Inspection Report

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

Westgate House Care Centre

Tower Road, Ware, SG12 7LP

Tel: 01920426100

Date of Inspections: 04 March 2014
03 March 2014

Date of Publication: April 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✖ Action needed
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Requirements relating to workers	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Westgate Healthcare Limited
Registered Manager	Mrs. Shiji Mathew
Overview of the service	Westgate Care Centre is a purpose built care home providing nursing or personal care to older people. The home has a purpose built unit for people living with dementia and also provides rehabilitation care. The home is registered to provide care for up to 109 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'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 March 2014 and 4 March 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and talked with other authorities.

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

What people told us and what we found

We inspected Westgate Care Centre due to concerns that had been raised. These suggested that people were not treated with dignity and respect, that their consent had not always been sought and that they were receiving inappropriate care.

During our inspection on 03 and 04 March 2014 we found that people's dignity was not maintained. We noted that people's bedroom doors had been left open and people were visible from the corridors in various states of undress. We also found that the needs, wishes, preferences and decisions of people who used the service were not at the centre of the assessment, planning and delivery of their care, treatment and support.

We found that the provider had not sought the required consent from people who acted on behalf of those who had complex needs and lacked the mental capacity to make or understand decisions themselves. Where the provider had not acted in accordance with relevant guidance and legislation people may have been unlawfully restricted because their preferences and views had not been sought.

We spoke with people who used the service and their relatives. Some of the people we spoke with were positive about the care they received. One person told us, "[Carer] is fantastic, so gentle and kind and knows just what I need, in fact most of the staff are very caring." However people did not always feel involved in the planning of their care. One person who used the service told us, "I don't know what's in my care plan, I would like to see it but the staff don't have the time to show me, I trust that they know what's best."

We found that people were not always cared for by suitably qualified, skilled or experienced staff. This was because the provider had not sought to ensure that staff were suitably skilled or qualified prior to commencing employment. One staff member we spoke

with told us, "I didn't have an assessment [of my skills] by the unit manager, and I haven't spoken to them about how I am getting on. They just take my word that I am doing okay."

We found that people's care records were not stored securely, nor were they always accurate and appropriate.

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

What we have told the provider to do

We have asked the provider to send us a report by 18 April 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 referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

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

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's privacy, dignity and independence was not respected.

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

Reasons for our judgement

We spoke with one person who used the service and they told us that, "They are very kind, and considerate. [Nurse] is very helpful and explains things to me in a way that demystifies things for me." One person's relative we spoke with told us, "I am here every day. They know both me and [relative] and do the little things to make our time normal. We like to each lunch together so the carers lay up a table for us both to enjoy. That's nice as it helps to keep things normal."

We spoke with the relatives of four people during our inspection and were told that they did not feel involved in their relative's care and treatment. People we spoke with told us the staff kept them informed of any action they were taking, however they were not always involved in the planning of the care for their relative. For example we spoke with one person's relative who told us that they had been telephoned at home when their relative had a fall, however they were unaware of how the person's care plan had changed following this. They told us that their views had not been sought, although they felt the staff were managing their relative's mobility well.

We asked people's relatives if they attended reviews of peoples care. People we spoke with told us they were able to approach staff at any time for an update or to ask advice. People told us they attended an annual review where their opinions were sought; however they were unaware that monthly reviews of people's care needs took place.

We spoke with people who used the service and asked if they were involved in the review of their care needs. They told us that they were not shown copies of their care plans and were unaware of what they contained. One person who used the service told us, "Care plan, no sorry, I have asked but never seen it."

We observed the lunch time meal and saw staff encouraging people to eat their lunch and

they provided support where this was required in a sensitive and respectful manner. We noted three people being supported to eat their meal and that the member of staff assisting each person was patient, even though the person was unable to respond. When staff provided personal intimate care to people we noted this was carried out in their room and the person's door was closed to maintain their dignity.

We looked at people's care records and noted that people's relatives had completed a document entitled life and times. This document had recorded a person's life history, their family and hobbies and interests. However when we reviewed all these documents we found they provided little detail. For example, one entry noted the person enjoyed music but did not elaborate on what type of music. This meant that where the person was unable to communicate their preferences verbally, staff were unaware of the specific types of activity they enjoyed. We also saw from these records that staff had not recorded people's individual preferences with regard to their personal care. This meant that people who used the service did not have the option to indicate preferences about their bed time routines, what they liked to wear or their meal choices for example. This demonstrated that the needs, wishes, preferences and decisions of people who used the service were not at the centre of the assessment, planning and delivery of their care, treatment and support.

People's privacy, dignity and independence were not respected. We noted that some people who used the service were sat in the lounge dressed in clothes that were too big for them. They appeared to be unkempt.

We observed one person who used the service remove their clothing in their bedroom with the door open. Staff passed by the bedroom whilst collecting plates and beakers following the lunch service. We noted that even though staff had noticed the person removing parts of their clothing it took them 15 minutes to respond to it. We also saw that one female required repositioning in their bed. We observed that, where they had been agitated, their top had moved and exposed parts of their body. We asked the manager to address the issue, and they sensitively covered the person. However during our inspection, where the majority of the doors in the home were kept open, we observed numerous examples of people's privacy and dignity being compromised by similar circumstances.

We spoke with the relatives of two people who used the service and who were unable to communicate due to their complex needs. The relatives told us that they had accepted people's doors were kept open. Staff had not asked them if they wished for their relative's door to be held open. They told us they had been asked to sign a document for the door to be locked when the room was unoccupied. One relative we spoke with told us, "Sometimes on here, the odd one or two can be a bit undressed, either in their rooms or the corridor, but I don't look, and the staff are usually quick to help them." One person who used the service told us, "I close the door and they [staff] open it, I have given up trying to get a bit of peace. The only time they leave it closed is when I have visitors, which I assume is because they don't need to monitor me."

This demonstrated to us that staff had not upheld and maintained the dignity, independence, and privacy of people who used the service.

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements.

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

During our inspection on 03 March 2014 we noted that staff sought verbal consent from people prior to supporting them. We observed people as they ate their lunch and staff supported people to eat where this was required. We also observed staff asking people if they were able to tend to their personal care needs, such as adjusting their clothing or administering medicines. We observed one person decline their medicine at one time as they were not ready to take it. We noted the staff member acknowledged this and returned later.

We looked at six people's care records, and saw that the provider sought people's consent for a range of areas. For example we noted that signed consent was in place in relation to confidentiality for care records and these had been signed by relatives in some examples.

The records we looked at for people who were living with either dementia or some form of cognitive impairment showed that people's capacity to provide consent had not been assessed thoroughly. One person's care plan we looked at recorded for several areas that they were unable to provide consent as they 'lacked capacity.' We noted these were for areas such as personal care, medicines, eating and night time care. We saw that a mental capacity assessment was included with the person's record but this had not been completed. Furthermore we noted that, due to the person's mobility needs, an assessment for the use of bed rails had been carried out. Bed rails were used to restrict the person from falling from their bed at night or during the day following this assessment. A best interest decision had not been sought, and the views of either the person who used the service or their advocate or relative had not been considered. A Deprivation of Liberty Safeguards (DoLS) referral had not been made. Therefore this person was being restrained to their bed without the appropriate assessments and controls being made which impacted on this person's safety, welfare and choice. We have raised this concern with the local authority.

We saw from the six mental capacity assessments we looked at that a comprehensive assessment of each area of people's ability to make informed choices had not been made.

The home used a standard pre-printed capacity assessment tool. This did not allow for rationale to be included in the decision which meant a reason for each capacity decision had not been documented. We did see that this document was reviewed at each monthly care planning review; however the views of the person, their advocate or relatives had not been sought. Furthermore, because the capacity assessment was a generic tool it did not allow for a personalised approach to be taken. For example, a person may be unable to make an informed decision about their financial affairs, but may be fully able to make a decision about how and when they liked to be bathed. The capacity assessments used by staff at Westgate Care Centre did not make this distinction. In every example that we looked at, people's lack of capacity had been decided in a carte blanche manner. This meant that people's capacity had not been assessed in line with the Mental Capacity Act 2005 therefore the provider had not sought people's capacity in line with legal requirements. This also meant that there was a risk that people subsequently may have been receiving inappropriate care against their wishes.

The manager showed us training records that demonstrated staff had recently undergone training in relation to mental capacity and deprivation of liberty safeguards. We spoke with staff members who were unable to demonstrate to us through discussion an awareness of the requirements of obtaining consent from people who lacked capacity. One staff member we spoke with told us, "Mental capacity is a decision and depends on their best interest. If I want to do something, I ask first and if they do not want it, I will do it to them as it is in their best interests." One member of staff we spoke with told us, "We would assess their decision making capacity, but I don't know who is involved. We had training recently which was a one hour session for mental capacity and DoLs." This meant that staff had not been provided with effective training and awareness to support people who lacked capacity to make decisions.

We also noted that the home did not provide access to an advocacy service for people. This meant that people who used the service and required the advice and support of an advocate may not be able to receive this. We spoke with the manager about this and they told us they would take action.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not always delivered in a way that was intended to ensure people's safety and welfare.

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

Reasons for our judgement

People's needs were assessed however care and treatment was not always planned and delivered in line with their individual care plan.

People we spoke with were overall positive about the care they received from Westgate Care Centre. One person who used the service told us, "[Carer] is fantastic, so gentle and kind and knows just what I need, in fact most of the staff are very caring." One person's relative we spoke with told us, "The hands on care is very good, the staff will tell me if there have been any changes."

We asked people if they felt involved in the planning of their care. One person's relative told us, "I would like to be given the opportunity to join in when [relative] care plans are reviewed." One person who used the service told us, "I don't know what's in my care plan, I would like to see it but the staff don't have the time to show me, I trust that they know what's best." This meant that people's care plans were not always developed with their wishes or the wishes of their representatives.

We saw from care records we looked at that people's needs had been assessed by either the home manager or a member of the nursing team prior to their admission. The initial assessment reviewed areas such as the person's medical history, current health needs, medicines, mobility, personal care requirements and nursing needs. We saw that people's assessments also sought information from other professionals involved in the person's care, for example hospital discharge teams and social workers. This initial assessment formed the basis of the person's care plan and was reviewed once the person moved into Westgate Care Centre.

Upon their admittance to Westgate Care Centre we saw that people's needs had been reviewed and individual care plans were developed to manage those needs. However we also found that, in some cases, the assessment had been carried out but the care plan had not been created. For example, a night time care plan was missing for one person who was bed bound and at high risk of developing pressure sores. The risk assessment

and daily records indicated they required repositioning in their bed every two hours. This would reduce the pressure placed on one area of the body, and reduce the risk of pressure sores developing.

However we noted that for one night prior to our inspection the person was repositioned after three hours and twenty minutes, three hours and twenty five minutes, and two hours and fifty one minutes. We looked to see what the night care plan stated for this person, and found staff had not developed one. Staff we spoke with were aware of the needs of the person, and told us they were updated about their care needs through a daily handover and their knowledge of the person. This demonstrated that staff had not provided care in accordance with the person's care plan, which meant the person was at risk of developing a pressure sore.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

People were not always cared for by suitably qualified, skilled or experienced staff.

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

Reasons for our judgement

We looked at the recruitment records for six recently recruited members of staff. We saw from these records that a copy of the staff member's application, curriculum vitae and interview record had been maintained for all of them. We saw from the interview record that each particular role included specific scenarios to evaluate a potential employee's knowledge. For example in the interview for a nurse we noted scenarios were created to demonstrate the knowledge around diabetes management. Where nurses had been employed, we saw the provider had checked with the relevant professional body to ensure they were registered.

We noted that where a person had been recruited from overseas, a copy of the visa entitlement was kept in their file. Each recruitment record we looked contained proof of identity in the form of a passport and utility bills to ensure people were entitled to work. We also found that for each of the people employed, the provider had sought a Disclosure and Barring Service check to ensure potential employees were fit to work with vulnerable people. We noted these checks had been reviewed by the manager, and none of the employees had commenced work prior to these checks being completed.

However, we also found that where the provider had recruited staff from overseas, they had not always ensured appropriate checks were undertaken before staff began work. For example, one staff member's recruitment file showed us that they had previously worked overseas in a role that did not provide care to people. The provider had accepted two references for the staff member from people who were not professionals in providing care to people but had commented on their ability to perform the role. We noted that one comment stated, "I would say that [staff member] is very competent."

We saw from a second record we looked at that two references had been sought, and where one reference was from a previous employer, the second was obtained from a colleague. We reviewed the provider's policy in relation to, 'Recruitment of staff.' This documented that a minimum of two references must be sought from a senior manager, e.g. home manager, director or human resources. It further noted that family and personal references were unacceptable. We asked the manager and provider how these references

provided a balanced and professional view of a person's competency in a caring role, however they were unable to answer.

We saw that where people employed from overseas had been employed, where they had provided copies of certification these had not been followed up. The recruitment policy stated that all professional, educational and in service qualifications claimed were required to be verified. The manager confirmed that this had not occurred. This meant that the service could not be confident that they were employing staff who had the necessary skills, attitude and experience for their role.

We looked at the induction process undertaken by staff. Staff we spoke with told us that they had shadowed a senior staff member during their first week. They told us this allowed them to orientate themselves with the home, review policies, and get to know people who used the service. Staff also completed a skills for care induction booklet which followed national standards for caring.

We asked how the provider ensured they were competent to provide care to people after this period. Staff we spoke with told us they did not have a formal assessment of their skills, and did not receive feedback from senior staff in relation to their performance. Staff told us that they met with the home manager six weeks after they commenced employment for a probation review. Staff also told us that this was sometimes attended by the unit manager, however one staff member told us the unit manager left during their meeting.

We asked the home manager how they were able to provide an individual probation review for staff, and develop a tailored package of training and support. They told us they spoke with the unit managers prior to the probation meeting and sought their feedback. However this did not always occur, and also was not documented in the staff member's review. One staff member we spoke with told us, "Induction was okay, but I didn't get any feedback so I could understand my strong and weak points."

We looked at the probation review records for staff, and found that none of the records we looked at contained feedback from the unit managers. We noted that objectives were not recorded in sufficient detail and were not measurable. For example, one probation review had identified that typing up care plan reviews had been identified as an area for development. However there was no clear documented plan of how this would be achieved other than noting, '[Staff member] to complete care plans and risk assessments. We asked if the manager had considered the staff member's literacy, or difficulty in understanding the care records. They told us that they had not and that probation reviews could be clearer.

We saw that in none of the records we looked at had the staff member received a review of their performance and development with their line manager. One staff member we spoke with told us, "I didn't have an assessment by the unit manager, and I haven't spoken to them about how I am getting on. They just take my word that I am doing okay."

This meant that the service could not be confident that they were employing staff who had the necessary skills, attitude and experience for their role.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. People's personal records were not held securely by the provider.

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

Reasons for our judgement

We looked at the daily handover record that staff referred to at the commencement of each shift. This documented what had happened during the previous shift and any issues that staff starting work needed to be aware of. We noted that the provider had used an old 2013 diary to record each entry. We saw that records for 27 and 28 February 2014 had been entered into the diary for 12 and 13 December 2013. Should staff seek information for a person who used the service in an emergency, there was a risk they may provide inaccurate information due to the inaccurate recording of dates. We spoke with the provider, who told us they would provide appropriate records for staff handovers.

People's personal records including medical records were not accurate and fit for purpose. We noted that people's risk assessments and care plans lacked sufficient detail to inform staff sufficiently about a person's needs.

We saw that staff had assessed one person's ability to communicate to staff that they were experiencing pain. This person had difficulty in communicating verbally to staff due to their complex needs. We noted the entry in the assessment stated, "Can't express pain." However when we looked at the corresponding care plan we were unable to see any further exploration of this. We noted staff had not considered how the person may communicate nonverbally to express they were in pain. Staff we spoke with however were able to demonstrate their awareness of this person, and were aware of how to identify if the person was experiencing pain.

One person's care had been recently reviewed by the dietician as they were at risk of developing pressure sores. This person was receiving their fluids and food through a percutaneous endoscopic gastrostomy (PEG) tube. This is used for people who are unable to swallow, eat or drink enough and for providing certain types of medication. We noted that an alteration had been made to the amount of fluid this person received, however this had not been updated in the person's care records. Staff had passed this information on through the handover.

We noted one record for a person's skin integrity had been updated following a fall. However the record was incomplete. It stated, "Had fall on 23 February 2014, [person] got bruise on right eyebrow and bruise around eye. Small skin tear on left hand and a . . [Incomplete text]." We saw that the information had been recorded on the person's body map, however we were unable to find a record to instruct staff how to manage this persons care. However staff we spoke with were aware of the person's skin tear and described to us the treatment they were providing.

One person had sustained a fall on 24 February 2014. This had resulted in the person's mobility becoming more limited. Staff we spoke with told us how they provided personal care to the person, and informed us that they provided two carers when providing personal care. However, we noted that other than an entry made in the handover and daily record, staff had not re-assessed changes to his mobility or manual handling needs. We noted that the person's corresponding care plans had also not been updated.

We toured each of the three units and found that each nurse's station was unlocked and the door was open. In one office we found that a filing cabinet which contained people's private and confidential information remained open. We also noted that on notice boards were regimes for personal care for people. As people's relatives or visitors such as contractors freely accessed the office they were able to see this information. This meant that people's private and confidential information had not been kept securely. We spoke with the provider who told us they would seek to install key pads on each office door so they were secure.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Regulation 17 1 (a) (b) The provider did not seek the views of people who use the service or their relatives in decisions relating to their care or treatment and did not protect people's privacy and dignity.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Regulation 18 The provider did not have suitable arrangements in place to act in accordance with the consent of service users who were unable to provide consent in line with the Mental Capacity Act 2005.

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Regulation 9 (1) (a) (b) The provider had not sought to incorporate the views of people who use the service or their representatives when developing or reviewing their care. Care plans did not always identify risks, and say how these will be managed.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: Regulation 21 (a) (b) The provider had not operated effective recruitment procedures in order to ensure that staff employed for the purposes of carrying were suitably qualified, skilled or appropriate to work with vulnerable people.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Regulation 20 (1) (a) and (2) (b)

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	An accurate record for each service user had not been maintained and people's records had not been kept securely.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 18 April 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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