Inspection Report

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

Brandon House Nursing Home

140 Old Church Road, Bell Green, Coventry, CV6 7ED

Tel: 02476638602

Date of Inspection: 31 October 2013

Date of Publication: November 2013

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

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard

Details about this location

Registered Provider	HC-One Limited
Registered Manager	Mrs. Zoe King
Overview of the service	Brandon House is registered to provide accommodation and nursing care for a maximum of 35 people. It provides a service for older people with dementia care needs.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Brandon House Nursing Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Meeting nutritional needs
- Cleanliness and infection control
- Staffing
- Supporting workers

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 31 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 sent to us by commissioners of services. We talked with commissioners of services.

What people told us and what we found

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at the time of our inspection. Their name appears because they were still the manager on our register at the time.

Three inspectors visited Brandon House Nursing Home to follow up on concerns raised during our last visit on 12 August 2013.

We reviewed the care of five people with varying levels of need. Some were unable to communicate with us so we spent a period of time observing how people were being cared for within the home. We also spoke with eight members of staff, the manager and the group's Quality Assurance Manager.

We found the service had made some improvements with pressure care management and the monitoring of people's weights. However, we identified there were still some areas of care and welfare where further improvements needed to be made.

Since our last visit the service had recruited more staff and there was less reliance on agency staff. Staff demonstrated a good understanding of people's needs and people responded positively to them. One staff member told us, "Staff are more content. They are able to support people without being rushed." One person told us, "Staff do a great job. It's a very demanding role and they are very caring."

Staff told us that new staff were now receiving an induction to the service and spoke positively about the support from the new management team.

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 03 December 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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

People we spoke with were positive about the care and support they received. Comments included:

"Staff do a great job. It's a very demanding role and they are very caring."

"It's exceptional at the moment."

A relative told us, "Anyone who has a need is always looked after and cared for."

We looked at a sample of care records on each floor. We saw an assessment of needs had been completed for each person which identified areas where people required care and support. Care plans developed from the assessments contained sufficient information, in a clear accessible manner, to guide staff and reflect good practice. Care plans were person centred and contained information about people's personal preferences and routines.

We looked at the care records of people who had pressure ulcers to their skin. We saw people had relevant tissue viability documentation in place to support management of the ulcers. Wound care plans for each ulcer provided information as to the individual dressing regimes. Wound assessment charts were completed and updated for each dressing change supported by photographs. People were using pressure relieving equipment appropriate to their needs. We saw the tissue viability nurse had been consulted where a need had been identified. Plans for the management of pressure ulcers had improved within the home since our last visit.

We looked at the care records for one person who was immobile and at high risk of developing pressure ulcers. We saw their care plan stated they should be repositioned

every two hours. We spent the morning in the lounge from 10.00am to 1.00pm. During this time we saw the person in a specialist chair and looking comfortable, but we did not observe them being re-positioned. An entry in the person's daily records indicated they had been assisted with personal care at 10.30am when their skin was checked for breakages and redness. Staff confirmed that any personal care would be completed in the privacy of people's rooms. We did not see the person taken to their room during this time. The manager later confirmed there had been an error with this entry. Inaccurate entries on people's records could result in people's healthcare needs not being met.

In one person's care plan we saw they were restricted to a limit of 2000 mls of fluids over a 24 hour period. The information within the care plan was unclear as to why this restriction was in place. We asked the nurse on duty, who was unable to tell us why this restriction on fluids was in place. They later told us that the restriction may be due to a kidney problem. We looked at the daily fluid intake and output records for this person. We saw that in the previous 14 days, they had exceeded the 2000ml limit on five days. We could not be confident that the intake of excess fluids would not have a detrimental impact on the person's health.

We saw individual monitoring charts for each person. These included charts for re-positioning people. We saw these charts were not being completed consistently and did not always record the position people had been changed to, for example right or left side or back.

When we visited in August 2013 we saw gaps in the topical medication records where staff had not signed to confirm they had applied the medicines as directed. Topical medicines are those that are applied directly to the skin. On this visit we saw there were still gaps in the records. For one person we saw they were to have a cream applied four times a day to their legs. Looking at their records, there were some days where staff had not signed at all to confirm they had applied the cream. We could not be sure topical medications were being applied as directed to prevent skin problems.

At our last visit we identified a number of people had lost significant amounts of weight. There was no audit tool in place to monitor or analyse people's weights. At this visit the manager provided us with a copy of a weight audit for the last six months which had been used to identify people who were at risk of malnutrition. We saw that where people had lost weight or had been identified as being at risk they had been referred to the dietician. We saw the dietician had raised the issue of possible errors in some of the weights recorded. The home had purchased a set of calibrated scales with a seat so weights could be recorded accurately for all people including those with mobility problems.

We observed one person being given a drink in a beaker with a straw when they were lying down which could have put them at risk of choking. There were no specific instructions in their care plan stating they should be sat up.

During this visit we found the home was much quieter and calmer than at our last visit. We observed some very pleasant kindly interactions between staff and the people who lived there. For example we saw one member of staff sitting with one person, talking to them quietly whilst holding their hand. We saw another staff member gently stroke someone's arm in order to wake them up. Staff spoke to people respectfully and provided reassurance when necessary. Staff demonstrated a good understanding of people's needs and people responded positively to them.

We saw staff engaging in individual activities with people during the morning. One person

had their nails painted while a member of staff sat with another person and read the newspaper to them. Age appropriate music was played in communal areas and we saw one person enjoyed singing along to it. It was Halloween and we saw many staff had dressed up in costumes. There were decorations around the home and people clearly enjoyed the occasion.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We saw menus were pre-planned by the provider to ensure people received a balanced diet. Breakfast was a selection of cereals or porridge, toast or a cooked breakfast. People had a choice of menu for both lunch and tea-times. On the day of our visit there was a Halloween lunch. People had the choice between beef and tomato topped with a herb and potato crust, chicken with salad or haddock and prawn pasta. For pudding people could have winter fruit meringue or strawberries and ice cream with a butterscotch sauce. The meals we saw looked appetising and provided people with a range of suitable and nutritious food.

We were informed that menus were provided to meet people's individual religious or cultural needs. A new Caribbean menu had been introduced for one person.

We observed people having lunch on both floors. On the ground floor most people ate in the dining room although a few chose to eat in the lounge. Four people had lunch in their bedrooms.Tables in the dining room were nicely laid with tablecloths, napkins, cutlery and condiments. On the first floor people ate in the lounge. We were told this was because the dining room was being used for staff training.

Some people did not want the food that was on the menu. We saw staff met people's requests for something different. For example one person asked for a cheese sandwich while another person asked for a bowl of cereal instead. The cook told us, "We just try and please them in any way we can. They don't always eat their dinner but we try to give them something else as an alternative." They went on to say, "Care staff tell me if people haven't eaten their dinner so we can sort out another option."

During lunch we saw staff supporting people to eat. Staff sat with people and supported them appropriately and at a relaxed pace. Staff made sure people who needed assistance with feeding had consented. They responded to people's facial expressions and body movements so they knew when people wanted more or when they had had enough. One person's care plan stated they were at risk of choking and staff must allow them time to swallow their food between each spoonful. We observed staff supporting that person to eat slowly and in accordance with their care plan. We saw staff prompting and encouraging those people who were able to eat more independently.

At our visit in August 2013 we identified eight people who had lost significant amounts of

weight. The cook was not aware of these people. On this visit the cook confirmed they were now informed on a monthly basis of all those people in the home who had lost weight. We saw this information was recorded on a board in the kitchen. There was also a list of people who had been prescribed food supplements. The cook told us that where necessary meals were fortified with full milk, butter and cream to add calories. All foods were fortified by the catering staff for people on the ground floor. Care staff fortified some foods such as porridge for people on the first floor. The provider may find it useful to note this could lead to inconsistency and people may not receive the extra calories they require.

The cook told us they were aware of people's special dietary needs which were also recorded on a board in the kitchen. They were aware of which people were diabetic and required a modified diet to manage their condition. They told us that where people had to have a pureed diet, each food type was pureed separately so people could still experience the individual tastes.

We observed that staff were completing charts to record people's food and fluid intake and their fluid output. We looked at the food and fluid charts of one person who had lost weight. The provider may find it useful to note that their food charts did not consistently indicate the precise food items they had eaten or exactly how much. For example, sometimes it just read dinner or pudding and "all" for the amount eaten. It did not indicate whether any of the foods had been fortified. This meant that it was not clear if the food the person had eaten was high calorie or not. We also saw staff were not always completing food and fluid charts at the time people were given something to eat and drink. We could not be sure the charts accurately reflected people's food and fluid intake. We raised this with the manager. They told us they were arranging for the dietician to deliver nutrition training to all staff which would include completion of food and fluid records. We saw an email from the dietician confirming they were happy to do the training once all the new staff were in place.

We observed that people were offered hot drinks and a selection of cakes, biscuits, yoghurts and slices of fruit at 11.00am and 3.00pm. The cook told us there was food available 24 hours a day for anybody who felt hungry at night. They told us, "There are always yoghurts and rice in the fridge. We leave out meat and cheese for sandwiches. We leave out biscuits, chocolates and fruit."

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

When we visited Brandon House we saw the home was clean and in good order. We saw new washable flooring had been put down in the communal areas. Other areas of the home had been recently decorated. Furniture looked clean and well maintained.

We looked at direct care areas such as bathrooms and communal toilets. We saw that they were mainly clean and tidy. During the morning we did notice an unpleasant odour in the downstairs bathroom and the floor appeared sticky and marked. When we walked past later in the day the odour was no longer there and the floor had been cleaned.

We saw that all bathrooms and toilets contained facilities for people to wash their hands effectively including liquid soap and paper towels. We saw there were notices over hand wash sinks reminding staff of good hand washing techniques. This would help to reduce the risk of the spread of infection.

We visited several people's bedrooms. We saw they were clean and there were no odours.

We spoke with one of the domestic staff. They told us they had all the equipment they required to carry out their cleaning tasks. They confirmed they cleaned all communal areas daily as well as people's en suite bathrooms.

We saw that protective clothing such as disposable gloves and aprons were available to staff to help them maintain good hygiene practices in the home. We observed staff wearing appropriate protective clothing when delivering personal care.

We looked at the laundry room and spoke with the person responsible for laundry. We saw that soiled and infected laundry was put into special bags. These were placed directly in the washing machine and dissolved during the wash cycle. This minimised the handling of soiled laundry and reduced the risk of cross infection. There was a sluice cycle on the washing machine to cope with soiled laundry. We saw evidence of a system that kept dirty and clean laundry separate. This meant the risk of cross contamination was minimised.

We asked the person in the laundry whether the sheets and towels were in good condition.

They confirmed they were and said, "Seeing as these sheets get washed every day, they are in remarkable condition." We asked what they would do if they identified any sheets that were torn or in a bad state of repair. They responded, "I would take it to the head housekeeper and ask if we should bin it or repair it."

We saw that there were some holes and cracks in the walls in the laundry. The provider may find it useful to that this meant effective cleaning of the walls would be difficult in order to maintain good hygiene standards.

We checked the sluice room on the ground floor. We saw the sluice machine had been removed since our last visit. We were told that a new machine had been ordered and they were waiting for it to be fitted. The sluice room was locked to prevent any risk to people living in the home.

Training records confirmed that most staff were up to date with their infection control training.

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

At our last visit in August 2013 there were not enough permanent nursing or care staff to cover all the shifts. The service was relying heavily on agency staff to fill staff vacancies which affected continuity of care. The manager and deputy manager had resigned their positions. Whilst a manager from another home in the provider group had stepped in temporarily, there was no permanent management team in post.

At this visit we saw a new manager and deputy manager had taken up positions on 30 September 2013. Both were registered general nurses and had previous experience of working in nursing homes. They had been in post for just over four weeks at the time of our visit.

The manager told us that over the last few months the service had implemented a recruitment process and filled all the vacancies for care staff. The service had not used any agency care staff during the week of our visit and for the previous two weeks.

On the day of our visit the manager was interviewing for bank care staff to provide cover for absence of permanent care staff due to sickness or annual leave.

The manager explained they had also recruited two registered mental health nurses and one registered general nurse. We met two of the newly recruited nurses during our visit. The service still had nursing vacancies to be filled. Agency staff were being used to cover some nursing shifts at night. The manager told us they used the same agency nurses to cover shifts to provide consistency of care. They confirmed they were no longer experiencing the difficulties in obtaining agency cover that we identified at our last visit.

We spoke with staff about staffing of the home. They confirmed staffing levels had improved over the previous weeks. One staff member told us, "There are more consistent care staff."

At the time of our visit there were 17 people on the ground floor and 11 people on the first floor. We were told there was one nurse on each floor on each shift. There were four care staff on the ground floor and three on the first floor during the day. There were two care staff on each floor at night.

Talking to staff we found them open and honest about the service and the challenges of the previous few months. One staff member told us, "Staff are more content. They are able to support people without being rushed." Another told us, "Staff morale is a bit better, especially between care staff." Another told us, "Communication between carers and nurses has improved." One staff member said, "It's got a lot better since when we had no manager. We are all pulling together."

On the day of our visit we saw sufficient staff on duty to meet people's needs without rushing. We saw that staff were friendly and supportive of people and observed relaxed interactions. During meal time we saw a couple of people were very vocal and demanding. Staff responded promptly and quietly dealt with their requests. We saw staff responded quickly to call bells. A new member of domestic staff who had previous experience of working in a nursing home told us, "The carers are really nice to the residents, kind. The ratio of carers to people is really good. There is always a staff member sitting in the lounge with them. They have always got someone to watch them."

One person's care plan we looked at stated they could be reluctant when being assisted with personal care. Although we were unable to observe personal care directly, we listened outside that person's room while staff were supporting them. Whilst the person was challenging and verbally abusive, staff remained kind and consistent in their approach.

We looked at ancillary staffing levels. There were four housekeeping staff. There was one working in the laundry and two cleaning in the home seven days a week. On the day of our visit there was only one member of housekeeping staff cleaning due to annual leave. The manager explained they had just employed a bank housekeeper to cover any future absence of housekeeping staff. There was a full time cook, a second cook and two kitchen assistants in the kitchen. There was a full time administrator and maintenance staff. The level of ancillary staff meant that care staff could devote most of their time to care tasks.

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

When we visited Brandon House in August 2013 we found that new staff were starting work in the home without an induction. At this visit the manager told us all new staff received an induction. This involved completion of all mandatory training followed by a period of shadowing a more experienced member of staff.

We spoke with a member of staff who had told us at our previous visit they lacked confidence in the abilities of new starters because they had not had an induction and lacked basic manual handling skills. During this visit they confirmed new staff now received an induction which involved completion of mandatory training before they went on the floor. The staff member told us they were aware of members of staff who had been taken off the floor until they had completed the required training. Another member of staff who had been recruited six months earlier told us they had not had an induction at that time, but that "staff do get this now". A member of staff who had recently started work at the home told us, "The first few days I was not on the floor. I was doing the e-learning and going through the files." Another new member of staff confirmed they had completed an induction and told us they had completed "all the mandatory training you need to work in the care system". New staff were supported with an induction into their new roles within the home.

We spoke to staff about training. They told us they received regular training, most of which was completed on e-learning. Some staff told us they had reservations about the value of e-learning. One staff member told us, "I don't get much out of training on the computer. I prefer face to face." The provider may find it useful to note that assessments following computer learning would support staff in understanding the practical implementation of the training they had received.

Some staff were receiving practical training in manual handling on the day of our visit. The manager told us that all staff would have received updated training in this area by 19 November 2013. Two senior staff members were due to attend a four day "train the trainer" course in manual handling to cascade the learning to other members of staff in the future.

We saw from staff files that managers were analysing staff training to identify people who

had not completed training as required. In one bank member of staff's file we saw a letter stating they would not be offered any more shifts until their training was up to date. Some staff told us they struggled to complete training within working hours. The provider may find it useful to note that providing staff with protected time to complete training would support them in completing their training in a timely manner.

The manager advised us they were looking at training for staff in areas specific to the needs of the people who lived at Brandon House. For example we saw the manager had arranged for a Tissue Viability Nurse to provide training in pressure area prevention and management and how it linked to safeguarding. Another member of staff had been appointed as incontinence lead for the home. They were going to liaise with the local authority incontinence team and then share the learning with other staff. The manager explained that by increasing staff's understanding and knowledge of these areas would support them in carrying out their roles effectively and safely.

When we last visited staff told us they were not receiving regular supervision. At this visit staff told us they had received supervision from the interim manager since then. The manager provided us with a matrix that showed which staff members the senior staff would be supervising. The manager told us, "We need to get to know staff's practices before we can supervise them." This meant supervision would be about supporting staff's individual working practices. The manager went on to explain that observations of practice would be implemented as part of the supervision and appraisal process. We were shown forms that would be used to record staff observations.

Staff we spoke with were positive about the support they received from the new management team. One staff member told us, "They are hands on as well which makes it easier." Another staff member described the new management as "very approachable". Staff also understood their responsibilities. A staff member said, "With every new manager coming in they try to do something to make it better. But the staff have to do something too. What you want at the end of the day is the best for people and their relatives."

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: The provider had not taken proper steps to ensure that each person was protected against the risks of receiving care that was inappropriate as the planning and delivery of care did not always meet people's individual needs. Regulation 9 (1) (b) (i).

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 03 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.

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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