Inspection Report

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

Princess Lodge Limited

11 High Street, Princes End, Tipton, DY4 9HU

Tel: 01215571176

Date of Inspection: 24 October 2013

Date of Publication: December 2013

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

Consent to care and treatment	✓	Met this standard
Care and welfare of people who use services	✗	Action needed
Safeguarding people who use services from abuse	✗	Action needed
Requirements relating to workers	✗	Action needed
Staffing	✗	Action needed
Supporting workers	✗	Action needed
Assessing and monitoring the quality of service provision	✗	Enforcement action taken

Details about this location

Registered Provider	Princess Lodge Limited
Registered Managers	Mr. Frank Brown Mrs. Jayne Elizabeth Whitehouse
Overview of the service	Princess Lodge is registered to provide accommodation and nursing care to a maximum of 36 people. People living there have a range of conditions related to old age which may include dementia.
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

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 October 2013, 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 talked with other authorities.

What people told us and what we found

On the day of our inspection 22 people lived at the home. The registered managers as detailed on this report no longer worked in the home and the position had been vacant for three weeks, however, we spoke with the deputy manager and the provider. We spoke with eight people who lived there, six of their relatives, and four members of staff. Several people who lived in the home were unable to tell us their experiences of living there so we spent time observing how staff interacted with people.

People were asked for their consent before any care was given so that staff acted in accordance with their wishes. One person told us, "They ask me nicely what I want all the time".

We saw good interactions between people who lived there and staff. One relative told us, "On the whole the care is good". We saw that people's needs were assessed by a range of health professionals and their healthcare needs had been monitored so that their health and wellbeing was promoted and met.

We looked at how the provider was protecting vulnerable people. Systems in place to protect people from the risk of unsafe care were not robust and they had not ensured people's wellbeing and safety.

We saw that the provider did not have effective recruitment and selection procedures in place to ensure that only staff suitable to work with vulnerable people were employed.

There were not enough staff on duty to ensure people received care in a timely manner. This meant that the provider could not fully meet people's needs and keep them safe.

We found that people were not asked for their views about the home and people were not listened to. Systems were not in place to seek the views of people using the service or audit all aspects of the quality of care so that any necessary improvements could be made.

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 14 December 2013, 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 Princess Lodge Limited 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

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

People were asked for their consent before care was given. One person told us, "Staff ask me when they are going to help me with my shower and ask if that's okay". We saw that where people were able to give consent they had signed the care records to agree to the care they received. For example, people were asked if they were happy to have their picture taken, to use bed rails for their own safety and, for staff to store and administer their medication. This meant that staff acted with the consent of people in relation to their care and support. This showed that people had a choice on how their care should be delivered.

We observed staff supporting people during a meal time, staff supported people patiently and explained what they were doing to assist them with their meal before they started to provide the assistance needed. All staff we spoke with told us that they always asked people if they were happy to receive care or support before providing it and in some situations relatives had been consulted about the care. The majority of people living at the home had on-going support and contact from their family who spoke on their behalf and supported them in decision making where they were not able to. One of the relatives told us, "Staff always let you know if anything happens, like if my mum is unwell". This meant that peoples' wishes were respected.

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 planned and 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

We looked at how people received safe and appropriate care that met their needs and protected their rights. We looked at five sets of care records and then spoke with some people who used the service and their relatives to see if their care and welfare needs were being met. We also spent some time observing how people were being cared for and how staff interacted with people.

People's needs were assessed and their care was delivered in line with their individual care plan. We looked at the records of three people who lived there. These included care plans that showed staff how to support the person to meet their needs. We saw care plans and risk assessments were in place that were relevant to people's assessed needs and were reviewed regularly. This meant that care and support plans were up to date to ensure that people's needs would be met in line with the support that was needed. All staff spoken with knew how to support people so that their needs were met.

Records we sampled showed that people were referred to other healthcare professionals where needed to ensure their healthcare needs were met. One relative told us, "If my mum is unwell they would get the doctor". We saw that staff interacted well with people using the service and treated people with kindness and dignity. One person told us, "They treat me nicely here and I like it". Another person said, "I think the staff are alright, it is good". We saw that people were dressed in individual styles that reflected their age, gender and the weather.

We observed that several people who had high dependency needs, who could not walk independently and had no verbal communication skills had spent most of the morning sat in sofas asleep in the lounge. Most people were largely left to themselves with little or no staff interaction except on occasions when they were prompted to wake up for a drink or food. We saw staff did not take the opportunity to spend time to engage and interact with people. People were unable to inform staff if their needs were being met and had no opportunity to engage in meaningful activities.

We observed that attention had not always been given to people's personal care. Staff spoken with told us that they did not have time to support each person with a bath or shower every day and advised that most people were supported to have a bath at least once a week. One person told us, "I want to have a bath more often but I can't." This meant that people's personal care needs were not always met as they wished which could impact on their well-being and self-esteem.

We observed a nurse administered medication to one person; they tipped the tablets on the table from the medication container and the nurse then picked up the tablets with their fingers and put them into the person's mouth. When asked, the nurse told us that the person would not take medication if given in the container. There was no care plan or risk assessment to support this approach. This was discussed with the deputy manager who told us that they were not aware of the practice that had been used. The person who took the medication told us, "I can take my tablets on my own, at times I take them with tea or juice". This showed that care was not delivered in a safe and appropriate way.

We saw that people generally sat around watching TV or observing passively. We only saw one activity, an exercise session taking place and only six people were engaged in that activity. No other activities were observed taking place. There was no information about activities planned for the home routinely provided, however, there was a poster informing of Halloween party planned for November and a poster showing planned events leading up to Christmas time. Three relatives we spoke with told us that the home could do with providing more activities. We saw that staff spent a lot of their time helping people with basic support needs but spent no time engaged with people in activities. Staff spoken with told us that the activities needed to improve but they did not have enough time to do this. This showed that people were not provided with enough activities to keep them stimulated to maintain their welfare and well-being.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

All of the staff we spoke with told us what they would do if they were concerned about any behaviour of their peers or people's relatives. This meant that staff were aware of what action they should take to protect people from any risk of abuse from other people. All staff we spoke with confirmed that they had received training in safeguarding vulnerable adults.

However, the training records did not reflect what we were told and showed that most of the staff had not received training in safeguarding vulnerable adults. The records we looked at confirmed that a few staff members needed refresher training on safeguarding vulnerable adults. This meant that people could not be assured that staff would have the appropriate knowledge and skills to protect them from risk of harm.

We found that there was no appropriate system in place to show that allegations of abuse had been recorded or responded to appropriately. One relative told us about an incident that could potentially have been an abuse or safeguarding matter. The provider was unable to show us any records related to this allegation and how the concerns were dealt with. This meant that there were no arrangements in place that ensured people were protected from the risk of harm.

We saw that the provider had a safeguarding and whistleblowing policy in place. However, there was no information in an accessible format for people living at the home. Our discussion with some of the people living at the home demonstrated that most of the people did not understand the concept of 'abuse' and 'harm'. One person said, "I'm not sure of what to do if people don't treat me well". This showed that information was not accessible to inform people living at the home of how they could raise safeguarding concerns.

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 cared for, or supported by, suitably qualified, skilled and 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 two staff files. The deputy manager told us that those were the only two staff files they could only find. Both files that we looked contained evidence of completed application forms and Criminal Records Bureau (CRB) or Disclosure and Barring Services (DBS) checks. This showed that some of the relevant information required as part of the recruitment process had been obtained.

In both files we looked at, we saw that there were no proof of interviews, references and records of nurse registration with their professional body. Two staff we spoke with told us that they were aware their references had not been obtained. The deputy manager and the provider told us that they were aware that staff files did not contain relevant information that was required for staff in the recruitment process in order to meet the required standard. The deputy manager showed us a file of work in progress that they had started to identify relevant information that is missing in all staff files. This meant that people had been employed at the home without all necessary checks completed.

In one of the files we looked at, we saw that one staff member had a CRB that had an offence recorded on it. We saw that the staff member had started work before the CRB check came through. The staff member confirmed that they started work before their CRB check was received. Another staff told us, "I started work before my CRB was cleared". We saw no evidence of references being obtained and there was no evidence of a risk assessment in place in regard to the member of staff. When asked, the deputy manager and the provider told us they were not aware of the staff's conviction as that would have been the responsibility of the previous manager. The provider stated that there were no concerns about the member of staff's work. The provider told us that they would ensure that they would look into this issue of concern. This showed that appropriate checks were not always undertaken before staff began work to ensure that people were to be cared for by suitable staff.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

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

On the day of our inspection there were 22 people living at the home. We were told by nurse in charge that on a typical day they would have one nurse, one senior care worker and four care workers between 07:00hrs and 14:00hrs; one nurse and four care workers between 14:00hrs and 21:00hrs and one nurse and two care workers at night between 21:00hrs and 07:00hrs. During the week the deputy manager is available during the day.

Some of the people living at the home had a diagnosis of dementia. Some people displayed behaviours that challenged the service. Some people required two staff to safely move them and some people had physical health needs. All people we spoke with including staff, relatives, and people living at the home told us that there were not enough staff to meet people's individual needs or to keep them safe.

We asked the provider and the deputy manager if they had a formal system in place to assess the number and qualifications of staff needed on duty at any time. The provider told us that a dependency tool 'care plan audit' was in use, but they were not able to show us this assessment or tell us how they had used it. The provider could not provide us with evidence on how they had carried out a needs analysis and risk assessment as the basis of deciding the number of staff needed to meet people's needs.

We observed that during the lunch time meal eleven people required staff assistance with feeding. There were not enough staff on duty to support people with their meals in a timely way. For example, we saw one person waited for 45 minutes for their meal at lunchtime. We saw that another person who remained in the lounge was shouting and getting agitated when they waited for their lunch. All staff told us that they did not always have enough staff around to help support people in a timely manner.

A number of people living at the home told us that there were not enough staff. On one occasion there were no staff in the large lounge for a period of 15 minutes when it was occupied by 19 people. We pointed this out to the nurse on duty who then called staff. One person said, "They are short staffed, I don't get the support all the time". Another person told us, "I have to wait to go to the toilet". One relative told us, "There seems not to be

enough staff most of the time I visit, I had to stop incidents happening".

Overall, the evidence we gathered showed that the current staffing levels did not meet people's individual or safety needs.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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 how staff were trained, supported and supervised to provide safe and effective care. Four staff that we spoke with told us that they had not received regular training relevant to their jobs. The training matrix that we saw showed that not all staff had completed all required training to meet the needs of the people using the service. The training matrix we saw, only showed that the areas covered in training were food hygiene, safeguarding vulnerable adults, challenging behaviour, moving and handling, dementia care, infection control and first aid. This showed that other areas such as health and safety, fire safety, equality and diversity, mental capacity act were not covered. This meant that specific care needs of people using the service were at risk of not being met in a skilled or consistent manner by staff.

The deputy manager told us that they knew that there were a lot of gaps in staff training and they were working hard to ensure all staff were up to date with their training. The deputy manager showed us a plan in place to roll out training to cover all core skill areas and other areas such as tissue viability, pressure area care, dignity of care, team building, confidentiality and, end of life care. Most of the staff had not received training required to gain the skills and knowledge to safely care for people who lived at the home. This meant that staff may not be able to safely and appropriately support people to meet their needs.

We did not see any evidence of staff supervision, appraisal and induction. All four staff that we spoke with told us that they had not had any supervision or appraisal since they have started working in the home. The deputy manager said that there were no staff supervisions or appraisals in place. One staff member told us "I only had half a day induction and I was left to get on with it". Some staff told us that they did not feel supported by management to get more skills and qualifications that were related to the work they did. This meant people were cared for by staff that did not have the skills, training and qualifications required to care for people and meet their needs.

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 had no effective system to regularly assess and monitor the quality of service that people receive.

The provider had no effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a major 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

When we asked people about their general views of the service provided their responses included comments such as, "Good," and, "Alright". One relative said, "The home is quite nice compared to others".

We asked for specific information during the visit relating to how the service assessed and monitored the support and care it provided to people. There was a considerable delay before some information was provided. Both provider and deputy manager could not access the information on the computer or were unable to find the information from the paper files. They told us this was because the information would have been held by the previous manager. The deputy manager confirmed that they had been in post since March 2013 and the provider reported they did regular visits but neither of them were aware of where the information was held.

The provider showed us the complaints policy, however there was no complaints information available in an accessible format for people. The provider was unable to show the system used for recording and reviewing complaints. We were not provided with details to show how each complaint received was investigated or that themes and trends from complaints could be identified. One relative told us, "I have made a complaint about my mum three months ago and nothing has been resolved yet, it's difficult to access management here." One person said, "They don't listen".

We saw no evidence of staff's meetings, residents' meetings or relatives' meetings. All the staff we spoke with told us meetings for staff do not take place. All residents and their relatives we spoke with confirmed that meetings did not happen. There was no system in place to demonstrate that peoples' views were taken into account to inform and comment

on how the service should be run.

All of the people using the service and their relatives confirmed to us that they did not have any surveys or questionnaires provided to them to give a feedback on how they felt the service was managed. We saw no evidence that any surveys for people who use the service and their relatives had been undertaken. One relative said, "My mum had been here three years but I have never been asked for feedback". The deputy manager confirmed that there was no system in place to seek people's views.

We saw that there was a system for recording accidents and incidents. We looked at the accident book and saw that an incident we had been aware of was not recorded. This meant that the system did not fully reflect all accidents and incidents that had occurred in the home so that themes and trends could be identified and acted on.

Records we saw indicated that the last medication audit was done on 18 June 2013 and, the last infection control audit was done in April 2013. The deputy manager stated that these audits should be done every three months. This meant that standards in medicine management and infection control were not being monitored regularly to provide some assurance that people received safe care.

The provider and deputy manager confirmed that no audits of staff files had been undertaken but they advised that had recently started the process of going through each file. The deputy manager confirmed no record keeping audits had been completed.

Prior to our inspection we had been made aware of a concern relating to the care and welfare of one person which had been investigated under safeguarding procedures. This meant that some staff did not take action to report concerns about vulnerable people.

The provider had not forwarded a statutory notification for the fall or allegation of abuse to CQC as required by the regulation. We saw that there was no overall system to record and track safeguarding referrals.

The absence of effective audits and checks showed that the systems in place for monitoring the standard of care provided by staff were not effective.

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 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) (b) (i) (ii) The registered person must take proper steps to ensure that each person is protected against the risks of receiving care and treatment that is inappropriate and unsafe, by means of the planning and delivery of care and treatment in such a way as to meet the person's individual needs and ensure the welfare of the person.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Regulation 11(1) (a) (b) Suitable arrangements should be in place to ensure that people are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs and respond appropriately to allegations of abuse.

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 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: Regulation 21.(a) (i) (ii) (c) (i) The registered person must operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character, has the qualifications, skills and experience which are necessary for the work to be performed. Ensure that a person employed is registered with the relevant professional body where such registration is required.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: Regulation 22. In order to safeguard the health, safety and welfare of people, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activity.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Regulation 23 (1) (a) (b)

This section is primarily information for the provider

procedures Treatment of disease, disorder or injury	The registered person must have suitable arrangements in place in order to ensure that staff employed are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people safely and to an appropriate standard, including receiving appropriate training, professional development, supervision, appraisal and obtain further qualifications .

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 14 December 2013.

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 12 December 2013 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** Regulation10. (1) (a) (b) 2 (b) (i) (c) (i) (e) The registered person must protect people, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity. The registered person must identify, assess and manage risks relating to the health, welfare and safety of people. The registered person must have regard to the complaints and comments made, and views including the descriptions of peoples' experiences of care and treatment expressed, by people, and those acting on their behalf. Where necessary, make changes to the treatment or care provided.

For more information about the enforcement action we can take, please see our

This section is primarily information for the provider

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. 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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