Inspection Report

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

Hazeldene House

Romford Road, Pembury, Tunbridge Wells, TN2 4AY

Tel: 01892823018

Date of Inspection: 27 June 2013

Date of Publication: July 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Hazeldene House Ltd
Registered Manager	Ms. Lorraine Cousins
Overview of the service	Hazeldene House is registered to provide residential and nursing care for up to 80 people.
Type of services	Community health care services - Nurses Agency only Care home service with nursing Care home service without nursing Domiciliary care service Supported living service
Regulated activities	Accommodation for persons who require nursing or personal care Nursing care Personal care 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 27 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

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.

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

At the time of our inspection, there were 37 people living in the service. The service was newly built and replaced one that had been on the same site. The first phase of the building of new premises had been completed and could accommodate up to 40 people. When the second phase of building was complete a maximum of 80 people could be accommodated at the service.

We used a number of different methods to help us understand the experiences of people using the service, because people had complex needs which meant they were not able to tell us their experiences. We observed how people spent their time during the day, how staff met their needs and how people communicated and interacted with staff. The registered manager was not on duty during the inspection so we telephoned them shortly afterwards to check on some information and give feedback on the inspection.

We observed that people were given choices about what to do, what to eat and where to spend their time each day. Their preferences and care and support needs were recorded on their care plans which were kept up to date.

People were comfortable in the presence of staff and staff demonstrated a good understanding of people's individual needs. Staff respected that people needed to retain their independence as far as was possible.

Relatives who were visiting told us they were satisfied with the service. A relative said they were ""very happy with the home" and another that their relative was happy living there.

The provider had effective systems in place to regularly assess and monitor the quality of the service. This included asking people and their representatives for their views about it.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

People's privacy, dignity and independence were respected.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and support. People and their relatives had been involved in making decisions and choices about the care people received. The admissions process was managed by the sales coordinator and the registered manager. The sales coordinator provided people, their relatives and health and social care professionals with verbal and written information about the service. If people then expressed an interest in moving in the manager undertook an assessment of the person's needs. The sales coordinator took initial details and sent out a brochure, they showed people around the building and discussed the accommodation they required and the floor they would like to be on. People were invited to visit and spend time at the service before deciding it was suitable for themselves or their relative.

All the people living at the service experienced dementia. People were supported to make their own choices and decisions as far as was possible. Records showed that people were consulted about the service at residents' meetings and individually. For example, they were asked about what meals they liked, what activities they would like to take part in and how they wished to be supported with aspects of their care.

People had tenancy agreements which they or representatives signed, people who had moved from the old service had had assessments of their capacity reviewed. The manager told us that if people had been assessed as unable to make the decision to agree to a tenancy, a representative had needed to be appointed for them to make sure that their interests were protected.

We spent some time observing people on two of the floors. We spent time on one floor before and at lunchtime. We saw that staff were responsive to people's needs, offered them choices and noticed if anyone seemed uncomfortable or in need of attention. They spent time with a person who was feeling unwell and offered them snacks and encouraged

them to drink. There was a set menu and we saw that the lunch provided was the one on the menu. People were offered two choices of main course and dessert, there was a meat and a vegetarian option. People chose what they wanted to eat at the mealtime and staff showed them plated up food if they needed visual information to help them make this choice. Staff said if people did not like either option they would be offered an alternative. People were also offered and served a choice of drinks. A person who needed to wear an apron to protect their clothing was asked by staff if they were happy to wear it and it was only put on after they had agreed. People ate their food independently if they were able to. People had plate guards and cups with handles on if they needed them to help them eat and drink in a dignified manner. We saw that when a person who had started to eat by themselves seemed to be struggling with this, staff offered to assist them. They did so in a way that did not undermine the effort the person had made. A person who needed to have a pureed diet was provided with their meal set out with the different food components separately displayed on the plate. This respected that they needed food to be well presented to promote appetite and good nutrition. The member of staff who assisted the person to eat gave them plenty of time and encouragement to do so.

The meal was taken in calm and unhurried atmosphere and. people ate at their own pace. Those who were slower at eating were not rushed and staff stayed with them to help if necessary. Staff said that mealtimes were flexible and if people did not wish to eat at set mealtimes they could have a meal when they liked. When we arrived we saw two people who were on different floors having a later breakfast as this was their choice.

We also observed that staff involved people when they were physically supporting them and explained what they were doing. For example when hoisting a person and assisting a person to rise from a chair to go to the lunch table.

People were supported in promoting their independence and community involvement. Care plans recorded the areas in which people were able to be independent and we observed that staff encouraged people to maintain their independence skills. For example, with eating and mobilising. The service had links with the local community; a local scout group had visited to sing carols at Christmas. During the inspection a person was visited by a befriender from a voluntary organisation and there were links with a local school.

People's privacy and dignity were respected. We saw that staff knocked on people's doors before entering and when supporting people explained clearly to them what they were doing. A person told us that staff never entered their room before knocking and asking if they could come in. We observed that when staff had supported people to locate the toilet they stayed close by but did not intrude upon people who could manage independently.

Staff attended Mental Capacity Act training so that they knew what action to take if people needed support with making significant decisions about their care or support. The manager told us that a small number of people had the capacity to make all their own decisions. Staff liaised with relatives, health and social care professionals if a significant decision was needed about the care or support of a person who lacked capacity. We saw examples of documents held on care plans that had been signed by relatives in respect of the care or support people needed.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People's needs were assessed and care, treatment and support was planned and delivered in line with their individual care plan.

The manager had undertaken needs assessments for people before they were offered a place at Hazeldene House, to make sure that it could meet their needs. People's records contained assessment documents and a visitor confirmed that an assessment of their relative's needs had taken place.

We looked at nine people's care plans and saw that they included information about all areas of their daily lives and the support they needed. People's choices and preferences about how they liked to be supported were recorded and there was information about their interests and social needs. We saw that care plans were reviewed each month and updated to reflect any change in needs. Staff we spoke with were knowledgeable about people's needs. For example, one person's care plan said they sometimes needed to use a standing hoist. Staff were able to describe occasions when this might be needed and when the person was able to manage independently.

The information in care plans was held on computer, senior staff reviewed it monthly and people's keyworkers updated daily information. Care plans were printed off each month and kept in a file for staff to refer to. The information was available on line for people's relatives to access. Where people were assessed as having capacity to give permission for their own relatives to see the information this was recorded. We saw evidence that relatives were asked to check that care plan information was accurate and up to date and that they had had agreed to what was written.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw that care plans contained risk assessments that were regularly reviewed and updated. For example, mobility assessments were completed that identified any specialist walking aids and the support people required from staff to move about the home safely.

We spent some time observing people in a lounge before lunch. We saw that staff were

observant and there was always at least one member of staff in or near to the lounges. During the observation period people in one lounge were watching television, reading a paper, watching staff, having drinks and relaxing or dozing. Staff spoke with and checked on each of the people in the lounge at least once and gave additional attention to a person who was feeling unwell. They asked a person who was leaning to one side in their lounge chair if they would like a cushion under their arm to stabilise them, and provided it when the person accepted. They offered drinks throughout the period and made fresh drinks if those people had had gone cold. Staff brought round a tray with a choice of two cold drinks and showed them to people so they could choose what they would like. Staff assisted people to drink if necessary. Staff spoke to people in a kind and caring manner and placed themselves at people's level if people were sitting so they were not talking down to them. A member of staff spent time talking with a person about the weather and other subjects that interested the person. We saw a member of staff remind a person that they should be wearing their glasses when watching television and cleaned the glasses after asking the person if they would like this done. The person was then happy to wear them.

Each person had been supported to make their own life story book and scrap book. The scrap books contained pictures of events and activities at the service that they had been involved in. The life story books included information such as family trees, photographs of people throughout their lives, such as at school or their wedding, photographs of houses they had lived in, pets and relatives. Staff said they looked at and talked about the books with people and that people enjoyed doing this.

People were supported to see health professionals when they needed to. Records showed that people saw health professionals such as G.P's, opticians, speech and language therapists and hospital specialists when they needed to. A GP visited the service each week, people could ask to see the GP and the home requested the GP see anyone they were concerned about.

The service checked that people were receiving sufficient nutrition and liquids. When people moved in the amounts they ate and drank and their weight was monitored. Staff continued to monitor these amounts until they were satisfied the person was maintaining a stable weight and having sufficient to eat and drink. They re-introduced the monitoring for people if, at a later date, the person were assessed as being at risk of not eating or drinking enough. We saw that the food and fluid charts used were completed in detail to include actual amounts of foods and fluids taken and were audited by senior staff.

People were provided with activities they could take part in at home or in the community. The service employed one full time and two part time activities coordinators. The manager said that when the building was complete they hoped to employ a fulltime coordinator for each floor. The full time activities co coordinator was not on duty during the inspection but we saw that a planned activity took place during the afternoon and during the morning staff spent time individually with people and chatted with them. For example, one person spent some time reminiscing with a staff member about an interest they had had in the past and another person chatted with staff about what was on television.

Information about outings and activities available was on display on each floor. Most of the information was in text and pictures to make it accessible to people and staff said people were also informed verbally about activities. There were photographs on display of outings that had taken place and been enjoyed by people. Regular outings took place, a river boat trip was planned and an outing to a nature reserve had taken place the previous week.

Staff said that usually it was possible to accommodate the number of people who wished to go on outings but this could depend on how many people who used wheelchairs went, as a member of staff was needed to push each wheelchair. A strawberries and cream tea was planned for people and relatives the following week as Wimbledon was underway, and special events had taken place to celebrate dates in the calendar such as mothering Sunday. Activities at home included singing, exercise and art sessions. There were pictures on display that people had painted and some vegetable plants being grown by people on windowsills that were to be planted outside by people. During the afternoon an outside musical entertainer "the singing cowboy" performed for people. We saw the session was well attended, people were enjoying it and engaging at a level they were comfortable with. A record was kept of the activities people took part in and their level of participation.

There was limited use of the garden and grounds for people due the construction work taking place. Staff supported people to go out for walks in areas of the grounds that were safe to access if they wished to, and one floor had an outdoor balcony area which had been used for meals and activities in fine weather. Staff told us people had enjoyed using it when the opportunity had arisen.

There were arrangements in place to deal with foreseeable emergencies. Gaps in the rota were filled by staff that people were familiar with from another of the provider's services, by staff employed on a flexible basis or by permanent staff. This made sure that continuity of care was provided and agency staff were never used.

Records showed that regular fire practices took place. An unplanned fire evacuation was recorded as having taken place the day before the inspection. This was in response to the fire alarm having been set off by mistake by a visitor to the building. Records showed that the evacuation of the building had gone to plan.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The home had a medication policy and procedure in place to provide guidance for staff regarding the safe management of medicines. Most of the time only nursing staff administered medicines; care staff who had had completed medicine administration training could undertake this task as well if necessary.

Appropriate arrangements were in place in relation to obtaining medicines. A pharmacy supplied the home with medicines and there was a process in place for the ordering of people's medicines on a regular basis. Most medicines were dispensed by the pharmacist in monitored dosage systems (MDS), to reduce the need for storing more medication in the home than was needed. The service had a pharmacy room on two of the accommodation floors. We saw that medicines were safely stored in the rooms and the temperatures of the rooms were monitored and recorded to make sure medicines were kept at the correct temperature. The temperatures of medicine fridges were also monitored. Records showed that procedures were in place to record when medicines were received by the service, when they were given to people and when they were removed from the service.

Medicines were safely administered. We looked at some medicine recording charts and saw that staff had signed them to confirm the time, the dose and the quantities of each medicine given. Some people had been prescribed medicines that were unsuitable to be administered using the monitored dosage system. We saw that these medicines were kept individually in their original pharmacy packages and medicine charts had been written up to show when and it what quantity they were to be taken.

Records were maintained of the running balances of medicines. However, the provider may like to note that we found that for a medicine that one person took in two different doses the balances did not match the actual amounts remaining in both packets. There were fewer doses in the packets than stated in the up to date running balance sheet. The person's medicine record sheet showed the person to have been administered the correct stated dose but it was not possible to establish if the reason for the missing doses.

We spoke with the manager shortly after the inspection who explained they had

investigated the discrepancy and found it had had occurred as the person had moved floors recently. The correct amounts of the medicines as recorded had not been transferred between staff on the different floors. The manager told us this was being addressed by additional medicines auditing and staff supervision.

We saw that some medicines had been prescribed for people who only needed to take them 'when required'. A procedure had been put in place to identify the reason they had been prescribed and what they might be needed for.

We observed a registered nurse administering medicines during part of the the lunchtime medicine round. We saw that they explained to people what they were giving them and made sure that people had drinks to help them with swallowing medicines. Where a person's care plan stated that they needed a full glass of drink to help them with this we saw the person was provided with one. They made sure that whilst they were with people administering their medicines the medicines trolley was locked and safely secured it in the pharmacy after the round.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.
The service was provided in new purpose built premises that had been specifically planned and designed to be suitable for people who had dementia and who were physically frail or who needed nursing care. It replaced an older service which had occupied the same site and had been demolished. The new service was partially under construction. The first phase of the new building was completed in November 2012 when people who had then lived the old service moved in. The accommodation was provided over three levels, the ground, lower ground and first floor. A basement level contained the kitchen, laundry and areas for staff to use, such as changing rooms. The laundry was well ordered and clean with facilities for washing soiled laundry. Clothes were labelled and when laundered placed in named baskets on a trolleys for each floor so they returned to the right people.

The reception area on the ground floor was welcoming and spacious with a seating area where people could sit with visitors and facilities for making drinks. The building was light and airy with plenty of room for people to safely walk around if they wished to. Corridors were free from any obstructions that might make them unsafe for people. Staff and the manager said that since moving to the new building people had become more mobile and active and spent more time socialising with others and less time in their rooms. We spent some time on each floor and saw that people were spending time watching television, reading papers chatting with other people or relaxing. People accessed their rooms if they wished to.

We looked at some care suites on each floor. Each person's door had their room number, their name and either a photograph or other picture on it to help them find their rooms. Doors were painted different colours to help people identify them. Each suite had a bedroom area, a dining area, an en suite shower and toilet and a kitchenette which was well equipped. The kitchenettes included fridges so people who were assessed as safe to do so and visitors could make drinks and snacks in their own rooms. The rooms were personalised with people's personal items such as ornaments, family photographs and plants and were all well-furnished and decorated. There were no unpleasant odours in the

rooms we looked at or throughout the whole building and the service was clean throughout.

The provider may wish to note that apart from individual photographs or pictures on people's doors, there was little in the way of other signage or pictorial information to help people find their way around each floor. One floor did have a board up showing the date and month, what day of the week it was and the weather. The toilets and bathrooms were all identified by written signs although there were no pictures of what the rooms were used for to help people identify them. In addition, whilst the first floor had blue carpets and a blue colour scheme in the lounge; the other two floors were identically carpeted in red and had the same colour scheme in the lounges. This meant that people who liked to visit different floors could have had difficulty orientating themselves. On all the floors, all the walls in the corridors were painted the same colour, which could have made it difficult for people to find which corridor their room was in. We observed a member of staff helping a person who seemed to be lost on one floor find where they wanted to go. A member of staff said in relation to the corridors "Some people do get a bit confused".

We looked round the building and saw that as well as the individual care suites each floor had a shared lounge and dining area with a kitchenette, an additional quiet seating area, an assisted bathroom and a station for staff leading off the lounge. Floors also each had an assisted bathroom, toilets and a sluice room. Staff served drinks and hot and cold snacks from the kitchenette during the day and we saw that they prepared breakfast there for people who had chosen to eat their breakfast later than others, or to get up later in the morning. The first floor accommodated a well-equipped hair dressing salon which also had an area where people could have manicures.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at five staff files; these included the files of nursing and care staff. The files were well set out and we saw that there was an effective recruitment and selection process in place to make sure that staff were safe to work with vulnerable people.

We saw that appropriate checks had been undertaken on prospective staff to make sure that they were safe to work with vulnerable people. The checks included proof of identity, depending upon when people had applied, a disclosure and barring service (DBS) check or a CRB (criminal records bureau) check, an application form with a full employment history, at least two references and for registered nurses, proof that their nursing registration had been kept up to date. Proof of permission to reside in the UK was in place on the files we looked at of staff who had moved from other countries. Staff files also contained interview records, employment contracts and evidence that they received supervision.
Staff we spoke with said that they had received an induction when they started working at the service and that they received the training they needed to equip them for their roles. We saw an example of an induction workbook; the staff member had been signed off by the manager as being competent at the end of their induction. Staff said that they had shadowed experienced staff as part of their induction until they felt confident to work alone. Staff confirmed that they received essential training and training on subjects that helped them understand people's specific needs. For example, a local hospice had provided end of life care training recently. We saw that a list of essential and other training already held and due this year on display. Training was tracked on a computer data base which was monitored to make sure training was all up to date.

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

The service employed a registered manager, a senior team leader, a senior carer, nursing staff, care staff, activities and housekeeping and administration staff. During the inspection the senior team leader was in charge of the service as the registered manager was not on duty that day. One registered nurse, two care team leaders and five care staff were on duty during the day. Due to staff sickness some cover had needed to be sought at short notice and had been provided by staff familiar to people. We looked at the rota and saw that it reflected that the ratio of staffing that was on duty during the day time, and that four waking staff were on duty at night. There were sufficient staff on duty to meet the needs of the number of people living at the service.

Staff told us they felt well supported and they received regular recorded supervision; we also saw that group supervisions took place and were recorded. Regular staff meetings were held. We looked at the notes of a staff meeting and saw that it had included health and safety, safeguarding and staffing topics as well as discussion about care planning and people's needs.

We observed that staff were friendly and caring and responded promptly if people needed attention. We saw that staff spent a considerable amount of time with a person who was unwell and with their relative who was visiting. They gave this attention in a calm and unobtrusive way to reassure the person and relative.

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 received.

Reasons for our judgement

The home had systems in place to assess and monitor the quality of the service it provided. People were asked for their views individually and at residents and relative's meetings and customer satisfaction surveys took place. We looked at the notes from the resident's and relative's meeting that had taken place in March 2013, people had been consulted about menus, activities and entertainment and given information about the progress of the construction work.

The provider had commissioned an external survey of relatives which had been completed in February 2013. The collated results showed that overall people were satisfied with the service, although they had raised some issues regarding parking and the temporary lack of usable outdoor space due to the building work. Where they raised other issues action had been taken to address them. For example, a review of the teatime menu to offer more variety.

The manager told us that an external compliance consultant tracked some documentation and records kept by the service to make sure that they were correctly completed and kept up to date. This included making sure that training was up to date and renewed when it needed to be, that staff supervisions took place regularly and that weekly reports by senior staff were completed when they should be. Staff confirmed that this information was relayed to the manager who reminded them of when they needed to update training.

The service offered the opportunity for people's relatives and representatives to meet together. This year the manager had introduced a family support group held every two months so that relatives and friends could meet and discuss aspects of supporting people with dementia. There were plans to have guest speakers at the meetings that worked in the field of dementia and staff said that meetings so far had been appreciated by the relatives who had attended.

People and their representatives also received information in a colourful quarterly newsletter which told them about activities, relatives meetings, progress on building work and other news about the service.

A visiting relative told us that they were "very happy with the home" and staff were good at communicating with them if there were any concerns or matters they needed to know about.

Records were kept to identify any incidents or accidents that happened, for example, any falls that people had. This meant that the manager could track any trends that might mean people needed additional support or a review of their needs. Notifications we had been sent and records showed that if people experienced a fall in their own room, the room was checked for any hazards.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We saw that people's care records contained details about who had been involved in their care, including how healthcare professionals and clinicians had been involved in supporting people's healthcare needs at appropriate times.

Internal audits took place; we saw that medicines audits, environmental audits, care plan and health and safety audits took place. Equipment was serviced when it needed to be to make sure it was safe to use and essential maintenance work took place.

Fire procedures were kept under review and the fire action plan and fire safety risk assessment had both been updated in October 2012. Fire drills took place regularly the most recent were on 6th and 26th of June 2013, the results of both drills were recorded as being satisfactory.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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