Inspection Report

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

St Peter's Site

St Peter's Site, Chertsey, KT16 0QA

Tel: 03005555222

Date of Inspection: 26 June 2013

Date of Publication: August 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Safety and suitability of premises	✖ Action needed
Staffing	✔ Met this standard
Supporting workers	✔ Met this standard
Assessing and monitoring the quality of service provision	✔ Met this standard

Details about this location

Registered Provider	Surrey and Borders Partnership NHS Foundation Trust
Overview of the service	This inspection looked at Blake ward and Clare ward in Abraham Cowley Unit at St peters Site. This location is a specialist Mental health unit. The location is registered for the regulated activities Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 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 26 June 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

As part of our inspection we at looked at two wards, Blake ward and Clare ward which were two of four acute admissions wards in the Abraham Cowley Unit.

We found that the environment and facilities in the wards did not ensure that people's right to privacy and dignity was respected.We found a number of environmental concerns which meant that people were not being cared for in a suitable safe, accessible and well maintained environment

People said that they had a care plan but they did not always evidence their involvement in their care plan. There were no system in place to ensure that people who were not legally detained could leave the ward.

The Expert by Experience spoke to six patients and concluded that patients generally spoke highly of the service. Occupational therapy and activities were well regarded and respected.

We observed some good interactions between staff and patients.

Safeguarding procedures were in place and staff received training to ensure people's safety

People were supported by staff who received appropriate professional development. However not all staff had received up to date supervision sessions to monitor their practice

The provider had systems in place to gather the views and experiences of patient's who used the service. Audits were undertaken to monitor the quality and safety of the service

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 16 August 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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. People's privacy, dignity and independence was not always respected.

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

Reasons for our judgement

At this inspection we looked at two people's care plans. A person we spoke to said that their care plan had been discussed with them. However when we looked at three people's care records in the other ward we found that the care plans did not contain any recorded information to confirm people's views. This meant that people and/or their representatives had not been able to express as to what was important to them in relation to their care and treatment.

Nursing staff reported that they gave people a copy of their care plan. None of the people who were interviewed said that they were provided with a copy of their care plan.

The Expert by Experience spoke to six people and them about their involvement in their care plan. They all said that they had a care plan. Three people said that that were consulted about their plan, however two people said they were not. Comments included, "I do have a care plan and I did help to draw it up" and "I do have a care plan but it was written for me about me". People also told the Expert that they felt that they were treated with dignity.

We saw that there was a range of information available on the notice boards in the wards to advice patients. Examples included menus and ward activities. We saw that there were pictures of staff and their designation to advice patients about who worked on the wards. A community meeting took place each week and the minutes were posted on a notice board for all patients to read. Patients were provided with an information pack. We saw that this information could be provided in other languages and in an audio version for people to be able to understand.

We also saw information displayed about the rights of detained patients and the role of the Independent Mental Health Advocacy (IMHA). The ward staff informed the IMHA of all detained patients. Patients could also self-refer to this service as the IMHA visited the ward a couple of times a week. The Expert by Experience spoke with people who said" "I have used advocacy several times during my stay at Abraham Cowley" and "I see the advocacy service", "I think they're excellent".

At the time of this inspection we saw in Clare ward that all of the viewing panels to the six single rooms were open. We asked a member of staff about this and they told us it was policy to keep them closed unless it was identified that a person needed 15 minute observations. During our inspection a member of staff closed the viewing panels. However, we observed a member of staff opening a viewing panel and left it open after they had made their observation. This meant that people's dignity and right to privacy was not respected. A patient we spoke to said that they would like the viewing panels to be kept shut when observations were not taking place. This meant that people's dignity and privacy was not being respected.
At this inspection we also found that the environment did not promote and respect people's right to privacy. (Refer to outcome10.)

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.

People did not always experience care, treatment and support that met their needs and protected their rights.

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 Trust had an electronic care record system called RIO. At this inspection the compliance inspector and the Mental Health Act Commission looked at two patient's records in Blake ward. We found that these were maintained in good order. One patient had two care plans and they had been on the ward for six days.The other person had only been on the ward for two days and had one care plan which had been completed on admission.

We saw that detailed risks assessments had been completed, which detailed how these risks could be minimised. Examples seen included risk of self-harm and violence and aggression. We found that people's medical notes were detailed and included prompts for recording people's views and discharge plans.

We found that patients physical health needs were recorded but we were concerned about the health condition of one person who experienced significant pain. This person's health condition was also identified as a potential infection risk. We saw evidence recorded about the actions that medical staff had taken such as requested investigations and we were also told that a referral had been made to a health professional for further specialist advice. However we found that there was no protocol in place for the supply of services with the acute hospital which shared the same site.

In the other ward we looked at three people's care records. We found that one person had one initial care plan and they had been on the ward for two weeks weeks. The other people had care plans but it was not clear which were the current ones

We looked at patients Leave forms in both wards and they were found to be in good order, with a copy given to patients and old leave forms crossed out.

At this inspection a person was admitted into the 136 Suite who was clearly distressed. We observed that staff promptly dealt with this situation. This person's first language was

not English but we observed that they were supported by a member of staff who was able to communicate to them in their own language.

Patients were offered fifteen minutes 121 time every day and if this did not take place, it must be recorded in patient notes. Staff told us how peoples one to one sessions were provided. The Expert spoke with six people who said that they did not have one to one time with nurses or doctors.

The entrance to the ward areas of the Abraham Cowley unit was via an airlock system at reception which controlled access to all of the wards. This allowed for free movement so that people could visit the "Caff", which also had a shop and where patients had their meals if they were well enough. We were told that the introduction of the air lock had resulted in fewer people absconding from the unit. However this meant that the rights of other patients who were not detained were not respected. We did not see any information to advise informal patients that they could leave the wards. The doors onto the wards were also locked and there was no system for informal patients to leave the ward without staff intervention.

Some people required fifteen, thirty minute and hourly checks by staff to ensure their safety and wellbeing. We looked at some of the observation check forms kept in the ward and we found that that these records had been completed to confirm that these checks had been undertaken.

We spoke to three members of staff who told us about their role and the process that was followed when new patients were admitted into the ward and the arrangements for discharge.

The Expert by Experience spoke with six people who generally talked positively about the service.

The service provided a therapy garden and there was an art room and a gym. Most people were able to access psychology. We saw information in the ward which advised people about the activities provided. This included DVD, therapy and relaxation groups, creative writing, quizzes and pamper sessions.

The Expert by Experience asked patients for their views about their activities who concluded that occupational therapy and activity workers were well regarded by people. Comments included "I have an activities programme and do several activities in the week." "I go to yoga and music in the café after 6pm" and "I go to relaxation, movement and I go to the art room." However two people said that there was not always much to do at weekends. Staff told us that plans were in progress for WI Fi to be made available for patients and an internet café.

We found that there were arrangements in place to deal with foreseeable emergencies. We saw procedures were in place for dealing with medical emergencies such as resuscitation. A range of emergency equipment was maintained on the ward, which was regularly checked. Examples of other contingency plans included utility breakdown and staffing.

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 use 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

We saw the provider's safeguarding procedure, which made reference to the local authority safeguarding procedures. We also saw safeguarding information displayed in one of the ward's office. This guided staff to respond appropriately to any allegation of abuse. We were told that the trust had a safeguarding coordinator in post. We also saw that patients were provided with safeguarding advice, which was available in the patients information pack.

Staff we spoke with told us that had been made aware of the Trust's policies and procedures and they had attended training in safeguarding. We spoke to six members of staff; they told us they were aware of their responsibilities in relation to the protection of vulnerable adults and they were aware of what action they would take if abuse was suspected or alleged. We were told that safeguarding concerns were also passed to the trusts safeguarding coordinator.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises because the design and layout, operation, and inadequate maintenance of the premises. The premises did not promote people's right to privacy, dignity and choice.

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

At this inspection we looked at both wards. Blake ward had the only Section 136 'suite' in the Abraham Cowley unit. It was small room off the ward activities room. We saw that this room was located near to the entrance of the ward. We observed that a person was being supported by staff in this room. We saw that this room had glass panels, which provided us with a clear view into this area. There were no blinds or curtains. This meant that people's right to privacy and dignity was not respected. We also found that this suite did not provide toilet facilities which meant that this person had to be escorted to one of the male toilets in the ward. We saw that staff remained in the corridor with the door open to the outer room, as was the door to the toilet itself and we were able to hear the sounds of the person using this facility which did not ensure their privacy and dignity.

We saw that this 136 suite had some gym equipment and some furniture. We saw that that most items would be difficult to move but there was a lighter table, which if thrown posed a potential risk to patients and staff. The use of this room as a section 136 room also meant that this room was not available for use by patients on the ward and the lounge was the only other communal indoor space.

Blake ward was a twenty bedded ward with three five bed dormitories, two for women and one for men. There were five single rooms in a separate corridor which were allocated on the basis of risk and degree of illness. Gender separation was therefore not always possible.

Clare ward had 21 beds arranged in three dormitories of five beds each and six single rooms. Patients who stayed in the single rooms in Clare ward had access to a bathroom but if they wished to have a shower they had to use the showers in the dormitories. There were separate gender toilets but not bathrooms. Patients' reported that the shower in the women's dormitory did not work very well and as a result women who wanted to have a shower, had to use one of the men's showers. We also found that the lock on the door of

one of the showers in the men's dormitory did not work. This meant that appropriate arrangements were not in place to ensure the privacy and dignity of people who used the service. A person who used the service said "I would like to shower without entering the men's' area as the women's shower does not work very well".
We also saw a room that was marked 'Female Lounge', this room was locked. We asked why it was locked and staff told us that male patients had been accessing the lounge and female patients now had to ask staff if they wanted to gain entry to the lounge.

We also identified a number of maintenance issues in both wards including a fire door that had broken panels, some of the kitchen units were not in good state of repair. In Blake ward the male and female toilets were arranged so that it was possible to use the door of one cubicle to block the exit of the second. We also noted that a female toilet door had a message on it "Lock broken out of order". This meant that patients did not have access to facilities that were suitably designed. "The Expert by Experience spoke to a person who said "there are not enough toilets in this place, some are locked".
Blake ward had a serenity room and a pastoral service. There was a family room off the ward, which was shared by all the wards on the unit. It had no access to fresh air, being totally enclosed and was not very private. There was a conservatory which overlooked the garden and which was used by family and visitors. We noted that the blinds were broken.
In Clare ward we saw that the entry door to the ward was boarded because the glass on the left side had been smashed; we were told by staff that this had been smashed about two weeks prior to our inspection. However, on the maintenance record sheet we saw an entry that indicated the door had been damaged in April 2013. We were not able to verify that other maintenance tasks had been completed in reasonable time because the maintenance records we saw were not all up to date. We also pointed out to staff that the light switch in a meeting room was damaged and that one of the chairs had a broken leg. This meant that people were cared for in an environment that was not appropriately maintained.

Clare ward was being cleaned during our inspection and general cleanliness was good but one of the toilets had a malodour and the sink in a bathroom next door was blocked with used water it. This meant that people using the ward were not protected against risk associated with unsafe premises. We found that there was a strong pervading odour in one room and that the toilet in this room did not have a toilet seat. Patients told us that at night there were some disgusting strong smells on the ward. The room had no external opening windows and when we entered the room we could not hear the ventilation fans working. We asked a member of staff about this and they said they would get it looked into. In another room we saw that the sink was blocked and the sink was full of dirty water. We could not hear the ventilation fans working in this room. During our inspection the maintenance team were on the ward who attended to this matter. Staff told us that that they had come to look at the ventilation fans in the toilet because we had raised this issue in the early part of our inspection.

Access to the garden and smoking area was though a secure door and down two flights of stairs. We saw that the stairs area was in a poor decorative state. On the first stair landing we saw that large pipes were projecting from the floor where a radiator had been removed. These pipes were not protected should a patient fall on the stairs. We saw that regular fire alarm checks took and there was a fire evacuation plan in place but we looked at three fire extinguisher service labels and found these were not up to date.
We saw that ligature risk audit checks were undertaken. In one of the wards a number of noticeable ligature risks were seen around the ward including some in areas it might be possible for patients not to be seen easily, for example there was a rail underneath the

stairs leading to the garden area
We saw that a number of patients were using the secured garden. We also observed that trees in the garden were identified as potential ligature risks. We were told that a rubbish bin had been removed because it had been used to climb up one of the trees to use a branch for a ligature. After our inspection the Trust informed us that the garden had been considered previously and it was decided that the trees would not be removed as this would impact on the garden environment. The trust informed us that how people were supported in the garden was dependent upon the individual's assessment of risk using green, amber and red zoning criteria. People considered at high risk would only access the garden under staff supervision. At this inspection we did not see any staff in the garden. The Trust also had a Ligature Minimisation Group who reviewed issues raised as a result of the completion of Ligature Audits in the local areas.

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 the time of this inspection there were nineteen patients in Blake ward. Twelve of these patients were detained and patient was on leave. There was an acting manager, two registered nurses and three health care assistants. We were told that this was the usual staff arrangement during the day. We were told that that had been a few changes of manager in Blake ward. The Acting manager in Blake ward had been in post since May 2013. We were told that the permanent manager's post was going to be advertised.

At night time people were supported by four members of staff. Some staff told us that additional staff were provided if any patients required more intensive supervision such as one to one observation. Staff we spoke to said that the staffing levels needed was dependent upon how busy the wards were. One member of staff said that in their view one more qualified member of staff would be beneficial on each shift. Staff told us that systems were in place for staff from other wards to assist each other when additional staff were required.

There were five consultants who have patients on the ward. We found that that this imposed a large workload on ward staff and we were told that there should only be two consultants. At this inspection we observed that nursing staff were very busy liaising with doctors other professionals. We also noted that nursing staff had to answer the telephones as there was no administration support

During this inspection Blake ward was very busy but we observed good interactions between staff and patients. A person we spoke with said "All the staff are so helpful". However the provider may wish to note that one person reported that they had been granted two, one half hour periods of section 17 leave a day but they could not often take this leave because of a shortage of staff.

Clare ward operated a 12 hour shift system with two qualified nurses and three unqualified staff on the day shift with two qualified nurses. Staffing also included one OT/ Manager who worked 50% clinical and 50% management time, three full time diversion activity co-ordinators, one full time fitness and wellbeing instructor, one fulltime psychologist and two full time psychology assistants who worked across the whole unit.

The unit manager told us about the arrangements that were being made to recruit to staff vacancies, which was an improving picture. The service also employed bank staff through NHS professionals. We were told that familiar staff were always requested. We spoke with three members of bank staff who told us that they regularly worked in the ward and they were made to feel part of the team.

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

Staff received appropriate professional development. We looked at six members of staff training records in both wards. We found that staff received appropriate professional development.

The training sheet recorded the date when staff had attended training and when their training updates were due. We saw evidence that staff had attended training in safeguarding adults and children, health and safety, fire safety, infection control, clinical risk assessment support and moving and handling and conflict management and physical intervention training called MAYBO. This meant that people were cared for by staff that were supported to deliver care and treatment safely.

We also saw that staff had received additional training such as Mental Health Act 1983, Mental Capacity Act 2005, equality and diversity, electronic care record training, equality diversity and information governance. Registered nurses had received training in medicines management.

However the provider may find it useful to note that not all of staff the training records had been updated for staff employed in one of the wards to evidence their attendance.

We were told that staff was appraised. This was evidenced by records but in one of the wards staff had not recently been supervised to monitor their practice. The acting manager acknowledged this and said that they were intending to address this shortly.

Staff we spoke said that they had received induction and they were supported to attend training and development. Staff were also able, from time to time, to obtain further relevant qualifications. Two care members of staff told us that they had attained national vocational qualifications (NVQ).

Staff spoke positively about the reflective practice sessions that had been introduced, which were run by the psychotherapy department. Ward support sessions were also held for staff to take in.

The manager of one of the wards told us that staff had been participating in the "safe wards" project. This is an intervention to reduce conflict in acute mental health settings which placed emphasis on promoting the health and wellbeing of staff. We were also told that the trust was developing nursing excellence in the acute areas, which was being led by a nurse consultant.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We found that that the provider had quality assurance systems to monitor the quality and safety of the service. We saw examples of audits that had been completed such as record keeping, infection control and a range of risk assessments including personal protective equipment, and first aid. Where improvements were identified this was outlined in an action plan. We saw completed health and safety audit had been undertaken in one of the wards. However the provider may wish to note that a recent health and safety audit had not been undertaken in Blake ward to assess the safety of the environment.

The trust had a clinical governance tool, the Periodic Service Review (PSR). We looked at the audits completed in October 2012, which had been conducted by other trust personnel external to this location. Team's feedback on the progress of the PSR and the results were monitored by the trusts quality action group. This audit looked across a range of outcomes, which included mandatory areas. We noted that mandatory and statutory training had been identified as an area for improvement and required a re- review to assess improvement.

We were told that clinical and safety alerts received from the National Patient Safety Agency (NPSA) were sent from the trust to the wards and communicated by Email. The provider had an electronic incident recording system known as Datix. A member of staff told us about a serious incident that had occurred and explained what learning and action had taken to minimise future risk to people.

The trust had systems in place for gathering people's views and experiences of their care and treatment, using "people experience tracker". We were told that completed questionnaires were sent back anonymously to the manager to action any issues.

The provider took account of complaints and comments to improve the service. The Trust had systems in place to respond to people's complaints. People Advice and Liaison Services (PALS) regularly visited the wards to meet with people to coincide with the

community meetings who also met with people to resolve any concerns.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's care plans did not always document that their care and treatment had been discussed in consultation with them. Arrangements had not always been made for people to be able to express what was important to them in relation to their care and treatment. Suitable arrangements were not always in place to ensure people's dignity and privacy. Regulation 17 (1)(a) 2(C) (i) (ii)
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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: There was no system in place to demonstrate how the needs of people who may need treatment in hospital will be met to ensure their health and welfare. There was no information to advise people or systems in place for informal patients to leave the ward without staff intervention. Regulation 9(b)(1)(i)(iv)

This section is primarily information for the provider

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider had not ensured that the premesis protected people's right to privacy, dignity, choice and safety. People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises because of the of the design and layout, operation, and inadequate maintenance of the premises. Regulation 15 (1) (a)(b)(c)(i)(ii)

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 16 August 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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