Inspection Report

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

Addaction - Cornwall

Trevint House, Strangways Villas, Truro, TR1 2PA

Date of Inspections: 09 January 2014
08 January 2014
03 January 2014
02 January 2014

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We inspected the following standards as part of a routine inspection. 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
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard

Details about this location

Registered Provider	Addaction
Registered Manager	Miss Anna Whitton
Overview of the service	Addaction Cornwall provided support to people who needed help with substance misuse (drug and alcohol) problems. Services were provided throughout Cornwall.
Type of service	Community based services for people who misuse substances
Regulated activities	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 2 January 2014, 3 January 2014, 8 January 2014 and 9 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information given to us by the provider and took advice from our specialist advisors. We were accompanied by a specialist advisor.

What people told us and what we found

Addaction Cornwall had locality offices in St Austell, Truro, Redruth, Penzance and Liskeard; although staff also provided people with support at over one hundred other locations such as GP surgeries and other meeting points.

The service has significantly expanded since April 2013. The service provided the single point of contact for drug and alcohol referrals. It also provided an assessment service which incorporated health screening. The service provided community drug and alcohol medically assisted recovery services (prescribing services) including Opiate Substitution Therapy. Drug and Alcohol Detoxification services, blood borne virus screening and vaccination services were also now provided. The service provided the single point of access to residential detoxification and rehabilitation services. A needle exchange scheme was in operation which ensured intravenous drug users could obtain clean needles with the objective of cutting down the risk of HIV infection. We concluded the transition had been well managed.

The service continued to provide community outreach, group and one to one therapy, support with life skills, employment and education, volunteer and peer mentoring, family interventions and aftercare support.

Over four days we visited and spoke with approximately 15 people who used the service at three locality offices. We also met with staff members, and attended two recovery groups where we observed practice.

We were accompanied by a specialist advisor who was a doctor who had knowledge of substance misuse services. The specialist assisted us in our judgement of the clinical services Addaction provided.

Everyone we spoke with was positive about the service. People told us the support they

received from Addaction had been extremely beneficial to assist their recovery. For example one person told us attending Addaction group and one to one sessions were "the best thing I ever did…absolutely fantastic."

We checked prescribing and medication systems in place and these were well managed. We checked how staff were trained and systems in place were satisfactory.

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

More information about the provider

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

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

Our judgements for each standard inspected

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's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

The inspection was conducted over four days. We were able to speak with people who used the service, attended two group therapy sessions, speak with the organiser of the service user advocacy group, and attended a 'recovery café' group.

All of the people who used the service, who we were able to speak with, were very positive about their experiences .We observed staff working professionally with the people who used the service. Everyone we spoke with said staff were supportive and did their best to meet individual needs. Typical comments included "it is such a haven for me…everyone has made me feel welcome....the staff have always got time, nothing is too much trouble," "I am more than happy with the service I receive," and "attending the 'breaking the cycle' group (family therapy) has been resulted in a major breakthrough in my recovery." Another person said the organisation was "good at allowing people to lead their recovery journey." One person, who was struggling with abstinence, said "when I have relapsed I have been able to come here and have never felt 'beaten up' or made to feel guilty, and staff have then helped me to move forward again."

We spoke with staff members regarding the support which was in place. People received support from a Substance Misuse Practitioner. These staff ensured people received a comprehensive assessment, and assisted the person to draw up a recovery plan. The Substance Misuse Practitioner could also refer people to other services such as detoxication at a hospital or via a residential programme.

We were told by staff at each centre there was a day programme. This was a rolling programme which people could repeat if it was helpful to them. Various groups took place including assistance with life skills, and money management.

Mutual Aid Partnership (MAP) groups were in place at each of the centres as well as set up at various other locations such as Bude and Launceston. The groups were facilitated by trained volunteers (mostly ex users of the service). The groups facilitated discussion

regarding various issues and problems people faced during their recovery and how these problems could be overcome. We attended a MAP group which took place at the Liskeard office. At the session people were invited to explore any concerns they had and develop plans to overcome their problems.

Some people, as well attending other activities and receiving other support, received acupuncture from staff, which they said was "really helpful." However the provider might like to note some people said there should be more staff trained in this technique, as some people said it was not always possible to receive this support when it was wanted.

We attended a 'recovery café' session. In Liskeard, at the time of the inspection, two recovery cafes were in operation; firstly on a Sunday afternoon at the Salvation Army hall and secondly on a Wednesday evening, at the Liskeard office. Similar sessions were provided throughout Cornwall. The sessions provided an opportunity for people to informally gather, have a cup of tea, socialise and/or receive support and guidance from volunteers and other people who used the service.

We were also able to attend a 'Breaking the Cycle' group. This facilitated family based work with individual's who used the service. Children, other family members/ significant others could also attend. At the session we attended people were supported by an art therapist who was able to use their knowledge and skills to assist people to explore their substance misuse issues. Participants told us the sessions were very beneficial to them, and had assisted them to break down barriers which were impeding their recovery.

We were able to speak with the chair of the Cornwall User Forum (UFO). We were told that Addaction had encouraged the development of the forum as an independent advocacy group. We were told Addaction had offered accommodation and support since the group's inception and helped finance certain forum activities. The chair person told us they believed Addaction was a "positive and optimistic service."

People who used the service also told us they felt services were much improved overall from the old mixture of Addaction and NHS trust provision. The chair of 'UFO' told us the emphasis on integrated recovery-based treatment was beginning to move people through the service and achieve some concrete goals. We were told the forum believed Addaction encouraged individual personal development through volunteering and an apprenticeship programme. We were told the forum found staff respectful and holistic in their outlook towards people who used the service.

We were told waiting times were generally good and keyworkers were becoming skilful at tailoring individual treatment programmes. The chair of 'UFO' told us initially the service had been a little patchy. They said some keyworkers did not seem familiar in how to signpost or help in specific areas (e.g. benefits and housing advice), or not able to offer enough individual time because of caseload management issues. However we were told these problems had mostly been addressed through training and service development. The chair of 'UFO' felt many keyworkers were now offering a 'gold standard' service. We were told Addaction as a whole was working really hard to embed good systems and cover "all the bases". We were told no complaints or negative feedback had been received by UFO from people who used the service.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People who used the services of Addaction Cornwall were very positive about the service provided. We were told staff were "very supportive", "non- judgemental" and "respectful."

Addaction Cornwall had undergone substantial change from 1 April 2013. From this date the service, in addition to the delivery of a wide range of psychosocial interventions, Addaction now delivered the majority of the clinical services for addictions treatment in Cornwall. Previously clinical services were provided by an NHS trust.

Addaction was subsequently responsible for prescribing opiate substitution therapy for around 800 clients. It now employed two psychiatrists (a consultant and a staff-grade specialist doctor). The service contracts, on a sessional basis, with eight general practitioners with a special interest (GPwSI), and employed six nurse prescribers.

We were told, by staff and people who used the service that the changes had been challenging as they resulted in significant changes in how the service operated.

We assessed governance and risk management systems in place. Systems were still being refined. We judged there was a clear governance and risk management structure at national level within the organisation. These processes fed into, and received responses from, regional hub meetings. This included the organisation's South West regional hub responsible for management of regional governance and risk issues. Matters considered included incidents, complaints, practice development, safeguarding, health and safety, risk, finance and human resources, and clinical issues. Within Cornwall good governance was achieved by a series of monthly or bi-monthly meetings including a Senior Management Team meeting, a Local Clinical Governance Group meeting, and an Integrated Medical Management Group.

We viewed two sets of minutes of the Integrated Medical Management Group. The minutes outlined there had been reviews, amongst other areas, of the role of non-medical prescribers, caseloads, provision for continuous personnel development and training, management and support to general practitioners with a special interest (GPwSI), professional relationships with local enhanced services general practitioners (LES GPs),

and the revision of some clinical protocols.

We also inspected two sets of minutes from the Clinical Governance Group which reviewed two incidents, reviewed specific tasks which Addaction nurses provided, as well as a variety of other clinical topics.

Referrals came from a variety of sources such as General Practitioners, housing and homeless organisations, job centres, young people's services and the probation service. A Substance Misuse Practitioner was based during office hours each day at each of the organisation's centres. People could also self-refer or drop in for assessment and support.

We were told a triage appointment was usually offered within 7-10 days. We were told assessments were discussed at a weekly clinical meeting and an appointment to proceed with treatment was usually provided within a further week. Thus a typical person would have embarked on a definitive treatment journey about 2-3 weeks from referral. We were reassured there was capacity to fast-track people into treatment sooner if there were particular needs which would make that appropriate.

The people, who used the service, said in their particular cases there had not been any significant delays in receiving assessment and treatment. We were told waiting times were generally good and keyworkers were becoming skilful at tailoring individual treatment programmes. The Chair of the Cornwall User Forum (UFO) told us initially the service had been a little patchy but this had now much improved.

Each person who formally used Addaction's services had a 'Recovery Plan' (Care Plan). The recovery plan was drawn up by the Substance Misuse Practitioner and the person who used the service. The recovery plan used an internet web based system. The format was developed by the Drug and Alcohol Team, and was used by all agencies in Cornwall who provided a service to people with drug and alcohol problems.

People were requested to give their consent to share the information between the relevant drug and alcohol agencies. As long as this consent was given, an information sharing protocol was in place to share information among the relevant different agencies. The registered manager told us satisfactory consideration had been given to issues relating to the Data Protection Act. If people did not want their information shared this did not happen.

We inspected three recovery plans so we could see how the process worked. Satisfactory information was contained within recovery plans inspected regarding the individuals' needs, and any risks and goals that had been set as part of the people's treatment.

The registered manager told us each recovery plan was reviewed at least every three months. However depending on the individual's needs this process could be completed more regularly.

We were told Addaction locally had good links with local partners such as the Police and Crime Commissioner, and police drugs liaison officers. A Drug and Alcohol Team (DAAT) primary care development lead attended the first part of clinical governance meetings. The registered manager and clinicians told us there were good links with the local coroner and the drug-related death coordinator which enabled the rapid sharing of information. The chair of the Cornwall User Forum (UFO) felt at times the service was still somewhat hampered at the interface with certain other agencies (e.g. mental health and probation services) where communications and responsiveness still needed to be improved.

We checked prescribing processes. Addaction had recently introduced a new clinical software system (HALO2). Staff told us there had been some teething issues around getting the prescribing module functioning smoothly but this was now largely resolved. The system provided a universal records system throughout Addaction and with some partner agencies. However the system does not communicate with the systems operated by local enhanced services general practitioners (LES GP).

The service no longer used paper records and all key workers had laptop and web access for clinical sessions. We reviewed a variety of clinical notes (for example three people on opiate substitution therapy (OST); and one person who misused alcohol.) We found the notes to be appropriately written and comprehensive. A series of traffic-lighted flags on the front screen alerted the operator to special risks (e.g. self-harm, overdose). A summary screen gave quick access to demographic information as well as a prescribing summary with pharmacy and collection details.

We inspected audit figures reviewing numbers of people who used the service, drug preference, time in treatment and retention duration. For Addaction a typical retention time for a person referred to the service for alcohol misuse was 364 days and for a person who misused heroin it was 1371 days. Lead clinicians told us the service was currently reviewing people who had been prescribed opiate substitution therapy (OST) for more than four years. We were told this was an attempt to refresh the recovery element of their treatment. We also inspected further audits reviewing referral rates by district and for dispensing arrangements for those on OST.

Review of people's records and discussion with clinicians did not raise any concerns around prescribing practice including titration, maintenance or detoxification. The service used the Royal College of General Practitioners (RCGP)/ Department of Health 'Orange Guidelines' as its main reference with regard to prescribing. There was also an Addaction protocol offering guidance around broad principles of treatment. People who used the service appeared to be appropriately assigned to set pickup days for prescriptions, and for supervised consumption according to clinical need. This was notwithstanding that rurality and transport links required a degree of compromise and negotiation compared with an urban clientele. We were reassured target dose levels were aimed at the Orange Book levels (for example 60-120 mls Methadone). We reviewed the case notes of a current person who used the service who was on very small doses (3ml) but it was apparent that this level was the result of a negotiated gradual reduction. We asked the chair of Cornwall User Forum about their impression of prescribing and OST doses. We were told UFO were not aware of any particular issues with either low- or high-dose prescribing regimes from client feedback, and had received no negative impressions regarding prescribing.

However the provider might like to note there was a potential safety issue with higher-dose Methadone prescriptions and screening for prolonged QTc interval on Electrocardiographs (ECG). At the time of the inspection the service was reliant on the person's GP practice performing an ECG and communicating results on their behalf. We were concerned this introduced potential vulnerability and may be medicolegally questionable if the prescription was being written by Addaction staff. We discussed this concern with the registered manager and we were told the service was exploring the purchase of its own ECG machine. We were told risk assessments were made with people at this prescription level around family history and co-prescribing (for example of Citalopram).

We were told repeat prescriptions were generated by prescribing clerks at the Truro office. We were told all requests (particularly dose changes) were required to be made by email

to furnish an audit trail. All changes were reviewed by the specialist doctor or consultant before signing. Blank prescription pads were securely stored. Batch numbers were recorded against patient names before they are sent out to pharmacies or other sites and all deliveries were by 'signed for' post or courier. There was a written protocol and instruction manual, provided by Addaction, for prescribing clerks.

Prior to the inspection we received a concern regarding alleged deaths as a consequence of prescribing errors. Prior and during the inspection we reviewed all deaths, between April and December 2013, of people who had used the service. We judged several of these were caused by unrelated medical factors and in no instance was it apparent that death could be attributed to failings in their addictions treatment. Most of the cases cited seemed to relate to people who engaged poorly with treatment services; but this did not seem to be as a consequence of procedural failure or clinical mismanagement.

Deaths of people who used the service were reviewed at service clinical meetings and at a separate debrief meeting with relevant field staff, once coroners' reports and investigations have been concluded. Any clear patterns which emerged were then explored including with partner agencies such as the local authority and the probation service. The chair of the Cornwall User Forum said they were not aware of any particular patterns in deaths which might suggest service failure.

We also reviewed in detail the death of one person by assessing their records. This person had been prescribed a relatively low-dose of Methadone and died of a presumed overdose. However their records testified, in our judgement, no clinical or service failure, and unfortunately the person had continued to misuse other substances over and above what had been prescribed to them.

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 appropriate arrangements in place to manage medicines.

Reasons for our judgement

We reviewed the Addaction clinical protocols folder (accessible for all workers through the Addaction Intranet) and saw a wide range of protocols and guidelines around specific medicines, risk assessments, prescribing, non-medical prescribing, analgesia in opiate substitution therapy (OST) clients, and clinical audit. Specific medication policies were thorough. These covered various aspects regarding the management of medication. For example the service had a general medication policy covering storage, administration and disposal. There were also policies regarding the management of controlled medication and the prescribing of medications such as Suboxone and Methodone.

We inspected the treatment rooms at Trevint House (Truro) and Gwilleans, (Redruth). The rooms, including equipment and surfaces, were all in good condition and clean. Medication refrigerators were in good condition with a completed daily temperature record. Vaccines kept were all within expiry date. Anaphylaxis packs were stored near the refrigerator and contents were in date. A protocol to use anaphylaxis packs was pinned to the notice board in each treatment room.

The provider might like to note that 'Sharps' boxes were not signed and dated when they were assembled. This was important should there for example be a needle stick injury.

We inspected the needle exchange facility at Redruth. We judged the facility was clean, well- organised and records were in order. We noted at Redruth there were detailed written protocols for managing body fluid spillages and an accompanying emergency kit for spillages.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

People who used the service said staff support was to a high standard and staff responded to their needs as necessary. People said when they had first come into contact with the service they were assessed quickly and staff ensured they received appropriate treatment.

Since the service expansion a comprehensive management structure has been developed. This included an area manager, two operations managers (each covering a specific geographical area), and locality managers responsible for different aspects of the service (for example criminal justice, volunteer/peer monitoring/ 'breaking the cycle'). At the time of the inspection, the person registered as the manager with CQC, was the regional director. We were told this arrangement was currently being reviewed now the service expansion and reorganisation had been completed.

Each office had a team of recovery coordinators. These staff carried a caseload of around 40 people who used the service. These staff would regularly meet with people individually, and would be responsible for ongoing assessment, signposting to appropriate services, writing and monitoring recovery plans with the individual concerned.

There were also life skills workers, and workers assigned to complete the 'Breaking the Cycle' family work. There were administrative staff at each of the centres to assist other staff. Nursing staff and other clinicians such as two psychiatrists (a consultant and a staff-grade specialist doctor) were employed. The service contracts, on a sessional basis, with eight general practitioners with a special interest (GPwSI). Six nurse prescribers (NMP) were employed.

There was also 'peer mentor' and 'recovery champion' programmes. These individuals were often people who had used the service, and now provided people who used the service with peer support. The organisation had an 'apprentice' scheme. This was a two year programme which enabled the person to learn the role for example of a recovery co-ordinator.

Many staff said they were very happy with the support they received from colleagues and their managers. For example we received comments which included "it is a great team," and that colleagues and managers were "very caring about how staff feel….management

are approachable and supportive." We were told there had been some issues around staff morale, sickness and case load since the changes implemented since April 2013. However staff told us the provider was aware of the issues, and managers had been as supportive as possible to address the concerns. We were also told the provider was working to fill any vacancies. We did not find any evidence that the concerns had compromised care or safety. Staff told us for example they thought the people who used the service received good care and support and the team worked in a very 'person centred' manner.

We received many positive comments regarding the organisation's culture. For example one member of staff said the organisation was "good at taking risks and was creative." They said there were limited barriers to ensure "ideas could be implemented faster."

We attended a clinical meeting which included most of the recovery coordinators, a nurse practitioner, volunteers and a clinician. The meeting was well organised. There was evidence of good communication among the team and everybody present had an opportunity to express their views and make a contribution. The meeting was business-like but also people had the opportunity to have a joke and share banter.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People who used the service told us staff were caring and responsive to their individual needs. Everyone we spoke with was satisfied with the service they received.

The service was in the process of introducing nurse (NMP) prescribing. This process commenced prior to the service transition in April 2013. We were told NMP provision was likely to play an important part in enabling efficient skill-mix. We were told more staff were being encouraged to pursue NMP training.

Prior to the inspection concerns had been raised to the Care Quality Commission, by a third party, about the place of non-medical (NMP) prescribing within Addaction. At the time of the inspection this was an area still in development and there was only one actively-prescribing NMP, although a second person would be starting imminently. The registered manager told us the service had six trained NMPs but had delayed starting their prescribing work because of the other significant changes within the organisation. We checked arrangements in place and were satisfied that Addaction had monitored this closely.

In respect of training for nurse prescribers, this was provided through Plymouth University (Peninsula Medical School). Trainees were mentored by an addictions consultant or a General Practitioner with Special Interest (GPwSI). Since the transition all NMPs were separately accredited prior to starting work with Addaction by the addictions consultant and the Addaction national pharmacy lead.

From discussion and from records inspected we saw there was a detailed protocol outlining the NMP's role and supervision. We were told all NMPs were supplementary (rather than independent) prescribers. This meant Clinical Management Plans were signed by the independent prescribing doctor. Suitability of people who used the service was discussed between NMP and independent prescriber and will vary according to confidence and expertise of the NMP. The independent prescriber retained clinical responsibility for the people concerned. Clinical Management Plans (CMP) were reviewed at appropriate intervals. We were told the software system prevented dosage change outside the parameters of the CMP, there were regular governance meetings and regular clinical

audits (for example involving, every three months, Addaction's Lead Pharmacist) to minimise the risk of human error.

We were also told NMPs were specifically supported by named GPwSI's for their client base. People's cases could also be 'escalated' from the Local Enhanced Services (LES) GP to GPwSI or specialist/consultant care as needed, and back again when problems were resolved. At the time of the inspection there appeared to be an appropriate skill-mix in prescribing, albeit currently with limited NMP contribution, as this aspect of the service was still in development.

We subsequently concluded there was no evidence that clinical governance around prescribing might be inconsistent or fragmented across different prescribing sources, or prescribing systems were not robust or were inflexible.

We also assessed general staff training. Staff and managers told us that training was delivered by a variety of methods for example in-house training, e-learning and attending courses from external training providers.

The staff we spoke with confirmed they had received an induction prior to them working unsupervised. The people we spoke with all had experience either as a person who had used similar services and /or as a volunteer and/or working professionally in another drug and alcohol service. Staff told us they had shadowed an established and experienced member of staff, which had enabled them to learn the role prior to working on their own.

The registered manager provided us with a copy of the organisation's policy which outlined what training staff, of different grades and roles, needed to be provided with. This was made up of 'mandatory' training (such as safeguarding, first aid, alcohol and drug awareness and infection control), and role specific training (for example medication management).

We inspected the training records for five staff. The records we were presented with were limited to what training people had received in the last year. The provider might like to note it was therefore difficult to ascertain if staff had received all of the training required according to the policy. Managers we met assured us there were central monitoring systems in place. However it is essential suitable records, to validate staff have received the appropriate training, are in place.

We checked arrangements in place for staff supervision. The supervision process ensured there was structured time for the individual member of staff to meet with their line manager to discuss their case load, any support and training needs and any performance issues. Each person had a record that they had participated on a monthly basis in the supervision process. The staff we spoke with all said they could speak to colleagues, their line manager or other senior staff at any time if they had any concerns, needed advice or support.

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.

Contact us

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