Inspection Report

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

Abbey Rose

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Tel: 01202877764

Date of Inspection: 15 May 2014

Date of Publication: June 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Serene Care UK Limited
Registered Manager	Mrs Vimla Heeroo
Overview of the service	Abbey Rose is a residential care home providing accommodation for up to 24 people.
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'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 15 May 2014, observed how people were being cared for and talked with people who use the service. We talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

In this inspection we considered five key questions: Is the service caring? Is the service responsive? Is the service safe? Is the service effective? 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 using the service and 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?
People were not protected fully against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. We identified concerns in relation to the recording, storage and safe administration of medicines.

The service had taken steps to ensure people's care and welfare needs would continue to be met in the event of foreseeable emergencies.

Is the service effective?
Staff had qualifications, skills and experience to carry out their roles effectively. However, because there were not enough staff to meet people's needs at all times, this put people at risk of not receiving appropriate care.

Is the service caring?
People were supported by kind and attentive staff. Care was observed to be respectful and responsive to individuals' needs. We saw that care workers showed patience and gave encouragement when supporting people.

People spoke positively about the support they received from staff. One told us, "The girls are nice. I wouldn't want to go anywhere else." Another described the care they received

as "very good indeed." Staff and people living at the home were seen to know and get on well with each other, and interaction was observed to be polite and positive throughout the day.

Is the service responsive?
People who used the service and their representatives completed customer satisfaction surveys. Where shortfalls or concerns were raised these were addressed.

The provider had a system in place to deal with complaints, but we found evidence that not all complaints were responded to effectively.

Is the service well-led?
The provider had made cuts to staffing levels. This meant there were not enough staff to meet people's needs at all times. It had also contributed to low staff morale. Management had not identified or addressed this issue.

Systems were in place to make sure that managers and staff learned from events such as accidents and incidents, complaints, concerns and investigations.

Staff had appropriate experience of care provision and were knowledgeable about the systems and processes required for a care home's effective operation. Stronger leadership was required to make sure all staff followed those systems and processes and to ensure people's care and support needs were met.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Before people received any care or support they were asked for their consent and the provider acted in accordance with their wishes. The importance of gaining people's consent to care and respecting their decisions was demonstrated by staff in their behaviour towards people at the home. For example, people were offered individual choices and meal options specific to them at lunch-time. Throughout the inspection we observed staff speaking to people respectfully. They sought people's consent to care and respected their choices about day to day living.

Staff knew what to do to support people who might refuse to give consent to essential care. For example, the care manager told us that they would try to find out if there was a reason for the person refusing care so they could try to support them in a different way. They told us they would also speak to the person's family and friends if appropriate. However, they were clear that their approach needed to be gentle and they had to respect individual choice. They were aware that they needed to balance people's rights to make choices with their responsibility to provide care and keep people safe.

When people did not have the capacity to consent staff acted in accordance with legal requirements and recognised good practice. We saw records in people's files of formal mental capacity assessments in relation to different decisions and areas of their care and support. We also saw extensive records of regular contact with both mental health teams and the local authority's Mental Capacity Act team in relation to people at the home. We spoke with a visiting community mental health nurse, and they spoke positively of the home's open communication and ongoing contact with relevant health and social care professionals. They described the care manager as being "very aware of mental capacity."

We saw that people's capacity to make decisions had been considered in relation to many aspects of their care such as the food they wanted to eat and what time they went to bed.

Where people did not have capacity to understand or make specific decisions, we saw a process for determining their 'best interests' had been followed. This included consultation with next of kin and relevant health and social care professionals.

We looked at the way the home was implementing the requirements of the Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act (2005) and aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. We spoke with the care manager who understood their responsibilities and showed us the action they had taken to ensure proper procedures were followed. They also described how they had responded to recent significant changes in legislation. They told us that they had identified additional people to whom the safeguards now applied and planned to take appropriate steps to ensure people's rights were upheld.

We were shown up to date records related to a standard authorisation to deprive a person of their liberty under DoLS. A formal mental capacity assessment and best interest processes had been followed. This included appropriate consultation with next of kin and professionals, and a decision from the authorising body that it was in the person's 'best interests' to remain at the home. When people did not have the capacity to consent to remain at the home, the provider followed correct practice and acted in accordance with legal requirement.

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 support was person-centred and delivered in a way which supported people's dignity and well-being. However, errors and omissions in the planning of care identified potential risks to people's welfare and safety.
There were arrangements in place to help ensure people received continuity of care in the event of an emergency.

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

Care and support was personalised and delivered in a way which supported people's dignity and well-being. We observed people receiving care and support during the inspection and saw that staff carried out their duties politely and respectfully at all times. For example, at lunch time we observed staff gently escorting people to the dining area at each person's pace. People were asked what they would like to eat or if they needed anything, and staff then responded accordingly. We spoke with five people at the home and they all spoke positively about the support they received from staff. One person told us, "The girls are nice. I wouldn't want to go anywhere else." Another described the care they received as "very good indeed." Staff and people living at the home were seen to know and get on well with each other, and interaction was observed to be polite and positive throughout the day.

We looked at care plans and supporting records for four people and they were detailed and easy to follow. They contained information about people's needs, their likes and dislikes and their preferred routines and activities. We found that care plans were regularly reviewed and updated to reflect people's changing needs. The home also communicated with relevant health and social care professionals such as community nurses and GPs to ensure people's needs were met.

Care plans contained risk assessments, specific according to individual needs. These included assessments for diverse risk areas such as nutrition, skin care and use of bed rails. The assessments included analysis of the different risks and gave clear instructions to staff about how to reduce those risks. We saw the risk assessments were reviewed regularly and updated according to any changes identified. Assessment of risks showed how the home took steps to ensure people's safety.

However, we found a number of errors and omissions in the care plans and daily records

which identified potential risks to the welfare and safety of people at the home. For example, one person's care plan for pressure sores stated they were to be turned or repositioned hourly. We looked at the record of how often they were repositioned and found a number of instances where there was no record of them being repositioned according to the identified need. On one day there was a gap of thirteen hours between turns. If this had been the case, it would very likely have had a negative impact on the person's skin condition.

Monitoring records of fluid intake were also incomplete and didn't follow a standard format. Some staff had recorded simply that a person received 'water' or 'sips', but had not recorded the amounts. It is essential that people receive adequate fluids, but poor record keeping indicated staff were not monitoring people's intake when required. In another person's care plan, a recognised tool had been used for calculating the person's risk of pressure sores. This was incomplete and the risk score had been wrongly calculated. The tool was of no use in determining the level of need or the care that person required. Errors and omissions in the care plans and daily records of care meant the provider was unable to demonstrate effectively how all of people's different care and welfare needs were met.

There were arrangements in place to deal with emergencies. A 'roll call' file was kept at the main entrance. This contained basic summaries of people's key care needs and individual personal emergency evacuation plans which described the different support they would need in the event of an emergency evacuation. Care plans were stored electronically and could be accessed remotely. This meant people's care needs would be known in the event of an emergency evacuation or relocation. The provider had taken steps to ensure people's care and welfare needs would continue to be met in the event of emergencies.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Appropriate arrangements had not been made for the recording, safe keeping and safe administration of medicines.

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

Appropriate arrangements were in place in relation to obtaining medicine. A senior member of staff explained how people's regular medicines were ordered on a four-weekly basis through the service's supplying pharmacy. Medicines were then delivered to the home before the start of each new month. People's health needs were supported because the service was able to obtain essential medicines as needed.

Medicines were not kept securely. Shortly after we began our inspection we found the door to the room where the medicines were stored was open. A cupboard in that room containing a large quantity of both unused and current medicines was also unlocked. This meant anyone would have been able to access those medicines, and they could have been tampered with or removed. People were not protected from the risks associated with unsafe storage of medicines.

Appropriate arrangements were not in place in relation to the recording of medicines. We looked at current and recent Medication Administration Records (MARs) for four people at the home and identified errors or omissions in two of them. For example, one person had been prescribed a variable dose of medicine when required. Staff had signed the MAR to record when the person had received the medicine, but had not recorded the amount given. There was no way of knowing the quantity of the medicine the person had received on those occasions. Another person's MAR for a controlled drug, also to be taken as and when required, was missing a staff signature for three instances when it had been administered. It was recorded in the controlled drugs book that the person had received the medicine on those occasions, but this did not match their corresponding MAR entries. Inaccurate recording of medicines administration meant the provider could not had demonstrate people had received sufficient or appropriate amounts of essential medicines at all times.

The systems in place for the management of medicines did not ensure the safe

administration of all medicines. A senior member of staff told us staff had been instructed to make sure all medicines were taken before signing to say they had been taken. During the inspection we observed a member of staff passed a person their medicines in a small pot. The member of staff did not then stand to see them take the medicines or return to check whether they had been taken. In another person's bedroom we found a tablet of a prescribed medicine left on a cupboard following the morning medicines round. Our findings called into question the integrity of the records of medicines administration. We could not be assured all medicines recorded as administered had actually been taken. This meant that there was a risk that people had not received their medicines as prescribed.

We carried out a check of medicines in use at the time of out inspection and identified three separate prescribed medicines that were out of date and should not have been in use. One of these was used for the treatment of angina and chest pains and another to relieve restriction to the person's airway. As they were out of date, there was a risk their efficacy had been altered and they would not have worked properly. One of the out of date medicines was supposed to have been discarded within eight weeks of opening. There was no recorded date of opening, which meant there was an additional risk its efficacy had been altered as it may also have been open for longer than was advised. People were at risk as medicines were being administered in potentially altered forms. This may have changed the way they were absorbed, increasing or decreasing their efficacy.

Arrangements for recording controlled drugs were not appropriate. Controlled drugs are prescribed medicines that have additional legal requirements for their storage, administration, records and disposal. We found that records did not contain accurate information about the amount of controlled drugs stored in the home. For example, there was no record of two drugs being returned to the pharmacy in the home's controlled drugs log and no record of one drug coming into the home. This meant that the home was not meeting the regulations in relation to the recording of controlled drugs.

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. People were restricted in their movements around the home because there were not enough staff available to support them.

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

There were not enough qualified, skilled and experienced staff to meet people's needs. When we arrived at the home to begin our inspection we found that there were three care staff on duty to provide personal care to the 23 people who lived in the home. Some people had significant care needs. One person, in particular, was receiving intensive support due to their deteriorating health. Staff told us that they required frequent and substantial support from two care workers which was reflected in their care plan. This meant that when the person needed support, one member of staff would be left to meet the needs of the other 22 people who lived in the home.

We spoke with three of the six care staff working over the morning and afternoon shifts during our inspection. They each told us they did not believe there were enough staff working to meet all of the needs of the people at the home at all times. We asked staff if there were enough staff working and one told us, "No, you can see for yourself." Another told us, "No, I don't think so." We asked if they had enough time to spend with people at the home and and they repeated "no, I don't think so." They described tea time as a particularly difficult time. They told us one member of care staff would prepare tea, one would serve food to people and one would do the medicine round. They told us this meant there were no staff to do other essential jobs, including responding to call bells. A third member of staff told us they were only able to answer call bells quickly "some days," which meant there were days when they were not able to respond quickly to people's call bells. They told us, "it doesn't feel there's enough carers."

People using the service were put at risk because the provider had failed to properly assess and reduce the potential risks associated with the staffing levels. On the day of our inspection we saw examples of how people were put at risk due to the home's staffing levels. We saw one person, who had dementia, got increasingly agitated as the day progressed. We observed staff were unable to devote sufficient time or attention to meeting the person's needs and requests effectively. Although staff acted to calm and distract the person, we saw they were unable to spend necessary time with them to find

out why they were so agitated or to try to alleviate the cause of their anxiety. The person appeared to experience avoidable and unnecessary distress, and their behaviour then escalated which had a negative effect on the atmosphere for other people in the home. A member of staff explained the staffing level was such that "If everything goes smoothly it's ok." Our findings were in line with that, and we saw that when things didn't go smoothly the staffing level was not ok. Staff were not always able to respond effectively to ensure the welfare and safety of people at the home at all times.

The care manager, who was responsible for the day to day operation of the service, told us they were able to respond to fluctuations in staffing due to sickness and absence with permanent staff. They spoke positively of staff. They told us that staff worked in a flexible way to provide cover at short notice and ensure people's needs were met. The service was in the process of recruiting additional people to add to their pool of permanent staff. However, we were told the new staff were intended to bring greater flexibility when setting the staffing rotas; their recruitment was not intended to increase the staffing level. We looked at the home's staff rotas for the previous fortnight and saw staff levels were constant throughout that period. Three care staff were working at all times during the day and then two care staff at night. In addition, the provider employed domestic staff and a cook for lunchtimes.

The home had changed ownership in the last two years. Staff told us that there had been cuts to staffing levels during that time. The current staffing rotas confirmed that there were only three care staff working during the day, and we found there was no additional cover provided while the care manager was on annual leave. The current registered manager managed the provider's two services, and this meant they usually spent only one or two days a week at each home. As a result of these different factors, we found the staffing level at the time of our inspection was insufficient to meet effectively all the care and welfare needs of people in the home.

The staffing level meant people's independence was restricted and their freedom of choice was not fully supported. During the inspection we carried out periods of observation in the service's main lounge area. At many times there were no staff present or readily available to provide support to people. At one point, for example, there were 11 people sat in the lounge and no staff present for over 15 minutes. Some people watched television, but we saw no other activities taking place during the morning of our inspection. In the afternoon we saw a member of staff trying to engage people in an activity, but this was poorly received. We asked staff about activities, and one told us, "people come in now and again, we do them when we can." Another told us staff, "don't always have the time to do that [support with activities]." They told us, "It's difficult. There used to be activities co-ordinators that came twice a week, now its once a month. Everything's been cut down."

On the day of our inspection it was warm and sunny. The home had a large and pleasant garden, which should have been accessible to people at the service if they chose. We spoke with two people who told us they wished to go outside, but they were not able to. We spoke with staff and they told us one reason that people were not able to go out into the garden was that there were insufficient staff to monitor and maintain people's safety outside. We asked if they could take people out in to the garden, and one told us "I don't think it's possible in the summer." Another told us, "We haven't the staff. If one is in the garden and one in the kitchen that leaves one in the lounge."

We spoke with the registered manager about this and they told us the doors to the garden were kept locked for the safety of people at the service. They did not raise staffing as a

factor in respect of this issue. We found that the staffing level was contributing to people being prevented from accessing freely and safely the outside space as and when they wanted.

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.

People who lived in the home and their relatives were given opportunities to give feedback, and their comments were used to improve specific aspects of the service. The provider had a system in place to deal with complaints, but not all complaints were responded to effectively.

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

Reasons for our judgement

There was evidence that learning from audits and investigations took place and appropriate changes were implemented. The provider carried out regular checks on the home to ensure it was safe. We saw that weekly checks were carried out on health and safety and the maintenance of the building. For example, the weekly bedroom audits had identified minor cleaning issues to be addressed. We found bedrooms were clean and tidy at the time of this inspection. There were also monthly checks on care plans and risk assessments and regular spot checks on staff performance. We looked at four staff files and saw records of regular spot checks carried out by a senior member of staff, when they observed and assessed different aspects of staff conduct and performance. We found that action was taken to improve the service as a result of these checks. This meant that people at the home benefited because the provider monitored the service they provided and took action to make improvements identified.

People who lived at the home and their representatives were asked for their views about their care and treatment and those views were acted on. We were shown a service user and family satisfaction survey from December 2013. The responses gathered had identified a number of areas people had wanted addressed, including provision of special food options for one person. We spoke with the cook who confirmed that the person was now provided with food options specific to their needs. People's views were sought and the provider took steps to act on feedback to improve aspects of the service.

The provider had a system in place to deal with complaints, but did not always have regard to people's views about the service. Records related to a recent complaint showed the provider had taken necessary steps to address the complaint. This had included involving appropriate external agencies in the process of investigating and responding to the complaint. However, we also saw records related to a complaint received in May 2013 from a relative of a person who had been living at the home at that time. The complaint

was about external doors to the home being locked and people not being allowed out into the garden on a nice day. During this inspection we found that external doors in the home were locked and people did not have access to the garden when they wanted. This meant that the provider had not used the person's feedback to improve the experience of people who lived in the home.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person had not taken proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe. People's needs were not properly assessed. The planning and delivery of care were not carried out effectively to meet the individual needs and ensure the welfare and safety of each service user. Regulation 9 (1) (a), (b) (i and ii)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered person had not protected service users against the risks associated with the unsafe use and management of medicines. They did not have appropriate arrangements for recording, safe keeping and safe administration of medicines used for the purposes of the regulated activity.

This section is primarily information for the provider

	Regulation 13
Regulated activity	Regulation
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 safeguard the health, safety and welfare of service users. They had not ensured that there were sufficient numbers of qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. 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 had not had regard to complaints and comments made, and views expressed by service users and those acting on their behalf. Regulation 10 (2) (i)

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 27 June 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will

This section is primarily information for the provider

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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