although when we looked with a nurse a record of this accident could not be found. This meant that some records lacked accuracy, were unclear and there was reference to accidents that may not have been recorded.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met: The provider must ensure that any complaint made is fully investigated, and so far as reasonably practicable, resolved to the satisfaction of the service user, or the person acting on the service user's behalf. Regulation 19 (2) b
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered persons must ensure that service users are protected against the risks of unsafe or inappropriate care and treatment arising from the lack of proper information. This is to be by means of maintenance of an accurate record in respect of each service user, which shall include appropriate information and documents in relation to the care and treatment provide to them.

This section is primarily information for the provider

	Regulation 20(1)a

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 17 October 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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