Inspection Report

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

St Catherine's Care Home

1 East Lane, Shipton by Beningborough, York, YO30 1AH

Tel: 01904470644

Date of Inspections: 10 September 2013
05 September 2013

Date of Publication: October 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✖ Action needed
Cleanliness and infection control	✖ Enforcement action taken
Management of medicines	✖ Action needed
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Wellburn Care Homes Limited
Registered Managers	Mrs. Amanda Jane Price Mrs. Judith Elizabeth Scurr
Overview of the service	St Catherine's Care Home provides residential and nursing care, including a specialist dementia unit and respite and personal care, for up to 55 residents. The home is located in Shipton-by-Beningbrough, just off East Lane. It is close to local amenities and York is just a short drive away by car or public transport. The home has two distinct units, Harewood and Mews. The Mews unit provides accommodation for people with dementia.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 5 September 2013 and 10 September 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, took advice from our specialist advisors and used information from local Healthwatch to inform our inspection.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

Prior to our visit we received some concerns about standards of care, staffing levels, the administration of medicines and infection control. We looked at these concerns as part of our visit.

People told us that they liked living at the home, however we saw practices which did not promote their health or wellbeing. Care records required development and staffing numbers were impacting on the quality of care being delivered.

Although people received a choice of food and drink, the time spent in the dining area impacted on their well being.

People were not prevented from the risk of infection because appropriate guidance had not been followed and there were inefficient systems in place to reduce the risk and spread of infection.

The time taken to administer medication meant that people did not always receive their medicines in a timely way which meant that people may not receive their medication as required.

Although the provider had systems in place to carry out quality checks we found that these were ineffective.

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

We have referred our findings to North Yorkshire and York Community Infection Prevention and Control, Local Authority: Commissioning, Local Authority: Safeguarding and Environmental Health. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against St Catherine's Care Home to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

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 receive care or treatment which met their needs and ensured their safety and welfare.

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

Reasons for our judgement

We carried out this visit in response to some concerns about how people were being cared for. During the inspection we looked at the care plans, risk assessments and daily records relating to seven people receiving care. We spoke with the manager, deputy manager and staff. We also spoke with people using the service and with visiting relatives.

People told us "I'm alright, well looked after with nothing to grumble about really."

We were unable to speak with some of the people living on The Mews unit so we carried out some formal observations. This enabled us to observe practice and look at staff interactions so that we could understand people's experiences.

We spent time looking at care records and discussed these with the manager and nursing staff who told us that all care records were in the process of being reviewed. We looked at care plans for people on both units. We found inconsistencies in the quality of information available. The care records we looked at were not kept up to date and we found gaps in some of the recordings or information which was missing. Care records did not always reflect people's changing care needs which meant there was a risk that the care people received was not appropriate and safe. Care planning did not meet the individual needs of people to ensure their welfare and safety.

We looked at four people's care plans that had fallen at the home. We saw that one person's care plans and risk assessment reflected their current needs. However, we saw that for three people their care plans had not been updated or reviewed after falls had occurred. We also saw that risk assessment were not always in place. This would have helped to alert staff to the fact that these people were still at risk of falling. We did see that two people had their falls reviewed by relevant health care professionals. However, their advice and investigations that were undertaken were not always recorded in the person's

care plans. This meant that staff may not have been made fully aware about people's current care needs.

We spoke with an individual as we observed they had a red area on their face. We asked the person about this they said they had caught their face the day previously. We looked at their care plan for 'skin integrity' this was last reviewed on 29 July 2013. There had been no entries made since this time. We also looked at the person's 'body map'. This did not have anything on it. We spoke with the deputy manager about this and took them to see the person. The deputy agreed the care plan and body map should have been updated by the staff to reflect this person's current condition.

We observed one person who was in bed. They were 'signing' for a drink. The care plan stated that they needed seven to eight cups of fluid a day. We looked at the fluid charts and saw the following amounts recorded 10/08 No fluid recorded, 11/08 No fluid recorded, 12/08 400mls of fluid recorded. This meant that it was difficult to see how much fluid this person was receiving. We also saw that this person had very dirty nails. There was no care plan to ensure that the individuals nails were checked regularly. The care plan also stated to be checked hourly throughout the night and regularly during the day. On the 10/08 checks were recorded at midnight, 06.40, 08.00 and 15.00 and then the next checks were dated 12/08 at 08.45. This person was unable to summon help as they could not use their nurse call so relied on staff checking them regularly.

We spoke with staff working on both units who spoke to us about the impact of current staffing levels. They said the staffing situation meant that the service provided was very task led. For example, getting people up, giving breakfast, giving lunch, giving medicines and getting ready for bed. Staff told us they had very little time to spend with people. Comments included "On a morning we are still getting people up at 11.45. People have to lie in because we are busy. Residents are suffering" and "People stay in the dining room from breakfast until lunch, this is disgusting." Another member of staff told us "People are put to bed early, we have no choice as night staff are so short staffed. We should complete charts for people three hourly but we are lucky if they get done very four to five hours.

Across both units we observed a lack of staff presence in communal lounges and dining areas which meant people were left alone for long periods of time. We also observed that some people were left alone in their rooms for long periods and although some had charts in place these were not always completed to show that they were being checked regularly.

We saw that there was a lack of stimulation and activity for people across both units but in particular The Mews. We saw a lack of memorabilia, magazines, rummage boxes and information to aid people to orientate to the day and time or provide social stimulation to enhance their sense of wellbeing. A member of staff told us "Some people like to paint but this is not provided. Activities are usually a film, very occasionally outings and usually local. Residents would love to go to the seaside."

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of inadequate nutrition and dehydration.

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

People were provided with a choice of suitable and nutritious food and drink. People told us that they had no complaints about the food. One person said "The food is lovely." Another person said "I always enjoy my breakfast and all the meals here."

The people we spoke with told us that they could get something to eat or drink at any time of the day or night. This was confirmed by the chef and staff we spoke with. A member of staff said "The food served here looks lovely. People have what they want. There is supper served also. One person is a vegetarian and we cater for them." We spoke with the chef who told us that when new people were admitted to the home they were informed about the person's dietary needs.

We also saw evidence that the chef was informed about anyone who needed to receive fortified foods to help to prevent weight loss. We saw that there were always two choices of food prepared for lunch and tea so that people could decide what they wanted to eat. The chef told us that if someone did not like what was on the menu they would cook something else for them. We saw that people could choose to have their meals in their room or in the dining rooms. We saw that staff asked people what they would like to eat and drink and we saw that their choices were respected.

In the dining room on The Mews unit we found 145 bottles of out of date fresubin supplements. This was concerning as it meant that people were receiving out of date food supplements or had not received them as prescribed.

At breakfast time we saw that there was a member of staff on duty in the main dining room who had the responsibility of monitoring people and encouraging people to eat and drink. They were assisted by other care staff. We saw that the staff spent time to assist people to eat and drink or prompt people where necessary. However, the provider may wish to note that a member of staff we spoke with said "We don't get told at handover about people who have lost weight or who are on fortified diets. It is difficult to get the time to read the notes." Staff need to be made fully aware of people's dietary needs so that people's needs can be met.

During our visit we looked at six people's care records. We saw that people's dietary preferences were recorded on their pre admission assessment. A further assessment of people's nutritional needs was undertaken after their admission. Where people's appetites were poor or their weight was not being maintained advice was gained from the person's General Practitioner (GP) or other relevant health care professional. However, we found some shortfalls with some of the nutritional care plans that we looked at. For example, we saw that one person's nutritional care plan had not been reviewed since 22 July 2013. Another person's nutritional care plan had recently been rewritten. However, the information contained in this care plan did not reflect the last two GP visits. Therefor this care plan did not reflect the person's current needs. Another person's nutritional care plan said they were receiving dietary supplements. However, these had been stopped by their GP.

Some people had to have their food and fluid intake monitored and recorded on a chart. We looked at the food and fluid intake records for people who required their weight to be monitored. We saw that these charts were not always completed appropriately. For example, on some days, on some charts, only breakfast had been recorded or lunch and tea. There were the occasional days on some people's charts where nothing had been recorded. This may place people at the risk of receiving the nutrition they needed and prevent the person's GP from gaining a thorough picture of people's dietary intake. We discussed this with the management team at the time of our inspection. They said they would immediately take steps to address this.

Prior to our visit we received concerns about people's dining experience. We were told that people were left in the dining room for hours after meals and that some people received no food or fluid for up to fifteen hours as they were put to bed post tea and got up late the following day. During our visit we spent time observing the dining experience both during breakfast and lunch. We saw that breakfast was provided throughout the morning and virtually up to lunchtime in the main dining room. Some people had only an hour gap between receiving their breakfast and lunch and we observed staff asking some people if they would prefer breakfast or lunch. This may effect people's appetite and enjoyment of their meal. We asked a member of staff about this they said "People may have wanted a lie in bed. Breakfast may nearly roll into lunch time on some days."

Cleanliness and infection control ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance had not been followed and there were inefficient systems in place to reduce the risk and spread of infection.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Prior to our visit we received some concerns about standards of cleanliness at the home which we shared with North Yorkshire and York Community Infection Prevention and Control Team. We agreed to carry out a joint visit to look at the concerns raised.

We looked at communal areas on both days of our visit and found there was dust, dirt and odours in some areas of the home which was unpleasant for people living there. Communal areas such as lounges and dining rooms had chairs which were dirty and stained. The carpet to the main lounge also looked stained.

Some of the equipment such as hoists, wheelchairs, weighing scales and pressure relieving cushion covers were dirty and stained. This meant they could harbour infection. We saw and were told that hoist slings were being used for more than one person and were not always cleaned between use. They were hung within bathrooms which was unhygienic as these areas were particularly dirty.

Tables and chairs were dirty and stained e.g. food debris on fabric and wooden surfaces, crumbs/debris under seat cushions. Some of the surfaces were damaged which made them difficult to clean.

Sluice rooms were dirty and smelly and waste was not being disposed of effectively. They were full of clutter and the detergent bottle running into the sluice was empty. We found that tiles and floor surfaces were dirty and in some cases chipped which made cleaning them difficult.

Several mattress covers and bed rail cushion protectors throughout the home were found to be stained some with faecal matter and some mattress covers and bed rail cushion covers were cracked or split. If mattress cover integrity becomes compromised, there is a

risk of the inner fabric of the mattress becoming contaminated and a reservoir for infection. This was not pleasant for people and increased the risk of infection.

Standards of cleanliness in toilets and bathrooms were poor with stained and dirty commodes and toilets. Soap dispensers were dirty and ingrained and there was a build up of dirty soap at the outlet. Some of the commodes were rusty and required replacing. Bathrooms were being used inappropriately for storage and some of the equipment was damaged (e.g. peeling enamel) and rusty, making effective cleaning difficult.

Clinical areas were cluttered and untidy. Sharps containers were not being used safely which poses a risk to staff. The fridge in the medicines room was dirty with substantial debris to the seals. We found sterile dressings which had been opened and items which were past there use by date.

Standards within the home should be in accordance with The Health and Social Care Act 2008 Code of Practice on the prevention and control infections and related guidance. We have issued a warning notice in this area.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

Appropriate arrangements were in place in relation to obtaining and returning medicines, which included controlled drugs. We saw reasonable stock levels were maintained.

We looked at the medicines records and stock for three people's controlled drugs and found these to be correct. We also checked the records and stock of a range of other medicines for five people as well as the medication dispensing packs for 12 people. The majority of records were complete and medicines could be accounted for. Our checks found the stock levels corresponded with the medication administration records (MARs). The majority of short term medicines such as antibiotics were administered as required. This meant that people were receiving their medication.

Despite this, we found suitable arrangements were not always in place for the administration of medication. We were told that most medication was given as people arrived in the dining room for breakfast. On the day of our visit we saw people arriving for breakfast and receiving their morning medication as late as 12 noon. There appeared to be no end time to the morning medication round. The nurse in charge was observed administering medication for the whole morning and into the afternoon without any real evident break. They told us that when people arrived for breakfast late then that delayed the process. We asked the nurse in charge about how this impacted on people. They told us that those medicines that were required to be administered at certain times and within a certain timescale were administered as required, for example pain relief and medication to treat certain conditions such as Parkinson's disease. We saw evidence of this as the MAR was marked with the time the medication was administered. We also observed certain medications being given at set times as required. However, over the period of a month we only saw a small number of entries where the time was written on the MAR. We were therefore unable to confirm if medication was always administered to people at the required times.

The majority of short term medicines such as antibiotics were given to people as required although we noted delays in courses of medicines being started because medicines were

not picked up at a weekend. We also observed medication being given in an undignified way. For example we saw people having patches and ear and eye drops administered at the dining table. We also heard staff say "Come on X it's your Parkinson tablet". This was said to a number of individuals. This did not promote people's dignity.

Medication was stored appropriately throughout our inspection. However, we were not able to view records of fridge and medication room temperature recordings. Staff we spoke with were not clear whether this took place. We found medication that should be stored in the fridge to be stored appropriately and marked with the date it was opened. However, we did note a number of creams that were out of date. We could not confirm from the records if these were in use. These were disposed of immediately.

We were told that the night staff carried out stock checks of the medication but no formal audits were carried out by management. Carrying out audits would help identify any issues relating to the safe handling of medication and prevent issues from occurring.

We looked at the information kept about medicines to help make sure they were administered safely. People's care plans contained information about their medication but this often lacked detail. We saw one instance where MARs had been updated by staff to alter the dosage required but we could not see information in the care records to indicate this changed had been agreed with the relevant healthcare professionals. We shared this with the nurse on duty during our visit.

There were inconsistent arrangements for recording information about how to administer medicines to be used 'when required', and we found the reason for giving 'when required' medicines was not always recorded. Lack of recorded information about these medicines meant that there was a risk nursing staff might not have enough information to administer them appropriately. This may also mean that people's health conditions may not be able to be properly reviewed.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

People told us that they liked the staff who cared for them. We observed a number of positive interactions between staff and those living on both units of the home. However, we also noted that some people received very few interactions and that those received were very task based which did not support their well-being.

Over both units we observed that the routines of day were delayed, this included getting people up, receiving medication, getting people to and from the dining room and supporting people with their meals. We saw that people were left unattended for long periods. We saw that some people were in bed in their rooms throughout the day. We saw from records that staff were supposed to check them reguarly however charts to demonstrate that these checks were taking place were not being kept up to date.

We saw that care was very task driven. We spoke with staff who told us "I feel there are not enough staff, usually four on an afternoon, I feel we need more because we have no quality time with people." And "staffing numbers do not permit us to ask people who are asleep at the tables in the dining room if they would like to go to bed. I would like to ask people if they want to lie down. Staffing levels don't permit this."

Another member of staff told us I would like to sit with terminally ill residents, we don't have enough staff to do this."

We looked at rotas and saw that there was a nurse on duty for each of the units throughout the day and night. There were usually five or six carers on a morning and four or five on an afternoon for the nursing unit and three for the dementia unit.

We spoke with senior management who said that additional staff had been recruited but they were waiting for police checks to be carried out before they commenced their employment. They told us that they had not made cuts to staffing numbers but had not replaced staff as they had left particularly as numbers of people at the home had decreased.

Staffing numbers need to be reviewed so that there are sufficient staff on duty to meet people's assessed needs. We spoke to the management about this. They told us that they had carried out some dependency rating and had acknowledged that additional staff were required. They said that delays with the Disclosure and Barring Service (DBS) had meant that there were delays in staff commencing work.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

While systems to audit and monitor the service were in place, they were not sufficiently effective in ensuring that people received safe care which met their needs.

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 provider had a range of policies and procedures in place to support the safe running of the home. These were produced at a corporate level with the manager of the home responsible for disseminating the information to the staff team. Current pressure on staff time indicated that this was difficult to achieve.

We looked at meeting minutes and could see that staff and service user meetings took place. A quality questionnaire had recently been issued and we saw that six people using the service had stated they could not choose when to get up or go to bed when they wanted. There was no evidence of any action taken to address this.

We looked at incident and accident recordings. There was a record of falls, accidents and incidents, but there was no analysis in place to look at trends or ways of minimising risks to people.

We did not see any evidence of any management audits or clinical meetings which were taking place. The nurses did have a handover at each shift but staff working at the home confirmed that they did not have time to read care plans which meant that people may not have their care needs fully met.

The area manager sent us a copy of their quality audit which had been completed in August 2013. They explained that these had been recently introduced and were based on the essential outcomes.

We asked to look at records of complaints. We were told that none had been received. However the information we received prior to our inspection and the staff we spoke with during our visit told us they had previously raised issues with the management team and that these had not been appropriately addressed.

The Director and senior management who were present during our visit acknowledged our

concerns and told us that they would take immediate action to improve the service. However, it was our view that while fundamental issues such as staffing levels and the provision of safe care were not in place, that the provider would not be in a position to drive improvement generally. We will review this area of practice in more detail at our follow up visit.

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 failed to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of planning and delivering care and, where appropriate treatment in such a way which meets people's needs and ensures the welfare and safety of service users.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: The provider has failed to protect people from the risks of inadequate nutrition and dehydration, by means of the provision of support where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs.
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The provider had failed to ensure that service users were protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had failed to ensure that there were sufficient numbers of suitably qualified, skilled and experienced staff to safeguard the health, safety and welfare of service users.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider had failed to ensure that they regularly assessed and monitored the quality of services provided.

This section is primarily information for the provider

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 19 October 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 30 September 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control** **How the regulation was not being met:** People were not protected against the risk of exposure to a health care associated infection due to the ineffective operation of systems designed to assess, prevent, detect and control the spread of infection.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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