

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

Clifton Court Nursing Home

Lilbourne Road, Clifton-upon-Dunsmore, Rugby,
CV23 0BB

Tel: 01788577032

Date of Inspection: 06 February 2014

Date of Publication: March
2014

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

Care and welfare of people who use services	✓	Met this standard
Cooperating with other providers	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	Crosscrown Limited
Registered Manager	Mrs. Nicola Helen Pepper
Overview of the service	The service is registered to provide accommodation with nursing and personal care for up to 40 older people.
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'.

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Summary of this inspection

Why we carried out this inspection

This inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

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 6 February 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 received feedback from people using comment cards. We reviewed information sent to us by commissioners of services.

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

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

What people told us and what we found

On the day of our visit 10 of the 40 people who lived at the home had a diagnosis of dementia or confusion. They were not able to tell us about their care and treatment. One person smiled and nodded to us when we asked if they were happy at the home. We spoke with three people who lived at the home, three relatives and care staff and observed how staff interacted with people.

Relatives we spoke with told us, "The manager is very friendly", "This place is fantastic" and "X and Y (named staff) lead by example." We invited people to share their views with us via a comments box that was left at the home, but no-one completed a comments card.

We saw that staff were compassionate and spoke reassuringly with people. They explained what was happening throughout the day. Staff encouraged people to make decisions about how they were cared for. When one person told a care worker their leg hurt, we heard the care staff ask if they would like the nurse look at it.

Staff recorded when other, external health professionals visited people. Records included the advice that was given and how the person responded to the recommended treatments. When people needed to transfer to hospital, information was readily available to make

sure their physical and psychological needs were known and understood by hospital staff.

The manager checked that people were happy with the quality of the service through surveys, informal conversations with people and their relatives and observing staff.

You can see our judgements on the front page of this report.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

How are the needs of people with dementia assessed?

We looked at the care plans for three people who had a diagnosis of dementia. We saw that the manager had assessed people's needs and abilities in hospital before they moved into the home. For those people who were not able to express themselves verbally, the manager met with their relatives and other health professionals, so they could get to know and understand the person. For one person who did not have close relatives, we saw the manager had made sure the person had an advocate to represent them.

The manager's assessment of needs included checking information about people's medical histories, known allergies, current medicines and their likes, dislikes and preferences. The manager assessed risks to people's nutrition, mobility, memory and understanding, for example.

For those people who had a diagnosis of dementia or confusion, the manager used a dementia assessment tool, which checked the person's ability to remember and make sense of information. The results of the test ensured that the manager knew which decisions the person would be able to make independently and which decisions needed to be made in the person's best interests. The best interests form named the people who were responsible for making decisions on the person's behalf.

We found that the nurses regularly reviewed people's care plans and updated them appropriately. A care worker told us, "We write up daily records. We might write in 'mood changes', or 'not eating well'. We see the nurses daily to tell them when the person's needs change. We notice if there is a difference." Relatives we spoke with told us that staff kept them informed about changes to their relations' care and treatment.

We saw that some people had end of life care plans in place. The manager told us, "If a person is on palliative care, and the families are ok about it, we can talk about advanced

care plans. I tell them we can always change things" and "We have end of life plans in place for some people. People and their relatives might not want to think or talk about it until they have an admission to hospital."

The manager told us some people with dementia were able to express their preferences for their end of life care. They said, "The doctor explains in terms that are easy to understand. Just because the person has dementia, it doesn't mean they cannot plan for their end of life."

We saw that for three people with dementia, who were not able to make future decisions about their care and treatment, a team of health professionals and people's representatives had made a medical decision in their best interests.

This meant that people's needs were assessed and care and treatment was planned in line with their individual needs.

How is the care of people with dementia planned?

We saw that the manager's assessment of people's needs and abilities was used to develop a detailed and individual care plan. Two relatives of people with dementia told us they were involved in planning their relation's care. We saw that people with dementia had a 'life story' book. The manager told us, "The key is to get to know the person. People or their relatives help to complete the book. The books help staff get to know and understand the person better." A care worker we spoke with explained which people were interested in gardening or in football, for example, and they knew people's preferred television programmes.

The instructions in the care plans were clear and minimised any identified risks. We saw that for those people who were not able to express themselves, their care plans explained how staff should note people's body language, facial expressions and response when they delivered care and treatment. In the daily records for one person who was not able to communicate verbally because of their dementia, we saw that staff had recorded that the person was, "Stiff, unable to cooperate, appeared to be in pain." Staff had assisted the person to their room and called the nurse, who had administered pain relief. This meant that staff responded appropriately to people who were not able to communicate verbally.

We found the manager had created care profiles, or snapshots, of people's needs. The care profiles explained which aspects of people's day to day needs they could undertake independently or whether one or two staff needed to assist them. We saw that the care profiles included people's cognitive needs, for memory and communication, for example. Staff told us this was particularly useful if a person had dementia or was not able to communicate verbally.

For one person with dementia, we saw their care plan for cognition, or understanding information, said, "Tends to become agitated at meals." The guidance for staff was to, "Give plenty of re-assurance and support, only one staff at a time. If it doesn't work go away and come back or try a different carer." A member of care staff we spoke with demonstrated a good understanding of this person's needs for support with meals.

We discussed with the manager that there was no obvious plan to orientate people with dementia around the home. For example, all the communal areas had the same colour walls and we did not see any obvious signs to enable people to recognise the door of their

own room. The manager explained that most of their current service users with a diagnosis of dementia were not able to mobilise independently. They explained that one person with dementia had initially occupied a bedroom on the first floor. The manager had put signs in the lift and on the wall opposite the lift doors, using the person's name and giving them directions. The person had now moved to the ground floor, so they were able to orientate themselves around the home without signs.

This meant that care and treatment were planned to minimise risks to people's health and well-being.

Are people with dementia involved in making decisions about their care?

In the care plans we looked at, we saw that the manager had identified people's interests and preferences for how they were cared for and supported. We saw that people or their relatives were asked their preferred form of address. We heard care staff using the preferred name that was recorded in one of the care plans we reviewed during their interaction with that person.

In the records of care we looked at, we saw that staff regularly communicated with people's families and advocates to make sure that day to day decisions about care and treatment were made in people's best interests. A relative of a person with dementia told us, "Staff phone me and say, 'I'm thinking of is it ok?'"

In one care plan, we saw that the person, who had dementia, was supported by an independent advocate. The manager told us that another person had an advocate who specialised in dementia, because the person had expressed preferences that were different to their relatives' wishes.

This meant that people and their relatives were involved in making decisions about their care.

During our visit we saw that care staff checked that people wanted to be cared for or supported and responded according to the person's wishes. For example, when one person did not want to continue receiving nail care, the member of staff responded by telling them it was alright and they could have the other hand done the next day. We heard staff checking with people that they still wanted to visit the hair dresser as arranged, before they accompanied them out of the lounge.

There were regular meetings for people who lived at the home which gave them an opportunity to express their opinions about their care and support. The minutes of the meetings were displayed in a communal area so that people who did not attend and their relatives would know what was discussed and agreed. The manager told us, "The activities lady sits with people who have dementia to support them to understand the discussion as it happens."

Are people with dementia provided with information about their care?

We saw that everyone who lived at the home was given a service user guide which explained what the service offered. People were advised of the services available in house and externally, the number and qualifications of staff and how to make a complaint for example. A copy of the guide was given to each person to keep in their room. This meant that people and their relatives could look at the information when they wanted to. The

provider might like to note, that we did not see a pictorial version of the guide, which might be useful to explain the service to people with dementia.

Relatives we spoke with told us that they felt well informed about the service and their relation's ongoing care and needs. One relative said, "The manager is very personable. We talk about things and she makes them happen" and "I agreed something was ok, but I still had to come to a meeting with the GP and sign to say I agreed. We had to follow the rules."

In the hallway we saw there were posters with information about religious services, the visiting hairdresser and the dates of the next service user meetings, for example. This meant that information was available to people and their relatives.

We saw there was a board with the names and photos of all the staff in a communal area, which helped people to become familiar with staff's faces. A member of care staff told us that care staff were keyworkers for up to three people, which meant they could focus on getting to know the individual well. Keyworkers made sure that the individual's needs were known and understood by other care staff.

How is care delivered to people with dementia?

A relative told us, "X has vascular dementia. The prognosis is a very slow gradient. The nurses are very good. The staff understand X's condition." In the care plans we looked at, we saw that staff kept a daily record of how people were, whether they ate well, slept well, the activities they took part in and their moods and behaviours. We saw that when staff were concerned about one person's physical health, they kept charts, such as food and fluid charts, to monitor their nutritional intake.

In a care plan for a person with dementia, we saw that staff kept behavioural charts, so they could monitor their response to different situations and staff. A member of care staff told us that X could present behaviour that challenged, but, "If you sit down and talk to her she's ok. Sometimes you need to let her calm down – walk away and come back and carry on." The clinical lead nurse told us, "Staff observe and record to check whether challenging behaviour is increasing or decreasing. We can refer people to the mental health team if we need to."

This meant that staff understood that changes in people's behaviour could be a sign of changes in their physical or mental health and well-being.

During lunch time, we saw there were printed menus, but no pictorial versions, to remind people of the options available. We heard staff asking people which meal they had chosen. When staff noticed that some people were not eating the meal of their choice, staff encouraged them to eat and offered them alternatives.

For those people who needed assistance to eat, we saw that staff sat next to them, chatted about the meal and explained what they were eating. A relative of a person with dementia told us their relation had been undernourished, but had gained weight since they moved into the home. They told us that their relation was beginning to eat independently and needed less assistance than when they first moved in. This meant that the care and support people received was appropriate and effective.

During the morning we observed a member of care staff organising a quiz in the lounge.

We saw that staff checked that people wanted to stay in the room for the quiz. Staff assisted two people to the quiet lounge to watch the television, when they said they did not feel like joining in. Everyone else sat in a circle so the member of staff could see if people lost concentration on the quiz. When one person appeared to lose interest, the member of staff addressed them by name, to regain their attention, and asked the question again.

We saw that second member of staff went and sat with another person with dementia who appeared disinterested in the quiz. The member of staff engaged in conversation with the person. A member of care staff told us, "When you are working with people (with dementia), you just chat along with them, whatever they want to chat about. They lead the conversation." They told us they knew and understood people's likes and preferences because, people with dementia had, "Photos and memory books, and we can talk with their families." During the afternoon, we saw that the chairs in the lounge were re-arranged, and staff engaged with people individually or in small groups.

Is the privacy and dignity of people with dementia respected?

We saw the records of staff's training for dignity and equality. The training explained how staff's language and behaviour were integral to ensuring that people felt respected and were able to maintain their dignity. The clinical lead nurse told us that the manager assessed staff's understanding and competence during their induction programme.

During our visit we saw that staff respected people's privacy and dignity. All the staff we observed spoke in a calm and reassuring way and called people by their individual names. We saw that for people with dementia, staff crouched down and kept eye contact while they explained what was going to happen next. We heard staff explaining choices and options to people.

We saw that people were able to spend their time in their preferred way and staff respected their choices. One person told us they liked, "Just sit here watching the world go by."

We saw that staff assisted people to move from the lounge to their bedrooms to make sure that people received medical treatment from the nurses in private. We heard staff explaining to one person who was able to move independently, why they needed to go up to their bedroom. The person agreed once they were assured that they could return to the main lounge afterwards.

We observed that staff closed the doors at either end of the main corridor to the toilets, so that people who needed assistance of two staff and a hoist were given maximum privacy. We saw that other staff understood the significance of this and used a second corridor between the lounge and bedrooms when the main corridor doors were closed. This meant that staff understood the importance of respecting people's dignity and privacy.

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

How does the provider work with others when providing care to people with dementia?

The manager told us, "Our accreditation with the Gold Standards Framework for dementia care includes the use of a 'rapid discharge sheet' and body map for transfer to other providers, particularly hospital. It makes us pro-active, not reactive, which helps us avoid hospital admissions." They said that by using the framework, admissions to hospital had reduced significantly.

A visiting health professional we spoke with said that staff called them out appropriately and worked well with them because, "We (the visiting health professional and the home manager) like to minimise hospital admissions." Care staff told us that they escorted people to attend outpatient appointments and when they transferred to hospital. They said, "They need someone who knows them."

The clinical lead nurse told us, "When people need to go into hospital, we send their transfer form, body map and care profile with them. We assess for pressure sores before they leave home and re-assess them before they come home."

We saw that when people transferred from hospital that the assessment of needs before they returned to the home was thorough and designed to minimise anxiety. In one care plan we saw the person, who had dementia, had bed rails because they had asked for them. They had not had bed rails before they went into hospital, but they said they had got used to them in hospital and it made them feel safe.

We found that one person presented behaviour that challenged staff, but the behaviour had not been explained by the previous provider. The manager had written short term care plans to ease the settling in period. The manager explained that, "Sometimes a change of environment can impact on people's behaviour" and "The short term care plan was for two care staff to assist with personal care, one to hold the person's hand and to talk with the person and explain, while the other staff delivered the care. The person is well settled now and their behaviour is changed."

We saw that the manager kept a transfer file for each person, ready to be taken to hospital with them in an emergency. The file included a form with contact details, medical history and current assessed needs. It included details of people's advanced care plans, if any had been agreed. For those people with an advanced care plan, the file was marked, "They wish to be discharged as soon as possible" and "They have expressed the wish to be cared for by staff that know them well and in the place they call home."

The transfer file contained body maps, marked appropriately, and information about people's preferred routines. Copies of people's care profiles, which included their physical and psychological and emotional needs, were included. This meant that hospital staff would know and understand if people were anxious, agitated or suffered from depression, and the effect this had on their behaviour and needs.

Are people with dementia able to obtain appropriate health and social care support?

Relatives we spoke with told us they were very impressed with the care that was provided to their relation and staff were quick to respond to changes in their relations' needs. They told us that staff sought advice from other health professionals when they needed to. One relative told us, "X has been much calmer since the psychiatrist was involved. I attended a meeting with X, staff and a psychiatrist. It gave me a proper understanding of X's diagnosis and prognosis." They told us that the subsequent changes to their relation's treatment were effective and appropriate.

We saw that nurses regularly monitored people's physical and mental health. The daily records we looked at showed that staff recognised when a person's physical or mental health changed. In the care plans we looked at, we saw that people with dementia were referred to other health professionals for support with their physical and mental health.

For example, when one person with dementia was at risk of poor nutrition, staff had arranged for their doctor and the speech and language team to visit them. In the daily records of care, we saw that staff followed their advice and offered the person soft, moist food and special enriched drinks.

The clinical lead nurse told us, "We would rather ring and call a doctor out than take a chance." A visiting health professional told us, "A patient may request a visit, or the staff may be genuinely worried about a person. Staff do call us out appropriately."

In one care plan we looked at, we found that because the person had dementia and an advanced plan of care in place, a specialist had considered that a particular medical treatment was not appropriate. The manager and the person's doctor had challenged the decision and treatment was successfully undertaken. The manager told us, "X has improved dramatically, even their cognitive abilities."

This meant that people obtained appropriate support for their physical and mental health 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 an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

Reasons for our judgement

How is the quality of dementia care monitored?

We found that people's care plans were regularly reviewed and changed when their needs changed. We saw nurses checked that people's physical and psychological needs were met effectively. For people with dementia, the nurses repeated the dementia assessment test every month, so they could monitor changes in the person's cognition, memory and behaviour. The manager checked that people with dementia had a life history book in place, so that staff knew and understood people's hobbies and interests.

The manager checked that people's care plans and individual risk assessments were regularly reviewed and up to date. The manager checked that short term plans were in place for short term needs, or added to long term care plans if in place for longer than three months. The most recent audit we looked at was marked, "More detail requested" and staff had signed to say 'amended and noted for the future'. This meant that the manager and staff took action to maintain the quality of care.

The provider monitored the quality of care though analysing surveys and questionnaires that people and their families completed. The provider visited the home regularly so they could see for themselves and ask people whether they were happy with their care and support.

We found that the manager was the lead on dementia care, because they had previously managed a residential home for people with dementia. The manager told us they monitored the quality of care through continuous observation of staff's practice and staff's interaction with people who lived at the home. The manager said, "I am hands on. I work alongside staff at double up to support people to bed or to the toilet. I walk around and I attend handover." Care staff told us that the manager was, "Good at dementia care" and listened to their suggestions for engaging with people with dementia.

The manager told us that they particularly watched how people with dementia responded

to staff, because people with dementia were not always able to express their feelings. Two relatives of people with dementia told us they had no concerns about the quality of care because, "The staff understand X's condition", "Staff A and B have been here for ever. They lead by example" and "I am as happy as I can be with his care."

We found that when a new person with dementia moved into the home, their care plans were reviewed after two weeks, when the manager had been able to observe how they responded to care and support. They told us that although people's relatives explained their knowledge of their relations, the impact of dementia meant that people's tastes and preferences might have changed without their relatives realising it.

The manager told us they planned to introduce a formal quality monitoring tool for people with dementia, which would support their current practice of surveys, care plan reviews, observation and listening to people and their relatives. They told us that an increasing number of people admitted to the home for nursing needs also had a diagnosis of dementia, so they wanted to formalise how they monitored the quality of care. They planned to use the care mapping tool, as per the University of Bradford guidance, because it was a well-established method designed to check whether people with dementia were supported effectively and would identify areas for improvement.

How are the risks and benefits to people with dementia receiving care managed?

The provider minimised risks to people's care by ensuring that staff were trained and supported in their role. We saw that staff had up to date mandatory training and training that was specific to the needs of people at the home, such as dementia awareness, challenging behaviour and end of life care. The clinical lead nurse showed us their training plan for nurses, which was colour coded to show when their refresher training was due. A member of care staff told us, "We can't miss the refresher training because we are given the booking forms with our wage slips."

The manager had recently attended a course with Age Concern on managing a dementia service. Nurses had specialist dementia training with the Alzheimer's society, which meant they understood the early signs of dementia, the treatments available and soothing and creative therapies, such as, promoting exercise and personalised activities. The clinical lead nurse told us, "All staff have dementia awareness training during their induction. The manager assesses their answers for understanding and competence." A care worker told us, "We had dementia awareness training. We were given booklets and had three months to complete them in."

The clinical lead nurse told us that staff training included staff taking the place of people who needed assistance, to ensure they would empathise with people's anxieties. They told us, "Staff training includes staff being blindfolded and fed, staff being blindfolded and ears covered and staff being hoisted, so they understand what it feels like."

During our observation at lunch time, we saw that the staff training was effective. The atmosphere in the dining room was calm and relaxed. Staff encouraged and assisted people to eat in a sensitive and friendly manner, explaining what was happening throughout the meal.

The manager made sure there were enough staff to support people according to their needs. The manager's assessment of needs showed that more staff were needed at peak times for getting up and going to bed, that is around 8 am and 8 pm, to meet people's

needs effectively.

The manager told us that staff had agreed to small changes in their shift patterns to have more staff available, with least disruption to people's preferred routines. This resulted in two shifts overlapping and working together for an hour at changeover. The manager told us that one night staff always paired with one day staff for this period to ensure information was shared between staff.

This meant that the manager took action to minimise the risks of people with dementia becoming anxious because they were supported by staff that were familiar to them.

The clinical lead nurse told us, "The staff group is really good. They are always willing to cover extra hours, for when palliative care is needed for example. The list of hours required is on the wall and staff sign to say when they can cover."

We observed that there were enough staff to meet people's needs effectively. We saw care staff constantly checking on people who preferred to stay in their rooms and chatting to them. They worked well as a group, supporting each other as necessary. They checked with each other that tasks had been carried out and worked effectively as a team when people needed more than one care staff to support them.

Care staff told us that they constantly monitored people who were at high risk so they knew straight away if their health deteriorated. A member of care staff told us, "People have charts in their rooms for repositioning, personal care, eating and drinking. If a person is under the weather, we record their fluid intake." We saw that staff kept behavioural charts for two people who had dementia, so they could monitor any changes in their cognitive abilities.

This meant that risks to people's care and treatment were managed effectively.

Are the views of people with dementia taken into account?

We found that people with dementia who lived at the home were not able to communicate verbally, so it was not possible to gain their opinion of the quality of the service. We saw that care staff took time to speak with people and explain what was happening. We heard that they used an appropriate tone to encourage and coax individuals to respond to questions, such as, what drink they would like and whether they would like to join in the activities.

The provider might like to note that while people with dementia often benefit from reminiscing about their past lives, there were no historical pictures or artefacts around the home that might encourage people with dementia to initiate conversations spontaneously.

The manager told us they regularly walked around the home and took every opportunity to speak with people and their relatives, so they could check whether they were happy with their care and treatment. The manager said, "I talk with people at breakfast time, observe staff and discuss their practice at supervision and speak to people in their rooms."

The manager told us, "At four to six weeks after admission, we check people's understanding and ask if it meets their expectations." A relative told us that the manager had been proactive in improving his relation's care. They said, "X had a wheelchair, but the manager recommended us to try a memory foam lining and said, 'Why don't we look at a better quality wheelchair?'" This meant that people who use the service and their

representatives were asked for their views about their care and treatment and they were acted on.

The manager told us they put out questionnaires for people who live at the home twice a year and had a relatives' survey every year. The surveys and questionnaires were sent directly to the head office for analysis and reported back to the home. This meant that the provider knew if there were any issues with the quality of the service.

We found that the provider had a complaints policy in place. People and their relatives were told about the policy and procedure when they first moved into the home and there was a poster in the hallway to remind them. A relative told us, "If I have any issues I raise them and I always get a positive response."

We saw that the manager held quarterly meetings for people who lived at the home. In the minutes of the most recent meeting, we saw that the manager acted on the suggestions that people made to make sure they were happy with the support available to them.

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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