# Inspection Report

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

# Fewcott House Nursing Home

Fritwell Road, Fewcott, Bicester, OX27 7NZ

Tel: 01869345501

Date of Inspection: 21 January 2014

Date of Publication: February 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

| | |
|---|---|
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Supporting workers** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✗ Enforcement action taken |
| **Records** | ✗ Action needed |

## Details about this location

| | |
|---|---|
| Registered Provider | Fewcott Healthcare Limited |
| Overview of the service | Fewcott House is a care home with nursing, which can accommodate up to 40 people. |
| Type of service | Care home service with nursing |
| Regulated activities | Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>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 to check whether Fewcott House Nursing Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

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 21 January 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 reviewed information sent to us by other authorities and were accompanied by a specialist advisor.

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 to see if the provider had made improvements since our last inspection in August 2013. At that time we had concerns about the standard of care and welfare experienced by people who used the service, how staff were trained and supported and how the provider monitored the quality of the service.

During this inspection we saw the provider had implemented processes that had led to improvements in the service. We found that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Staff we spoke with told us they felt supported and had received training and supervision. One told us "I feel supported, it's good since [the manager] came. Everything is more organised". One person told us "it's my home and I'm happy here".

During our inspection we looked at the provider's quality assurance and risk management systems. At our last inspection we identified that the provider did not have an effective system to regularly assess and monitor the quality of the service that people received. We also found that the provider did not have an effective system to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. At this inspection we found that the provider had introduced some systems to evaluate the quality of the service and to identify, assess and manage risks. However, we found that some of these systems were not being effectively operated. We also found that the

provider did not have comprehensive oversight of the risks affecting all aspects of the service and therefore the approach to managing risks was not coordinated and structured.

Records relevant to the management of the service were not always accurate and fit for purpose. For example, records relating to the supervision of staff. Records were not always kept securely and could not always be located promptly or easily.

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

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

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

## More information about the provider

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

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

## Our judgements for each standard inspected

**Care and welfare of people who use services** ✓ 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 planned and delivered in a way that was intended to ensure people's safety and welfare.

### Reasons for our judgement

At our previous inspection we raised concerns that people's care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare, or in line with their individual care plans. During this inspection we spoke with ten people and the relative of one person. People we spoke with were complementary about the home. One person told us "it's jolly nice. There aren't many places that aren't nice but this has to be one of the best". Another person told us "it's my home and I'm happy here".

During this inspection we looked at the care records for nine people. We saw that the provider had introduced a new care planning system. The new care plans and assessments were person centred and written with the involvement of the person. This information had been used to form a detailed and individualised care plan. Nurses and senior care workers were allocated time to update care plans and involved people and their relatives in the reviews. We spoke to one person's relative who told us "we had a care plan meeting". We saw an action from this review was for a referral to be made to the dentist. This person's relative told us that the dentist had visited and undertaken some dental work. We saw that care plans were written in detail and were up to date. This showed that people's needs were regularly assessed and care and treatment was planned and delivered in line with their changing needs.

We saw that care plans identified risks to people's health and welfare. Risk assessments were reviewed monthly or before if any changes had been identified. For example, we saw that one person, who had been identified as at risk of developing pressure ulcers, had specialised equipment in place to prevent skin damage. No one living at this home had pressure ulcers at the time of our inspection. Other risks to people's care, welfare and safety were identified by staff. Specific risk assessments were also carried out and management plans implemented. For example, we saw if some people required bed rails, risk assessments were in place to ensure that they were used safely. We saw evidence that bed rails were reviewed on a daily basis to check that they were working and fitted correctly.

People had detailed moving and handling risk assessments and care plans. For example, a person who had reduced mobility needed a hoist. We saw that the risk assessment and associated care plan informed care workers how to carry out the procedure safely. Guidance to staff included the make and model of the hoist to be used as well as the type and size of the sling. We observed one person who was transferred from a wheelchair to a chair. Two care workers helped this person move and talked and reassured the person throughout. This showed us that people were being supported safely and appropriately with their moving and handling needs.

We looked at the care records of people who had been assessed as being at risk of becoming malnourished or dehydrated. Records of eating and drinking were being maintained. We saw that two people's care plans indicated that they should drink at least 1500mls of fluid in a 24 hours period. One of these people had not drunk the amount of fluid that was recommended and their care record had also identified that they were not eating much. We saw that action was taken and they were referred to a speech and language therapist (SALT). This person was assessed by the SALT during our inspection. We spoke with the SALT who told us that care workers had taken prompt and appropriate action. They said "staff are excellent, knowledgeable of the residents and provide a high quality of care".

We were accompanied at the inspection by a specialist advisor for people with learning disabilities. We observed staff interacting with the four people who have a learning disability. We looked at their care plans and activity records and asked care workers about these people's needs and preferences. The provider may find it useful to note that although these four peoples care plans were suitable for a nursing home they did not reflect the structure, terminology and person cantered planning that would normally be seen in a learning disability service. Whilst the home appeared to be able to provide adequate care for these four residents, nurses and care workers would benefit from more training in best practice approaches when supporting people with learning disabilities. This included developing an understanding of person centred planning and the promotion of independence, choice and control. We discussed this with the provider and senior management team who acknowledged that the home was not currently equipped to provide services for any new people with a learning disability without extensive further training and development.

At our last inspection we found care was not being planned to meet people's social needs. The home has since employed an activities co-ordinator. We saw activity schedules pinned up on the wall in the lounge. We observed people involved in individual activities with the co-ordinator in the morning. During the afternoon a guitarist played and sung with the residents. We looked at people's activity logs and saw that the guitarist visited every two weeks. During this session people appeared happy. One person told us "there is a lovely atmosphere". Throughout other times of the day we saw nurses and care workers interacting with people in a meaningful way. We noted that people in other areas of the home, including their rooms, were regularly seen by staff and invited to attend group activities. This meant that people benefitted from meaningful engagement with staff.

**Supporting workers** ✓ Met this standard

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

## Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

## Reasons for our judgement

At our last inspection, we raised concerns that nurses and care workers were not appropriately supported in relation to their responsibilities. The provider has since appointed a clinical nurse manager. During this inspection we spoke with one nurse and three care workers. They told us they felt able to raise any concerns with the manager who they described as "approachable". Care workers and nurses told us they felt supported in their role. One care worker told us "I feel supported; it's good since [the manager] came. Everything is more organised". Another told us "I like my job, it's a good team, I feel very supported". A nurse told us "[the manager] is always there, I can ask any questions".

We spoke to a nurse who had recently been employed at the home. They told us they had received an induction which had included shadowing other nurses and completing training. For example, in activities such as medicines management and first aid.

At our last inspection we were concerned that nurses and care workers had not regularly received supervisions or appraisals. We saw that all nurses and senior care workers had received supervision since our last inspection. Although not all care workers had received supervision yet the provider had introduced a system to train senior care workers and nurses to deliver supervision to care workers. We saw evidence that six staff had attended this training on 9 January 2014. We saw that dates had been planned to deliver supervision to those that had not yet received it. We looked at the supervision records and saw that supervision provided care workers with the opportunity to discuss their areas of responsibility. Development needs and concerns or successes were also discussed. Staff were given a copy of their supervision and appraisal record and signed to say they agreed with the comments and any action plan. This showed that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

**Assessing and monitoring the quality of service provision**

✖ Enforcement action taken

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

## Our judgement

The provider was not meeting this standard.

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

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

## Reasons for our judgement

During our inspection we looked at the provider's quality assurance and risk management systems. At our last inspection we identified that the provider did not have an effective system to regularly assess and monitor the quality of the service that people received. We also found that the provider did not have an effective system to identify, assess and manage risks relating to the health, safety and welfare of people who used the service. At this inspection we found that the provider had introduced some systems to evaluate the quality of the service and to identify, assess and manage risks. However, we found that some of these systems were not being effectively operated. We also found that the provider did not have comprehensive oversight of the risks affecting all aspects of the service and therefore the approach to managing risks was not coordinated and structured.

The provider had introduced some systems to identify, assess and monitor the quality of the service provided. For example, we were told that staff had identified that people were not showering or bathing frequently enough. This had been assessed as presenting a risk to personal hygiene and people's skin integrity. The historical records did not allow staff to identify the reason why people were not bathing or showering. An audit, with new recording sheets, had been created to assess showering and bathing for all residents over a five week period. At the time of our inspection the audit was in its second week. We saw minutes of a staff meeting, dated 2 January 2014, which confirmed that staff had been informed of the audit and the need to record accurate and thorough records. We were told that after five weeks the audit would be evaluated to identify how they might be able to increase the number of showers and baths that people took. We were told that the aim of this exercise was to improve personal hygiene and maintain people's skin integrity.

Where the provider had introduced systems to improve the quality of the service, these were not always being effectively operated. For example, we saw that 'documentation training' had been delivered to 10 members of staff on 17 December 2013. The training

had been provided to ensure that "Staff knew the reasons why documentation had changed and what their responsibilities were". We saw that following the training staff had been asked to complete a 'knowledge test' on 'principles of good record keeping'. This test was designed to enable the provider to evaluate the effectiveness of the training. We were told that staff had been requested to complete and return the knowledge tests by the end of December 2013. At the time of our inspection none had been completed and returned. The provider had not effectively operated the system that they had put in place to assure themselves that the training they were delivering was effective.

Relatives and representatives of people who used the service were asked for their views about care and treatment. We saw a letter, dated 18 December 2013, which had been sent to relatives and representatives of people using the service. The letter included a 'quality assurance questionnaire' and invite to attend a 'residents, relatives and representatives meeting' on 17 January 2014. We saw five completed quality assurance questionnaires had been returned. We were told that the service was waiting for more responses before they analysed the results. We looked at the five questionnaires and saw that the majority of responses were positive and comments included "you have made a lot of recent improvements". We saw some evidence that relatives and representatives views were acted on. For example, one comment was: "a list of names of nurses and carers would help as I'm bad at remembering names". We were told that the provider was in the process of taking photographs of staff members and that they planned to create a board with photos of staff, their names and their roles. We saw that relatives and representatives had been informed of this at the meeting on 17 January 2014.

We saw that the provider was in the process of obtaining feedback from people who used the service to support them to assess the quality of care provided. We were shown seven completed questionnaires. The responses had not been analysed at the time of our inspection. We were told that the results would be analysed after all the people living at Fewcott House had had the opportunity to respond. Comments in the completed questionnaires included "more access to the garden". We saw that a newsletter sent on 18 December 2013 had stated "it is our intention to make substantial improvements to the garden this summer to ensure that our residents can take every opportunity to enjoy the outdoor space". The letter requested people to volunteer to assist with the garden improvements. The service had introduced systems to obtain the views of people and their representatives in relation to the care and treatment they received. At the time of our inspection we were unable to evaluate whether these systems had been effective because they were still being implemented.

The provider had introduced some systems to identify, assess and manage risks relating to the health, welfare and safety of people. For example, we saw that a monthly audit of food and fluid charts was conducted. Food and fluid charts were used when a person was identified as being at risk of malnutrition or dehydration. At our last inspection in August 2013 we saw that food and fluid charts were not fully completed or reviewed. At this inspection we saw that the monthly audit highlighted if people were not drinking the recommended daily amount. Actions from the audit were identified. For example, "requires encouragement with hourly fluids and high calorie soft foods. Monitor closely and report daily to the manager". The audit resulted in a document that was used in the daily handover meeting. This document gave specific instructions to staff with respect of each person who had been identified as 'at risk'. We saw that the number of people on food and fluid charts had reduced from 11 in November 2013 to four in January 2014. We were told that this was because people's weight had increased and stabilised. The system which had been introduced to identify, assess and manage risks relating to people becoming

malnourished or dehydrated was being effectively operated.

Some of the systems that had been introduced to identify, assess and manage risks were not being effectively operated. The provider was not always able, where necessary, to make changes to treatment and care provided across the service, because clinical audits had not always resulted in clear conclusions. For example, we saw a record of an audit of falls during the month of December 2013. The record identified the individual people who had fallen and what action had been taken with respect of the specific individuals. However, the audit had not identified if there were any patterns or trends relating to falls across the home. Therefore conclusions could not be drawn as to whether any action could be taken to reduce the risk of falls for all people.

The provider did not always have systems in place to identify, assess and manage identifiable risks to people, staff and visitors when accessing the premises. We observed a number of health and safety concerns during our inspection, for example, the clinical waste bins were not locked and areas of the carpet in the downstairs corridor were damaged. We raised these concerns individually with the provider. We asked the provider what system they had in place to identify, assess and manage risks in relation to the premises. We were told that they did not have a current risk assessment in place for the premises. We were shown a document entitled 'home management audit', which the provider told us they planned to use on a monthly basis. Amongst many things the document prompted the person completing it to identify and evaluate a range of environmental risks. However, this tool had not been used at the time of our inspection. The provider had not effectively implemented a system to identify, assess and manage environmental risks at Fewcott House.

The provider  did not effectively operate a system to ensure that when cleaning and maintenance requirements were identified, that these were prioritised and completed to the satisfaction of the provider. For example, we saw monthly cleaning audits were completed. The audits for December 2013 and January 2014 clearly identified areas for improvements, actions required and the person responsible for the actions. We looked to see what actions had been completed from the December audit. We were told and observed that some of the actions had been completed, whilst others had not. However, the audit column entitled 'date achieved' had not been completed. It was not clear who had responsibility for ensuring that all the actions were done. The staff member who completed the audit told us that it was given to the provider. We spoke with the provider about what system they had in place to ensure themselves that actions were prioritised and completed to their satisfaction. We were told that there was no formal system in place.

There was evidence that the provider had made changes to the care provided as a result of the analysis of an incident that resulted in harm to a person. We saw that investigation of an incident in November 2013 had identified that "poor moving and handling practice may be the cause of bruising". This had resulted in actions for staff to receive refresher training in moving and handling techniques and the use of wheelchairs. The target date for completion of the actions was 30 December 2013.

There was evidence that the provider had made changes to the care provided as a result of comments made by people and those acting on their behalf. We were told that the service had recently involved an independent mental capacity advocate (IMCA) to assist a person with making a decision in relation to their care. As a result the service had identified that they could improve upon the support that they provided to people with making informed choices. We saw that training had been delivered to staff in relation to

advocacy and the role of an IMCA. We were told that the aim was to enable staff to "listen and hear and to take action and get outcomes for people". At the time of our inspection 10 members of staff had received the advocacy training and another training date for 10 staff was scheduled for the week following our inspection.

There was evidence that the provider took account of complaints to improve the service. We looked at the complaints file and saw that there had been four complaints since 1 September 2013. One complaint related to clothing and washing. We saw that this had been investigated and as a result a number of actions had been identified to prevent a similar situation arising in the future. These included ensuring that a property list was completed on admission and that the key workers kept property lists for people updated with any changes. Another action was for night staff to load the washing machines overnight to ensure that there was no shortage of clean clothing. We spoke with the manager who confirmed that the action plan had been implemented.

**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.

Records relevant to the management of the service were not always accurate and fit for purpose. Records were not always kept securely.

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 plans contained people's personal records, including medical records that were clear, factual and accurate. We saw evidence that people's care records were being reviewed and updated on a regular basis. Daily records were being completed which clearly reflected the care, support and treatment, that people received. Records showed that people were protected from the risks of unsafe or inappropriate care and treatment because risk assessments were in place that assessed the safety and effectiveness of their care. This meant that people's personal records including medical records were accurate and fit for purpose.

Records relevant to the management of the service were not always accurate and fit for purpose. We looked at a number of audits and found that completion of actions was not recorded in the audit documents. This meant that it was difficult for the provider to assess, from the audit document, whether it had been effective in achieving what was required. There was a risk that identified actions would not be followed through and completed. For example, we looked at a catering audit completed on 27 September 2013. This identified seven actions. The 'date achieved' column was blank and therefore we could not be sure that the actions had been completed. One of the actions had been: "Hold a meeting with the kitchen staff and management on menu and kitchen defects. Meeting should be minuted". We asked the provider if a meeting had been held and whether records of this meeting had been made. The provider told us that they had held a meeting, but that records of the meeting had not been made. We spoke with the kitchen staff who confirmed that a meeting had been held and that they had raised two defects in the kitchen. The defects were still outstanding. Without a record of the meeting it was difficult to identify what had been agreed in the meeting and what the actions were. We saw that the kitchen defects had been placed in the maintenance book in October 2013, however these remained incomplete. Records were not supporting effective management of the service.

Staff records were not always accurate. For example, we looked at the supervision records for two nurses and two care workers in detail. The template for supervision included strengths, areas for improvements and agreed action plans. We saw that areas for

improvement had been identified for all four members of staff. However, three of the supervision record action plans, both for the employer and employee, did not describe the required improvements. In all four cases the action plan did not describe what action should be taken and what support should be made available to ensure that improvements were made. Staff supervision notes also did not provide a written record against which improvement could be measured. This meant that the information in supervision records would not support staff to improve their performance as intended.

Records could not always be located promptly when needed. During our inspection we were told that regular staff meetings were held. However staff meetings had not been recorded until the most recent meeting on 2 January 2014. We asked to see the minutes from the most recent meeting, these could not be located promptly, but were eventually found. The absence of records from historical staff meetings meant that it was difficult to evaluate whether learning from audits had been regularly communicated to staff to improve care and treatment.

Records were not kept securely. For example, during our inspection we saw that people's care records were kept on a shelf in the nurses' office. The door to this office was unlocked. Staff confirmed that this door was kept shut but not locked. We also saw that staff training and supervision records were kept in an unlocked cupboard in an office. We observed that this office was unlocked and at times was unoccupied with the door open. This meant that confidential information was not held in accordance with the requirements of the Data Protection Act 1998.

**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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Records** |
| | **How the regulation was not being met:**<br><br>Records relevant to the management of the service were not always accurate and fit for purpose. For example, records relating to the supervision of persons employed for the purposes of carrying on the regulated activity. Records were not always kept securely or located promptly. Regulation 20(1)(b)(i), (2)(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 12 March 2014.

CQC should be informed when compliance actions are complete.

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

**This section is primarily information for the provider**

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

### Enforcement actions we have taken

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

| **We have served a warning notice to be met by 07 March 2014**<br><br>This action has been taken in relation to: | |
|---|---|
| Regulated activities | Regulation or section of the Act |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Assessing and monitoring the quality of service provision**<br><br>**How the regulation was not being met:**<br><br>The provider did not effectively operate systems to identify, assess and manage risks relating to the health, safety and welfare of service users and others who may be affected. There was no holistic risk assessment in place for the building and premises. The provider did not have effective systems in place to assure themselves of the quality of the service. Maintenance work was not always quality assured. Systems which had been implemented to assure the provider of the quality of training were not being effectively operated. The provider did not have a system to assure themselves of the quality of supervision. Therefore the provider was unable to have regard to the information contained in the records, designed to protect service users from unsafe of inappropriate care through appropriate records relating to staff supervision. Regulation 10(1) (a), (b), 10(2) (b) (iii) |

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

## About CQC inspections

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

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

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

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

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

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

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

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

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

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

## How we define our judgements

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

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

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

## How we define our judgements (continued)

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

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

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

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

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

## Glossary of terms we use in this report

### Essential standard

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

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

### Regulated activity

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

## Glossary of terms we use in this report (continued)

### (Registered) Provider

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

### Regulations

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

### Responsive inspection

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

### Routine inspection

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

### Themed inspection

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

## Contact us

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