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

Bromford Lane Care Centre

366 Bromford Lane, Washwood Heath, Birmingham, B8 2RY

Date of Inspection: 17 July 2013

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

- Respecting and involving people who use services: Met this standard
- Care and welfare of people who use services: Met this standard
- Safeguarding people who use services from abuse: Met this standard
- Management of medicines: Met this standard
- Staffing: Action needed
- Supporting workers: Met this standard
- Assessing and monitoring the quality of service provision: Action needed
- Records: Action needed
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<th>Registered Provider</th>
<th>Bondcare (Bromford) Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Bromford Lane Care Centre can provide nursing and personal care to up to 116 people.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Care home service with nursing</td>
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| Regulated activities | Accommodation for persons who require nursing or personal care  
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Treatment of disease, disorder or injury |
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Bromford Lane Care Centre had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Management of medicines
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 17 July 2013, checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with carers and/or family members. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by commissioners of services and reviewed information sent to us by other authorities.

What people told us and what we found

At the time of our inspection 80 people were living in the home. We spoke with 10 people, nine staff and seven relatives. We looked at the care records of seven people. We observed the interactions between staff and people living in the home to get a view of how people were being treated when they could not verbally express their needs.

We saw that the interactions were caring and friendly. People told us, "It's alright here" and "Get nice food and a choice. I choose when I go to bed and get up. I choose what I want to wear and they help me." Relatives told us, "X always looks clean, well presented, we can see him in private but we are happy to see him in lounge" and "Treat mom with dignity and respect, carers seem to know her well and what she likes." This showed people were happy with the service they received and were supported to make choices.

Where people had complex needs our observations were that not all staff had the skills they needed to meet their needs so that people were safe from the risk of harm.

Systems in place for the management of medicines ensured that people received their medicines as prescribed.

There were sufficient staff on duty to meet the needs of people and staff were supported to carry out their roles.

The systems in place for monitoring the quality of the service provided were not robust.
Records in place did not ensure that staff had the information they needed to care for people and did not reflect the care provided.

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 17 September 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

**More information about the provider**

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

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

Respecting and involving people who use services  ✔  Met this standard

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 meeting this standard.

People were treated with dignity and supported to make choices about their daily lives.

Reasons for our judgement

People were supported to maintain their dignity. We saw that people were appropriately supported throughout the day. One relative to us that staff, "Treat mom with dignity and respect, carers seem to know her well and what she likes"

Our observations of interactions between staff and people in the home showed that the interactions were caring and friendly. We saw that people were complimented about their hair after they had attended the hairdresser. People were spoken to in a polite and caring way.

We saw that staff addressed people by using their preferred names and staff supported people to make decisions about what they did during the day and helped them to make choices about their daily lives. One person told us, "I can go to bed and get up when I like." Another person said, "I was asked what I wanted for lunch yesterday." This meant that people were supported to make choices about their daily lives.

We saw that people were involved in planning their care where possible but where they were not able to make decisions their relatives and other people involved in their care were included in making decisions about people’s care.
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

Six of the seven relatives we spoke said they were happy with the service. Comments included:
"Not noticed any changes in quality of care as it has always been good?..You can ask staff if you want to know anything and they tell you. If he was unwell they would tell you."

"Some recent improvements, no major concerns ? some staff changes that are better. Like decoration of lounge as now wall paper and looks homely. Started to do trips."

One relative said they hadn't seen any real improvements in the service and six people we spoke with were all happy with the service they received. People said:
"It's alright here. I like to smoke; staff take you out for a cigarette."
"Can go to bed and get up when I like."
"Very excellent care."

One person was generally happy but felt that because they spent a lot of time in their bedroom staff tended to forget to offer them drinks from the tea trolley. They said "It doesn't take much for the staff to forget." The relative of this person also commented that they found that the bed was not being changed by staff so they had taken on this role now.

We observed the interactions of staff with people throughout the day including lunchtime. We saw that staff were attentive to people ensuring that they received regular drinks. We saw that drinks were available in bedrooms for people who spent most of their time in their bedrooms. On one floor staff brought people ice lollies. This meant that people's hydration needs were met on a very hot day.

We saw that people were well presented and dressed in individual styles and in clothes that were appropriate for the weather. People were supported to attend the hairdresser and comments were made about how nice they looked afterwards. This meant that people received positive comments about their appearance making them feel happy.

At lunchtime we saw that there was plenty of food available and people had been offered choices. People enjoyed their meals and dietary needs in respect of culture, choice and
health conditions were met. For example, one person with a sight impairment was told what was on their plate and where their drink was placed in relation to their plate. This meant the person knew what they were eating and their drink was accessible to them.

The provider may find it useful to note that although people enjoyed their food the mealtime experience could have been better for some people. For example, some people had to wait 20 minutes for their meal whilst everyone was seated. We saw that some people were not provided with the equipment that would have made it easier for them to eat their meals such as plate guards and thick handled cutlery. We saw that one member of staff got up and left the table whilst supporting a person to eat to assist someone else without explaining to the person where they were going. Condiments were not available to people and napkins and spoons were in short supply which meant that there was delay in people receiving their meal.

We saw that improvements had been made to ensure that people were involved in meaningful activities. Pets had been introduced into the home and people were able to watch chickens and rabbits in the garden. One person had got a small dog and used a small area of the garden to plant things and take the dog for short walks. We saw that people who walked around the home could stop at various points and pick up and use things such as dusters. Staff whose specific responsibilities were to organise activities spent a couple of hours on each unit every day. We were told by the acting manager that a trip to Weston Super Mare had been arranged for people who wanted to go.

The provider may find it useful to note that we saw that in some areas of the home the television had been muted and loud music playing at the same time. This could cause confusion to people as the sounds did not match the pictures they were watching.

We saw that people's health needs were being met. Records showed that people's weight was being monitored and referrals were made to the dietician where required. Since our previous inspection there had not been any significant skin damage to people whose mobility was limited showing that this was managed appropriately with the use of pressure relieving mattresses and cushions. We saw that a doctor had been called to see someone during our inspection. We were told about an incident a few days before our visit which showed that a community nurse and psychiatrist had been called to assist one person. This showed that people's health needs were met because referrals were made to the appropriate professionals.

The provider may wish to note that a care plan for one person was not very detailed. Staff we spoke with were not able to consistently tell us how they supported the person so that the person received consistent care in a way that respected his rights and others of others.
Safeguarding people who use services from abuse  ✔  Met this standard

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

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People living in the home and their relatives that we spoke with told us that they were staff treated people well. People living in the home told us:
"Staff (are) alright, there are no staff that I don't like."
"They don't do anything that will make you unhappy, I would tell them."

All of the staff we spoke with told us that they had received training in the protection of vulnerable adults. Staff we spoke with were knowledgeable about the different types of abuse and knew what actions they were required to take if they suspected abuse had or was taking place. This should mean that people were cared for by staff that had the skills and knowledge to protect them from harm.

We saw that people's ability to make decisions was assessed. People were encouraged to make decisions where possible but if they were not able to make decisions relatives and health professionals were involved to make decisions that were in their best interests. For example, some people refused to take their medicines and it was agreed by the doctor if the medicines were necessary and if so how they would be given without the individual knowing that it had been given. This ensured that decisions were made in the best interests of people by people who knew them well.

Since our last inspection concerns raised with us about the care given to some people had been appropriately responded to by the acting manager. Some issues had not always been raised with the appropriate people quickly however we saw that actions had been taken to protect people from further harm. The provider may find it useful to note we saw that some staff were unable to divert or occupy one person resulting in three incidents occurring during our inspection. This meant that some people on the unit were not protected from the risk of injury.
Management of medicines  

Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had got appropriate arrangements in place to manage medicines.

Reasons for our judgement

Following our last inspection we referred our concerns about the management of medicines to the pharmacist support from the Cross Birmingham CCG. They visited the home and also found that the management of medicines was particularly poor on one unit but that there were issues on other units too.

Several visits were carried out by them and the service was supported to make improvements in the management of medicines to ensure that people received their medicines as prescribed. Reports shared with us showed that improvements had been made so that people were generally getting their medicines as prescribed.

The provider may find it useful to note that there were some issues such as details in PRN (as and when required medicines) protocols, recording of medicines that were given 1 or 2 tablets and that the time intervals between medicine doses was sometimes longer than appropriate that needed to be addressed to achieve full compliance. Senior staff told us they were aware of these issues and in the process of addressing them.
Staffing

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 staff to meet people's needs but there were some staff that needed further knowledge to ensure that people got the consistent support they needed.

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 saw that there were sufficient numbers of staff available to support the people living in the home. We judged that there were sufficient staff available because we saw that people who needed assistance to eat were provided with the support they needed in a timely way.

We saw that staff went in to assist people in their bedrooms when they asked for this. We saw that where people needed close supervision and monitoring staff were allocated time to do this. One person told us, "Staff are nice." A relative told us, "Things are coming together" and another said, "Staff are very good." Two staff confirmed that there were always sufficient staff on duty to meet people's needs.

We saw that some people had complex needs that at times challenged the staff. We saw some staff were able to support the person well and other staff were not able to support the person so that they or others were not at risk of harm. For example we saw that one person who had one staff with them at all times still hit or pushed three people during our observations. This meant that not all of the staff had the right knowledge or skills to support people with complex needs.

We saw that some staff experienced difficulties in communicating with one individual whose first language was not English. Adequate systems had not been put in place to ensure that the staff were supported to understand what the individual was expressing and this had led to outbursts which may be caused by the individuals frustration of not being understood.

In addition to care staff there were staff whose specific duties included cleaning, laundry, cooking and activities. This meant that staff had responsibility for specific areas of work and had the expertise to carry out their roles.
Supporting workers

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Staff we spoke with told us that they had received induction training when they first started their employment. Staff told us that they had received training in areas that included manual handling, first aid, fire and dementia. The manager told us and staff confirmed that they had received recent training in writing care plans. This meant that staff should have the skills and knowledge needed to carry out their roles safely.

The provider may find it useful to note that staff we spoke with, staff interactions we observed and records we looked at showed that some staff did not have the skills and knowledge they needed to ensure that they were able to support people appropriately. This included training in mental health awareness, responding to behaviours that staff found difficult to manage and the use of charts to monitor people's behaviour was needed. For example, the needs of people with mental health difficulties were not adequately recognised by staff because they had not received adequate information and support and this had resulted in one person requiring emergency hospital treatment. Two staff we spoke with were unsure of how to use the behaviour monitoring charts in place for people.

We saw that there were some systems in place that ensured that staff were updated about people's needs if they had been off duty. These included handovers from senior staff and reading care plans. Staff told us that they received supervision and they felt that they could ask for support and advice. This meant that staff were supported to be kept informed of changes in people's needs and supported by senior staff in carrying out their roles.
Assessing and monitoring the quality of service provision  Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not got an effective system to regularly assess and monitor the quality of service that people received.

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 saw that some audits carried out in the home identified issues that needed improvement and there were action plans in place to monitor the progress of the actions taken. These included infection control, medicines, servicing of equipment and general issues such as odours.

The senior management team in the home monitored the number of accidents and incidents and action was taken to address individual events. For example, we saw that referrals to the falls clinic and the use of bed rails and bumpers following accidents had been instigated. Senior staff were not able to provide an analysis of trends or causes of the accidents and incidents. This meant that actions were taken to address the needs of individuals but there was no overview of accidents and incidents and no learning could take place to prevent a repetition of them.

We saw that a record of safeguarding alerts that had been raised by the home were available. Safeguarding alerts raised by other people were not included in the folder so that there was not a full picture of the issues being raised. There was no overview or trends analysis to show what issues were arising so that actions could be taken to address them and reduce their incidences.

We were told that a review of care was undertaken by the unit managers who produced a weekly report for the acting manager of the home. The acting manager and her senior team carried out walks throughout the home and observed practices, sat on handovers with staff and met with families. We were told that surveys had been carried out and actions taken as a result. For example, the laundry staff were responsible for ensuring that clothing were tagged so that they it was identifiable who they belonged to.

We were told that care plans were being audited however there was not a record of all the care plans that had been audited or when others were due to be audited. During our inspection two of the care plans were recorded as having been audited however the level
of detail in them was not sufficient for staff to know how to manage the needs of the individuals they related to. This meant that the level of auditing of care plans was not robust.

We asked the provider what actions they had taken to monitor the quality of service provided since our last inspection. The quality manager provided weekly reports of visits to the service which looked at the cleanliness of the home, management of skin damage and so on. We were told that monthly visits were carried out by the provider’s representative and the findings were discussed at meetings where action plans were developed. At the inspection we asked for the action plans for May and June to be sent to us by 18 July 2013. We asked the provider how they had assessed what training was needed for staff in the home. We asked for the staff training needs analysis and the plans to achieve this to be forwarded to us by 18 July 2013. At the time of writing this report we had received only some this information.

Following our last inspection we had asked the provider to send us information about the system they were using to monitor the quality of the service. The information we had received was not detailed enough for us to be assured that there was a robust quality monitoring system in place at Bromford Lane Care Centre. Further details about the quality monitoring system was requested following our inspection however at the time of writing this report this had not been received.
Records

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.

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

The care plan for the management of one person's mental health was not detailed enough to show how staff were to recognise and deal with a deterioration in their condition. Staff spoken with were unclear what the individual's mental health condition was and how to manage it. For another person there was not an adequate plan on how to meet a person's linguistic skills by for example using pictures or words. This meant that care plans were not detailed enough for staff to know how to care for people.

Skin inspection records were inconsistently completed with no obvious patterns showing how often they were carried out. We saw that bath and shower records showed gaps in recording. This meant that it could not be determined whether people had received the care they required. Staff reflected this confusion as they were not sure whose responsibility this was and how often they should be recorded. This meant that it was not possible to ensure that people had received the care they received and there was not an accurate record of the care provided.

We saw that charts in place to monitor people's behaviours were not completed appropriately so that they enabled patterns and triggers for behaviours to be identified and plans put in place to address them.
### 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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td><strong>Staffing</strong></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>Not all staff had the skills and knowledge to care and support people so that their needs were met safely and in a consistent way. Reg 22</td>
</tr>
<tr>
<td><strong>Regulated activities</strong></td>
<td>Regulation</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td><strong>Assessing and monitoring the quality of service provision</strong></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>The quality monitoring system was not robust and there was no trends analysis to show shortfalls in the service and the corrective actions to be taken to ensure the service achieved compliance with regulations. Reg 10</td>
</tr>
<tr>
<td><strong>Regulated activities</strong></td>
<td>Regulation</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Records</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
</tbody>
</table>

Care plans were not detailed enough to ensure people’s needs were met by staff in a safe and knowledgeable way. Care records were not completed consistently and did not provide an accurate reflection of the care provided. Reg 20

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 17 September 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.
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 judgment 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.

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Met this standard</td>
<td>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.</td>
</tr>
<tr>
<td>✗ Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>✗ Enforcement action taken</td>
<td>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.</td>
</tr>
</tbody>
</table>
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:

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<td>Cooperating with other providers</td>
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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.