# Inspection Report

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

# 4 Piggy Lane

4 Piggy Lane, Bicester, OX26 6HT

Tel: 01865747455

Date of Inspections: 07 January 2014
06 January 2014

Date of Publication: February 2014

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

| | |
|---|---|
| **Care and welfare of people who use services** | ✖ Action needed |
| **Safeguarding people who use services from abuse** | ✖ Action needed |
| **Management of medicines** | ✓ Met this standard |
| **Staffing** | ✖ Action needed |
| **Assessing and monitoring the quality of service provision** | ✖ Enforcement action taken |
| **Records** | ✖ Action needed |

## Details about this location

| | |
|---|---|
| Registered Provider | Southern Health NHS Foundation Trust |
| Registered Managers | Mrs. Shirley Ann Knight<br>Ms. Pearl Whiteley |
| Overview of the service | Piggy Lane is a location of two bungalows, each able to provide accommodation for five people with learning and physical disability. It is situated in Bicester. |
| Type of service | Care home service without nursing |
| Regulated activity | Accommodation for persons who require nursing or personal care |

# 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 6 January 2014 and 7 January 2014, observed how people were being cared for and talked with carers and / or family members. We talked with staff, reviewed information given to us by the provider, took advice from our pharmacist and talked with commissioners of services.

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

Piggy Lane has two Registered Managers named on their inspection report. Although both names are on the Care Quality Commission Register, only one of these was in post at the time of the inspection.

We inspected Piggy Lane on 06 January 2014. We had concerns across a wide spread of outcomes, and returned the following day to inspect further.

We were not able to speak with people who used the service. We were able to conduct an observation of the delivery of their care. We observed many episodes of good, personalised care and warm interactions by the care staff. However, they told us that they were not always able to deliver a high standard of care because of long-standing staffing problems. They said they had far too much to do, and this sometimes compromised the safety of the care they could deliver.

We noted that there were insufficient processes in place for the safety of the people who lived there. We were informed of other episodes of safeguarding concern, and noted the lack of records for these incidents. We alerted the local safeguarding team about these.

We checked the medications policy and procedures. We found that one medication was out of date, and  a lack of consistency in the way in which stock numbers were kept.

We checked the staff rosters for the previous three months, and the month to come. There were dates where staffing was either inadequate for the requirements of the people who lived there, or inappropriate for the continuing wellbeing of the staff.

There was an organisational failure of effective communication and engagement with staff with extensive local knowledge.  We heard that the care staff felt they were "badly-managed" by the two on-site managers, and "let down" by their employing authority, Southern Health NHS Foundation Trust.

We asked for specific records relating to incidents, to safeguarding and for day to day management. These were not able to be found. This impacted directly upon the quality of the service delivery, and the safety of people who lived there.

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 11 March 2014, 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 Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against 4 Piggy Lane 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.

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 did not always experience assessment, care, treatment and support that met their needs and protected their rights. Care staff communicated and responded to people in a warm and supportive manner. We saw many episodes of appropriate social interaction and good care. However, staff told us that a lack of follow up by senior staff meant that some people experienced delay in having their assessed physical health needs met. For example, because of one person's level of disability, their bed was not appropriate to their requirements. This had been identified in July 2013, but no action had yet been taken to address this. We asked the manager why this was. She told us she did not know as another member of staff had been asked to deal with this. This staff member told us "It is in hand, I am going to meet a relative soon to discuss this". Meanwhile, the person had not had the equipment they required for over seven months. Due to their condition, this person was not able to raise any concern about this unsatisfactory incident.

A further example was that one person required a specialist feed as their sole source of nutrition. A delivery was delayed, but this was not followed up in a timely manner. By the time the delivery was made, the last bottle of feed was already in progress. This meant that care and treatment was not delivered in a way that ensured people's safety and welfare.

On the day of the inspection, we noted there was a low stock of incontinence pads. A delivery was made the following day, by which time there were very few incontinence pads left, in a service which continuously used them. This meant that if there had been a delay in the delivery, no supplies would have been immediately available.

We read some comprehensive care plans and assessment documents. These were personalised and relevant, and were stored correctly. However, actions noted by other

healthcare professionals had not translated into the care required.  For example, one person required a food diary and monthly weighing. These were requested by a consultant and a dietician in July 2013. The food diary was absent, and staff we spoke with did not appear to be aware one had been requested. The requested monthly weighing had not taken place in a consistent manner, and this had not been checked by a senior member of staff.

These omissions were not single episodes, and occurred over a period of months, yet had not been noted due to a lack of care management. The manager was unaware of these omissions when we asked her about them, and said these supervisory duties came under the remit of another member of staff. This meant that care was of a quality less than required for the person's stated needs.

We asked the staff to describe how they worked during the day, and how this impacted on the people they cared for. They told us they delivered all personal care, dealt with episodes of illness such as epileptic seizures and supported people on their activities out in the community. They also prepared and cooked the meals, gave medications, and did all the cleaning as there was no cleaning contract in place. One member of staff said "It is so unsafe here at times, you have no idea. It is simply not possible to give the care we would like all the time; we work miracles as it is."

We saw that the care staff had worked hard to deliver a comprehensive level of warm interactions and support within their limited resources of staff and available time. We were told of many activities people were enabled to partake in, and heard of a recent trip to "Winter Wonderland" in London. The member of staff told us what a wonderful occasion this had been for the people supported to attend, and said "It is moments like this that make it worthwhile. They were so happy afterwards."

**Safeguarding people who use services from abuse** ✖ Action needed

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

## Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of harm, because the provider had not taken reasonable steps to identify the possibility of harm and prevent harm from happening, or responded appropriately to safeguarding incidents

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 who used the service were not protected from the risk of abuse or harm, because the provider had not taken reasonable steps to prevent harm from happening. We spoke with the manager about safeguarding procedures. She told us she had been in post for six months and was fully aware of all relevant procedures and her professional responsibilities. We asked about staff training, and saw electronic records that assured us that staff had recently attended the appropriate training.

We saw the relevant policy and procedures on the office wall; it contained all relevant and up to date contact details. We then asked the manager to describe any recent safeguarding alerts or incidents in the service. She told us there had been none since she came into post.

As we had heard of three specific incidents that concerned us, we described these to the manager and asked for her response. One person had been able to leave the building, unseen and unsupported, whilst the two staff on duty attended to another person. Another incident had occurred where one resident had been physically assaulted by another person whilst being supported in town. A third incident had recently occurred where a person with a wheelchair experienced a car reverse into it.

We asked what safeguarding processes had been put into practice for each of these incidents. We found that few appropriate actions had taken place, and the recording of each of these incidents was either minimal or totally absent. We were concerned by the response we heard, and alerted the safeguarding team to the comprehensive lack of records and action taken. We asked the manager and a senior member of staff why the records were lacking in detail or absent. They told us they did not know.

We spoke with the care staff about their responsibilities. They were clear about the different types of abuse, and how they would recognise it. We asked them how they would report any concerns. They said they would tell either or both the senior member of staff

and the registered manager. They told us it was their assumption that this would then be dealt with through the most safe, effective and appropriate channels. We asked if they had alerted the managers to the incidents above. They told us they had.

This meant there was clear evidence of an organisational disconnect between taught policy and day to day practice. It also demonstrated lack of professional responsibility. The provider had not responded appropriately to any reporting or allegation of harm.

**Management of medicines** ✓ Met this standard

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

## Our judgement

The provider was meeting this standard.

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

## Reasons for our judgement

We read the medications policy and discussed this with staff. They told us how medications were prescribed and ordered. Appropriate arrangements were in place for the ordering and supply of medications.

We heard that all staff had been trained in medication administration, and saw records to confirm this. Whilst checking the storage of medications, we noted that the recording of medicines administered lacked organisation and that correct records were not always in place. For example, one medication was listed as having 44 tablets left, but there were only 43 tablets. Initially, the senior member of staff could not establish how this had happened, although eventually found this information on the medication administration sheets. The provider may find it useful to note that appropriate arrangements were not always in place in relation to the safe recording of medicine.

Medicines were stored correctly, however we noted in one case that differently-dated medications were stored together in the same box. This constituted potentially unsafe practice because the medications which expired first may have been used in the wrong order. The provider may find it useful to note that we found one out of date medication that was still being stored and could have been used.

We observed single use disposable medication pots being used for multiple medications and people. The provider may find it useful to note that this meant that there was a risk of cross contamination. The manager told us that disposable cardboard pots had been ordered, but had not yet arrived. These were due to be delivered within the next day.

**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 and experienced staff to meet people's needs and safeguard their safety and welfare at all times.

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

There were not enough skilled and experienced staff to meet people's needs. Staff told us they were constantly stretched to deliver a safe service to people they cared for. They described a long-standing problem with a lack of care staff. They said the manager and senior managers at Southern Health were all aware "but nothing changes."

We discussed this with the manager. She described a "problem with the Southern Health recruitment practice." She said that staff were recruited centrally and that they were then allocated to an appropriate service without necessarily viewing the service first. She described an occasion where one member of staff had started work there, but only stayed one day, as the service was not as they had imagined. The manager told us she hoped recruitment would improve if she was able to interview staff herself, describe the long working hours required, and ensure that potential staff could travel there.

We checked the staff rosters for the previous three months, and the month to come. There were dates where staffing was either inadequate for the requirements of the people who lived there, or inappropriate for the continuing wellbeing of the staff. Staff told us the agency usage was high, and staff sickness was "always high." The manager agreed with both of these statements when directly asked. One member of staff told us that staff were "constantly tired but took all the extra shifts offered by the current vacancies on the roster." We found an episode where a member of care staff had worked eleven out of fourteen shifts. The person responsible for the running and maintenance of the rota told us she had not noticed this.

The care staff told us they were not always enabled to deliver a high standard of care because of long-standing staffing problems. They said they had far too much to do, and this sometimes compromised the safety of the care they could deliver. For example, they described an episode where an elderly person had left the building, unseen and unsupported, whilst the two staff on duty attended to another person. They told us local managers and their employing authority were aware of these issues but "had done nothing useful about them."

A staff member told us "It is impossible to do everything we are asked. If I am cooking lunch, I also have to care for people here, change them, make sure they cannot access cooking food, tell the agency nurse what to do and hope she does it, give medications and try to get on with the cleaning, and try to stop one person disappearing out the front door. Meanwhile, two people sit in the office with the door shut".

We asked where other members of staff were at this time, and were told sometimes there were only two of them on duty, and the other person would be out supporting a resident in the community. This meant that there were not sufficiently robust staffing arrangements in place to deal with foreseeable emergencies. For example, if one staff member was out of the unit, that sometimes left one person to deal with a person who may be experiencing a seizure and therefore require two people to safely help them and administer medication.

We were told that some staff worked fourteen hour shifts, with no break allowed. A senior manager from Southern Health NHS Trust told us that this was satisfactory as "They were paid for fourteen hours, and did not work all of that time."

On the roster for January, we noted that 10 out of 24 staff were allocated to the same training day; this meant there would be an acute shortage of staff available to work. We showed this to the manager who described this as "just not possible to make it work." We asked the person responsible for the rota how this error had occurred. She was not able to tell us, and told us she was unaware of it.

There was a single member of staff on duty in the bungalow on night duty. There were no provisions for obtaining immediate assistance should a person have a seizure or there be another emergency. People who required two members of staff to assist them with their personal care were not offered this support overnight. This meant that both the individual and the staff member were put at risk. Staff told us "it has always been this way."

Staff told us of the difficulties with employing agency staff instead of contracted staff. They said that some agency staff known to the service were very good, but that short term agency staff sometimes lacked appropriate skills and experience. We asked the manager if she thought regular agency staff were able to deliver the same level of care and knowledge as contracted staff. She told us they could. We asked if they were familiar with the Southern Health policies and procedures. She said they were not, and acknowledged that if an incident happened, they would not necessarily know how to deal with it in accordance with local guidance.

One member of staff told us of an incident that had happened in one of the bungalows. The agency member of staff had been asked several times to carry out care for the residents, but that it had not taken place, causing more work and disruption to staff and, crucially, a lack of care delivered to people in a timely manner. An agency care worker had been employed, but did not do as the staff asked her. This caused a great deal of anxiety to the staff, of which the manager and deputy manager were unaware. Whilst they had booked the agency care worker, they had not checked with the unit to ensure that this was working effectively.

During our inspection, the managers spent the majority of their day in their office on the unit and appeared to be unengaged with staff and people there. They appeared unaware of the day to day social transactions, care delivery and difficulties which had arisen.

Other members of staff said that some of the residents became anxious and unsettled if

new staff were in the building. They told us that one resident cried and became distressed, and that another became very angry. The staff who spoke with us were clearly unhappy about this long-standing issue which one described as "never-ending; managers know, and yet nothing changes. They do not seem to care about the residents being unhappy or about us being very tired and fed up." We addressed these concerns with the manager. They acknowledged the difficulty of the situations we described.

**Assessing and monitoring the quality of service provision**

✖ Enforcement action taken

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

## Our judgement

The provider was not meeting this standard.

The provider did not operate an effective system to regularly assess and monitor the quality of service that people receive. The provider did not operate an effective system to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

We have judged that this has a major 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

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service, and others. During our inspection, we identified multiple areas of substantial concern regarding the lack of quality monitoring within the service. Specifically, we found that some issues previously identified to a junior manager had not been acted upon and followed through to completion, even over a prolonged period of months. These issues had not been recognised by the home manager, and had not been followed up at a more senior level. This meant that people being cared for by the service could not be assured that the quality of the service was as good as it should have been. Also, they could not be assured that the lack of quality and follow up had been noted, monitored or addressed. Examples included the lack of timeliness and follow through for personalised equipment, personalised care requirements, and standard ordering of necessary supplies. This was evidence that learning from incidents and investigations had not taken place and as a consequence appropriate changes had not been implemented.

We noted a lack of robust procedures for medication management and clinical care checks, and some evidence of false assurance where systems appeared to have been checked, but had not been. An example of this was the check of care plans. This indicated that all care on them had been carried out, as assessed, yet weights had not been checked regularly and consistently. This error had not been noted by the home manager. This meant that the manager was falsely assured that clinical and procedural checks were in place and audited when no such checks had existed.

Staff told us of poor communication between the care staff and their managers. We asked them for examples. They told us that the manager's preferred communication style was "to write in the communication book, then hurry back to the office and close the door".

Another person told us the manager has said there was an "open door policy" but that had not translated into practice. We asked for a specific example and were told "Staffing, a constant issue, but we are constantly told to get on with it. Staffing again, we tell them agency or unfamiliar staff upsets the people who live here. The manager just looks at staffing numbers, not on the effect it has on the quality of the service. They just don't want to hear what we keep telling them."

We heard of staff working within what they described as "an unfair organisation that threatens us, and doesn't listen to our opinions." We were told that a meeting had been held after a recent internal 'Mock CQC inspection'. The staff we asked were unaware of any action plan arising from this.

We heard of an organisational failure of effective communication and engagement with staff, thus not enabling them to make effective contributions to the delivery of good care to people they knew well. For example, the recently introduced and extended cleaning list had not been discussed with staff, and no indication given as to how they should be enabled to deliver this with no cleaning contractor to help. There was no clear information available from the manager on how this had impacted on the provision of safe and effective care to people who lived there, and who required high impact interventions and treatment. We heard that a senior Southern Health manager had told the staff they had "better pull themselves together or we will not commission this service and it will close". We looked for minutes of this meeting but were unable to find this documented anywhere. However more than one person told us this. We addressed this issue with the senior manager so she was aware of this description.

Staff told us how they wanted to give even better care to their residents, but felt actively prevented from doing so by being asked to undertake non clinical tasks. They told us they felt inadequately supported and that when they raised concerns, these were not minuted in team meetings or otherwise dealt with. One member of staff described their dismay to read minutes of a staff meeting where the manager had described "moaning staff." We checked the minutes to ensure the veracity of this comment. This meant that staff were asked their opinion and views on the quality of the service but their views were not acted upon.

**Records** ✖ Action needed

**People's personal records, including medical records, should be accurate and kept safe and confidential**

## Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not been properly maintained.

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 were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not consistently maintained or stored. This meant that people had been placed at risk of harm.

We had not intended to inspect this outcome, but were so concerned by some of the practices we saw relating to documentation and its' storage that we chose to include it in the inspection.

We asked for specific records relating to incidents, to safeguarding and for day to day unit management. These were not able to be found, in a single case. When we asked the reasons for this, we were told that some of these records did not exist. The manager told us they had not realised these were necessary. It was apparent there was a significant lack of rigour regarding document recording.

We saw that some other records were stored inappropriately, and many documents were left scattered about a desk in the office. The potential impact of this was profound, as care records with updated information were found mixed up in a bundle of assorted roster forms and management data. This meant they could not be found quickly when requested.

People's personal records including medical records were not always accurate and fit for purpose. We noted gaps in notes where weights had not been carried out on the requested time intervals, and supplements had not been fed. There was a lack of a food diary requested by a consultant. This impacted directly upon the quality of the service delivery, and the safety of people who lived there.

**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 activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Care and welfare of people who use services** |
| | **How the regulation was not being met:**<br><br>Proper steps had not been taken to ensure the assessments of needs supported the planning and delivery of care and treatment in a way that was intended to ensure safety and welfare. Regulation 9 (1) (a) (b) (i) and (ii). |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | **Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Safeguarding people who use services from abuse** |
| | **How the regulation was not being met:**<br><br>Suitable arrangements were not in place to safeguard people against the risk of abuse. Reasonable steps were not taken to identify the possibility of abuse and to respond appropriately to potential abuse or allegation of abuse, including acts of neglect or omission. Regulation 11 (1)(a)(b)(3) (d) |
| Regulated activity | Regulation |
| Accommodation for persons who require | **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** |

**This section is primarily information for the provider**

| | |
|---|---|
| nursing or personal care | **Staffing** |
| | **How the regulation was not being met:**<br><br>The registered person had failed to take appropriate steps to ensure that, at all times, there were sufficient numbers of suitably skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22. |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | **Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Records** |
| | **How the regulation was not being met:**<br><br>People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records had not been properly maintained. Regulation 20 |

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 11 March 2014.

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 31 March 2014**<br><br>This action has been taken in relation to: | |
|---|---|
| Regulated activity | Regulation or section of the Act |
| Accommodation for persons who require nursing or personal care | **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Assessing and monitoring the quality of service provision** |
| | **How the regulation was not being met:**<br><br>The registered person had not protected service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems. Regulation 10 (1). |

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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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:

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

### Regulated activity

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

## Glossary of terms we use in this report (continued)

### (Registered) Provider

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

### Regulations

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

### Responsive inspection

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

### Routine inspection

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

### Themed inspection

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

## Contact us

| | |
|---|---|
| Phone: | 03000 616161 |
| Email: | enquiries@cqc.org.uk |
| Write to us at: | Care Quality Commission<br>Citygate<br>Gallowgate<br>Newcastle upon Tyne<br>NE1 4PA |
| Website: | www.cqc.org.uk |

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