Care Quality Commission

Inspection Report

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

Castlewood

North Somerset Community Partnership,
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Tel: 01275546801

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

Standard		Outcome
Respecting and involving people who use services	✓	Met this standard
Care and welfare of people who use services	✓	Met this standard
Cooperating with other providers	✓	Met this standard
Safeguarding people who use services from abuse	✓	Met this standard
Cleanliness and infection control	✓	Met this standard
Requirements relating to workers	✓	Met this standard
Supporting workers	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	North Somerset Community Partnership CIC
Registered Managers	Mrs. Thelma Howell Mrs. Helen Mee
Overview of the service	North Somerset Community Partnership is registered to provide NHS Primary Care service to the people of North Somerset.
Type of services	Community healthcare service Diagnostic and/or screening service Community based services for people with a learning disability Rehabilitation services Urgent care services
Regulated activities	Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury

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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 4 February 2013 and 5 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We sent a questionnaire to people who use the service, talked with people who use the service, talked with carers and / or family members and talked with staff. We reviewed information we asked the provider to send to us, reviewed information sent to us by other authorities, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with other authorities. We talked with local groups of people in the community or voluntary sector.

What people told us and what we found

North Somerset Community Partnership (NSCP) provided a wide variety of community NHS services across the county. During the inspection we looked at the service provision, across the county and several specialist services such as the learning disability, diabetes pulmonary rehabilitation teams and the community teams and wards.

All the people we spoke with told us the staff had treated them with dignity and respect and they were very kind and helpful to them.

People we spoke with told us they could express their views. They told us they were given appropriate information and involved in making decisions about their care and treatment. Staff told us, and we observed, times of visits were planned with people to be mutually convenient.

We spoke with 20 people who used the service, 10 relatives, 26 staff and four professional colleagues from other agencies. All these people told us NSCP provided an excellent service. One person told us "I couldn't fault them". While one professional told us "they work well with us and information sharing is good".

People were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We saw the provider had systems in place to monitor and review the quality of the service they provided.

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 privacy and dignity were respected.

Reasons for our judgement

People we spoke with told us they were happy with the service North Somerset Community Partnership (NSCP) provided. We spoke with people who received a service from the many and varied specialist teams, who provided care to people in their own homes or community healthcare settings.

Two people told us, they had received care since the organisations inception and considered the staff as friends. One person commenting on the staff told us, "the staff all treat me well". While another person told us "we are on first name terms but they did ask first".

People who used the service had varied needs, with some people's needs being very complex and other's having communication and memory difficulties.

All 20 people we spoke with told us they were treated with respect and dignity and felt involved in decisions about their care and treatment. This meant people were asked for feedback and were enabled to influence and make choices about the service provided.

We observed care being given to 10 people all with very differing needs. We saw community staff interacted with people who used the service in a friendly, respectful and informative way. We saw people were treated with respect and dignity, for example, staff were observed to make good eye contact and used touch to reassure people. We observed staff addressed people in the way they preferred, and were careful to explain what they were doing, and why, at all times. People we spoke with said they felt well informed, involved, and consulted.

We heard staff offer choices and encourage people to make decisions in relation to their care and treatment. We saw patient's consent to treatment was documented in their notes. Community staff said that consent to care and treatment was a frequently re-visited reference point in their work. Three relatives told us "the staff are brilliant and always keep me informed about my relative." Another person and their family told us that the positive contact we observed was typical of their experience of the community staff,

We saw people were asked for their feedback at the end of a visit by the tissue viability service and also the Disabled Adults Rehabilitation and Resources team (DARRT). We were shown patient satisfaction surveys that had been completed and analysed for the pulmonary rehabilitation team which showed 89% of people rated their overall experience as very good or excellent. In the DARRT survey 83% of people rated their overall experience as very good or excellent.

The staff told us they were able to obtain interpreters through 'language line' (which is a telephone interpreting service), or written information, for people whose first language is not English.

We saw the community learning disability team's website provided comprehensive information about the services offered, and was presented using accessible language and symbols.

We observed the various teams collected information about the 'protected characteristics' in relation to meeting the equality and diversity needs of people who used their services. This meant they could better plan to meet the present and future diverse community and individual needs.

The learning disability team had reflected on the characteristics of its patients against the needs of minority communities. It had recognised that referrals from black and minority ethnic communities were too low in relation to the known characteristics of local populations. This meant that people's diverse needs were appropriately met by the varied teams across the county.

Staff working with people with a learning disability told us they were comfortable working with people who may lack the mental capacity to take decisions.

All 26 staff spoken with demonstrated they had received training in, and were familiar with the requirements of the Code of Practice to the Mental Capacity Act 2005. Some Community staff had a less detailed understanding of the requirements, but told us they could, and did, call on support from lead specialist nurses. This meant that people's rights and consent to care and treatment were respected and protected to ensure care planning and delivery met people's needs and protected them against the risks of unsafe or inappropriate care.

New approaches to 'telehealth' services were being piloted by community teams. For example: people with certain health conditions enter and send information about their blood pressure and pulse into tablet computers for review at NSCP offices. We were told early results from the pilot suggested that involving people in their care in this way had encouraged continued independence. They told us this form of health care reduced anxiety, while also reducing the demand for physical contact with NSCP staff.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

All 20 people who used the service, 10 relatives and 26 staff we spoke with felt the service provided excellent care to people. They were very enthusiastic about the good care provided.

We looked at service provision across the county and across the spectrum of specialist services provided by North Somerset Community Partnership (NSCP).

We looked at examples of care records in all areas inspected and saw the referral, assessment, care planning and delivery of care was well documented. The specialist services used clearly defined referral criteria to admit patients to the care of their service. This referral information was used to plan care and ensure that relevant colleagues were appropriately involved.

People we spoke with who used the services told us "they arranged a visit and took a long time to talk about everything. I now feel much more informed about what's wrong and what to do". Another person told us "they helped me with my inhaler technique and it works much better now". While the third told us "they provide a very good service and responded well when I had problems".

All care records seen were written using an approach designed to promote safe practice through separate recording of opinion, facts, analysis and planning. This approach promoted evidence-based practice while enabling appropriate reflection about more complicated issues. This meant care and treatment across all areas was planned and delivered in a way that ensured people's safety and welfare.

We tracked the care of people through discussion with individuals and care records. Two people we spoke with told us "they are very thorough; I can't fault them". Another person described the referral process. They had been contacted by the team on one day and visited the next day. Equipment was provided that same day and the person taught how to use it. They told us "the staff are all brilliant and so quick and helpful". This was confirmed in the care records seen.

The community team for people with learning disabilities took great care to build a

comprehensive picture of people's needs to underpin the delivery of services. The team was conscious that thresholds for access to children's and adult's services were different. This meant that some people who were being seen by the adolescent services no longer received a service on reaching 18 years of age. This was due to the different criteria for access to adult services. The provider might find it useful to note the team is unable to engage with people before they reach 18 years. The service told us it had not been commissioned to engage in transition arrangements with children and young people before they become adults.
The paediatric diabetes nurse specialist told us they had an essential list of topics which they discussed with a person and their family on diagnosis, and showed us a copy. They told us families were asked to sign next to each topic to confirm they had received the training and understood the content. This meant staff were sure they had understood the management of diabetes to maintain their child's health. One person told us they were concerned about the transition to adult services as no arrangements had been discussed. They said "the care has been absolutely fantastic".

The various nurse specialists told us about the referral criteria for their services. We looked at examples of the referral forms and saw they had been assessed quickly and people had received an assessment visit within the specified timescale. All specialists emphasised the importance of ongoing assessment at every visit, and including other professionals as needed.

Staff in the specialist teams we visited told us about the care pathways they had developed for their service. For example the diabetes nurse specialists told us about their integrated diabetes care pathway based on national guidance. This meant that appropriate information sharing about a person's condition was shared with other professionals to ensure safe care for people where more than one professional was involved.
We spoke with one person who used the tissue viability service. They told us "it's an excellent service". They said everyone was very caring, and their nurse was very experienced.

The specialist nurses and Disabled Adults Rehabilitation and Resources Team (DARRT) told us there was no difficulty getting the equipment that people needed for their treatment, within 24 hours. They told us more specialist equipment would take longer, but they worked with the person to find a "best fit" in the interim.

The specialist nurse told us they had recently focussed on reducing the incidence of pressure ulcers. They described the work done to raise awareness of the action required to prevent pressure ulcers. They told us this had led to an increased demand for equipment such as special mattresses and cushions. The specialist nurse was confident there was a high level commitment to investing in equipment for people's care.

During the inspection we visited the Bladder and Bowel service and focused on the service provided to children and young people. The staff told us they followed the published National Institute of Clinical health and Excellence (NICE) guidelines in their service provision.

The provider might like to note we were told children and young people were being seen in adult clinics. This, together with the staff not being trained paediatric nurses, could impact on appropriate care provision. The staff told us they had received training from the product company about the care of children who used their product.

We spoke with two parents of children who used the service. Both told us the staff used appropriate child friendly language and gave good explanations which the children understood. However they reported a lack of written information or guidance to helpful websites. They told us the service had helped their children and improved their quality of life.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We observed specialist services worked well with other providers of care, both within and outside North Somerset Community Partnership (NSCP). They told us this was central to the care they provided. We saw many examples of good communication with colleagues across the services we visited, and staff told us this was key to good care provision.

The community learning disability team was aware of national evidence that people with a learning disability were at risk of failures to recognise and promote their health care needs. The team was made up of members from three organisations; NSCP, the local authority's social services department, and Bristol. We saw good evidence from files, and heard from staff, that the contributing agencies and individual team members worked hard to mitigate the problems of working across three different sets of agency systems and procedures.

The learning disability team supported local providers with advice and guidance about good practice. For example: in relation to the Mental Capacity Act 2005 and the deprivation of liberty safeguards.

The community ward teams told us of a number of examples of good co-operation across these teams, including in relation to safeguarding practice. This ensured people's health and welfare were protected through appropriate information sharing.

We were told about regular community ward staff meetings with colleagues in the social services department, designed to discuss new and existing mutual cases. We saw community ward staff played their part in integrated care arrangements.

We were told of communication problems in relation to some hospital discharges that had led to action to improve outcomes for people. Where problems were experienced in relation to discharge arrangements the circumstances were detailed and analysed by planning staff. We saw examples of lessons learned that had been shared with relevant staff for the benefit of people who used the service. Staff told us they met regularly with staff from local NHS trusts, community teams and the ambulance service to consider particular barriers to good outcomes for people, and how they could be overcome.

The nurse specialists told us, and we saw, pathways for patients with their particular speciality had been developed to ensure good information sharing across all professionals and care services. For example we saw all people who used insulin had an insulin passport, which contained vital information if they were going into hospital.

The diabetes nurse specialists told us they worked closely with their counterparts in the three local acute hospitals, and had a good relationship with the medical teams there. The diabetes nurse specialists told us they sometimes saw patients jointly with the GP and practice nurse, and also facilitated patient groups with a dietician.

All staff we spoke with told us they felt integrated working was well established. We spoke to a patient who confirmed they had seen the diabetes nurse specialist with a dietician, and said they felt communication with other professionals was good. The provider might find it useful to note that transition arrangements and communication for children and young people to adult services were very limited.

We looked at seven people's notes and saw that relevant information from other services was available and had been used in their assessment, care planning and delivery. We also saw detailed referral letters to other services, and updating other health professionals, including the patient's GP and consultant.

We asked all 10 people we spoke with if they felt communication with other providers was effective. They told us they felt the various agencies all worked well together and had no concerns.

We saw there was a "single point of access team" which provided one contact point for people needing to access a wide range of health and social care community services in the area. The manager told us the team structure supported them to work closely with social care colleagues and other health professionals.

We spoke with four healthcare professionals from outside of NSCP who told us they worked well with community nurses and that communication was good with all NSCP staff.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We saw North Somerset Community Partnership (NSCP) had a safeguarding and a whistle blowing policy. These provided staff with clear guidance for the protection of people who used the service.

The policies contained contact details for the local authority safeguarding team and information about how to escalate concerns, if staff did not feel they were being addressed either appropriately or in a timely way. The policies contained a flowchart of what to do if abuse was suspected for both a child and a vulnerable adult. In the whistle blowing policy we saw clear guidance for staff about how to report whistle blowing concerns.

All 26 members of staff we spoke with told us they were aware of the policies. They demonstrated good knowledge and understanding of the forms abuse can take. All staff were clear about their role and responsibilities in such situations. Staff told us they would not hesitate to use the whistle blowing policy if they identified poor practice, either from within NSCP services or from other professionals.

We saw training records which showed 79% of staff had completed their safeguarding training. This demonstrated staff in all departments had a good awareness of how to protect people from abuse and ensure their human rights were respected.

The registered manager told us there had not been any allegations of abuse made to, or reported by, the service.

All of these measures meant people were protected from the risk of abuse, and staff were aware of how to report any concerns regarding their safety.

Cleanliness and infection control ✔ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We accompanied a variety of staff visiting people in their own homes. All staff we observed demonstrated a good understanding and adherence to good hygiene and prevention of infection practices. This included hand washing, the appropriate use of alcohol hand gel at all relevant times and careful handling and storage of clinical waste.

We observed staff used appropriate personal protective equipment such as aprons and gloves. Staff told us they were aware of the policy about waste management and were able to describe the disposal of different forms of clinical waste. We saw appropriate sharps containers were taken to the homes, where necessary, and observed the diabetes nurse specialists giving advice to people about the safe disposal of sharps.

All staff we spoke with knew the name of the lead person for infection control. They told us mandatory training in infection prevention and control had been provided by this person. Nursing staff told us they had been trained and competency assessed in the aseptic, non-touch, technique to minimise the potential spread of infection when redressing wounds.

We saw training records which showed 85% of staff had received infection control training within the last 12 months. We were shown the induction programme for new staff which included training about the prevention and control of the spread of infection. This demonstrated staff in all departments had a good awareness of how to protect people from the spread of infection.

Staff told us they were kept up to date with current research and best practice guidelines in infection prevention and control. They said the infection control lead person circulated important documents to all teams and issues were discussed at meetings. This meant staff implemented the latest good practice guidance for the benefit of people who used the service.

All people we spoke with told us the staff were very thorough about washing their hands and used protective equipment. One comment was "the nurse is always very particular about infection control".

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.

There were effective recruitment and selection processes in place. Appropriate checks were undertaken before staff began work.

Reasons for our judgement

We reviewed this outcome to check up on the recruitment practices in the North Somerset Community Partnership (NSCP). In June 2012 during the Safeguarding and Looked after Children's inspection we found not all appropriate checks were undertaken before staff commenced work, to ensure the protection of people who used the service.

We spoke with the Human Resources (HR) manager who described the actions that had been taken to address the shortfalls identified in June 2012. We saw departmental managers and personnel recruitment staff had received training in safer recruitment practices, to ensure people were protected by appropriately recruited staff. The HR manager showed us effective recruitment and selection processes were now in place.

We reviewed seven personnel files of staff, across the different professional disciplines within NSCP who had been recruited recently. We saw all appropriate checks had been undertaken before the staff began work. This meant the safety and well being of people who used the service was protected.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

All 26 staff spoken with confirmed they had regular meetings with their immediate managers. They told us managers were approachable. Staff said they were satisfied with the support arrangements in relation to both employment issues and professional practice. All staff told us they had regular one to one meetings with their manager and received clinical support and supervision.

We looked at staff records and saw that annual appraisals had been carried out. Staff told us they felt "valued" and "listened to" in the organisation, and that communication across the organisation was good. One member of staff said their manager was "brilliant".

Staff confirmed they were given appropriate opportunities to undertake training and continuous professional development. This meant they were enabled to meet the requirements of regulatory bodies for example the Nursing and Midwifery Council and the Health and Care Professions Council. All specialist staff were able to give examples of study days and conferences they had attended recently or had booked. Some staff were undertaking postgraduate courses in their specialist area.

Specialist staff told us they received a lot of support from specialist colleagues in the south west region. They told us they were part of local and national networks of colleagues from other trusts working in their specialty. This meant staff maintained their expertise and knowledge of the latest research and best practice guidelines. It also demonstrated they were well supported to deliver safe care and treatment to an appropriate standard for the safety and well being of people who used the service.

Team managers and other senior staff across the various teams in NSCP showed us evidence staff had undertaken all mandatory training and additional courses specific to their professional roles and practice. We saw the computer reporting systems which identified staff who had not attended training or undertaken the e learning or were in need of update training.

We looked at staff training records and saw these were up to date for each person. They showed that all statutory training, which included training in fire safety at work, infection control, manual handling and basic and intermediate life support, had been completed and

dates booked for training in 2013.
We were told staff had also been trained in safeguarding children and vulnerable adults and how to recognise signs of possible abuse. All staff we spoke with confirmed they had received this training.

Staff told us there was access to a wide range of external training opportunities in addition to the mandatory training. Community ward staff showed us they each have a 'training passport' which identified courses attended. This meant people were being cared for by suitably trained staff.

Members of all teams confirmed that in addition to good personal training and management, they felt well supported by knowledgeable colleagues. We saw several examples of up to date appraisals. We saw computer database evidence that appraisal and training requirements across the teams were up to date. All members of staff spoken with confirmed this information.

Training in 'whistle blowing' procedures was incorporated into safeguarding courses. The provider might find it useful to note that some community ward staff we spoke with were unsure about the detailed difference between abuse alerting and whistle blowing. Staff's commitment to drawing attention to any poor practice they came across was clear but in some cases lacked detailed understanding of people's employment rights under the Public Interest Disclosure Act 1998.

We visited the training department and talked with the staff responsible for ensuring all staff in NSCP were offered and attended training. We were told about, and shown, the managed learning environment where staff completed all e learning. We saw it had a test at the end of the learning to ensure staff had understood and retained the learning for application in practice.

Staff confirmed they had access to up to date training. All 26 people we spoken with told us they were confident in the competence and expertise of the staff across the teams.

The tissue viability nurse specialist told us they undertook regular training with the community link nurses who took the lead for tissue viability issues in their team areas. She showed us a resource pack that had been developed to support the link nurses in their work.

The tissue viability nurse also told us they carried out annual competency assessments of community link nurses against a detailed framework. This ensured staff had good skills and knowledge in the treatment of leg ulcers, pressure ulcers and wound care. It meant community teams had a good resource that was easily accessible. This ensured people who used the service were protected from potential skin, and wound, break down.

All 26 members of staff spoken with were enthusiastic about learning and improving their skills to ensure safe and appropriate care provision to people who used the service.

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 provider had effective systems in place to monitor the service provided. There was an annual schedule of audits which monitored the quality of the service and highlighted where improvements were needed. We saw copies of audits undertaken and progress reports on meeting shortfalls that had been identified. This demonstrated the service addressed issues that had been highlighted through audits.

All people spoken with told us the various staff always asked for feedback about their visits or service provision. People told us they were "very happy with the care given" and "I am always telling them how good they are". Other people told us the staff had good knowledge and skills in their specialist areas.

We saw significant evidence that North Somerset Community Partnership (NSCP) used a variety of processes, and sources of information, to assess the quality and safety of its service.

We were told, and saw that, NSCP sent regular patient satisfaction surveys to people who used their services. The results were obtained from a sample of people suggested by local teams. People we spoke with confirmed they received patient satisfaction surveys which asked for their views of the service.

Two people we spoke with told us they had received a questionnaire about the service that week. They told us their response was "it's all excellent". Another person we spoke with told us if they had any concerns they would feel able to raise them. However they said they had experienced "absolutely no problems".

We observed a 'working together for change' group made up of people who used the service, learning disability team members, advocates, family members and NSCP managers. We observed professionals in the group listened actively to suggestions made. We saw there was a commitment to involving people in service level, as well as individual, planning. We observed people worked to ensure that information received was accurate and appropriate. For example, the team had gathered information about day services. The provider might find it useful to note this suggested improvement was needed to achieve a

more personalised service for people.

We saw minutes of regular multi disciplinary clinical governance meetings and their quarterly reports. These reports demonstrated that incidents and audits were discussed to identify where lessons could be learned to improve practice.

All staff we spoke with were aware of how to report an incident. Some staff told us they were routinely involved in investigation of incidents and identification of lessons learned. We were told by the managers that any lessons learned were incorporated into policies and procedures. They told us new policies and procedures were highlighted to staff and each member of staff was expected to read and sign new policies. We saw evidence of this in some team areas. This ensured staff were aware of any changes to practice.

We were given lots of examples of learning in practice across all the team areas. The tissue viability nurse told us she had expanded the number and locations of clinics she held in response to feedback from people, who said they wanted to be able to access treatment closer to their homes.

The tissue viability nurse also showed us analysis of the investigation reports into serious incidents involving pressure ulcers. They identified a common issue was that staff were not always following the relevant policy. In response they developed an audit tool and a number of Standard Operating Procedures (SOP) to be used depending on the level of risk assessed. Staff in the community wards were fully aware of these and we saw them in use in people's care records held in their homes.

The tissue viability nurse also told us about the pressure ulcer group which looks at the outcome of investigations to decide whether or not the development of a pressure ulcer had been avoidable, and if appropriate action had been taken.

The diabetes team told us they were notified of any insulin-related incidents through the clinical governance systems. They told us the number of incidents for their team was declining. They told us they had been involved in providing particular support to one group of staff as a result of learning from an investigation.

All staff told us team meetings were held on a monthly basis to share information about the service. We saw the structure of meetings ensured that information was fully recorded and actions needed were itemised. The action section of the minutes showed who would be responsible for carrying out any actions. This meant people were clear about their responsibilities to ensure service improvement for people from identified learning.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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.

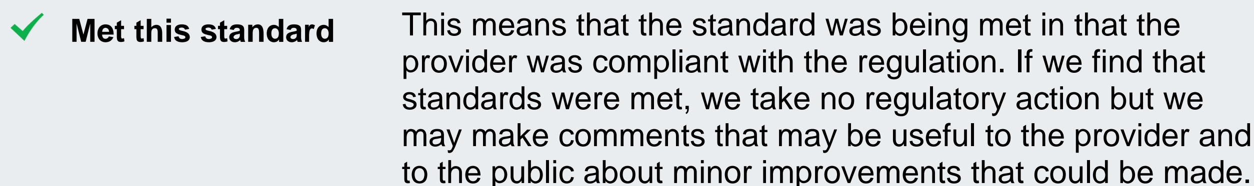
In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

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

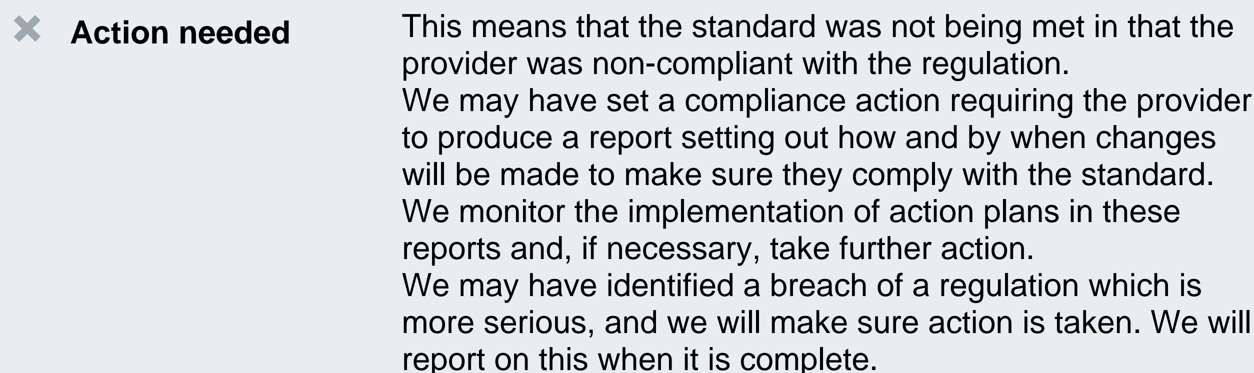
How we define our judgements

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.

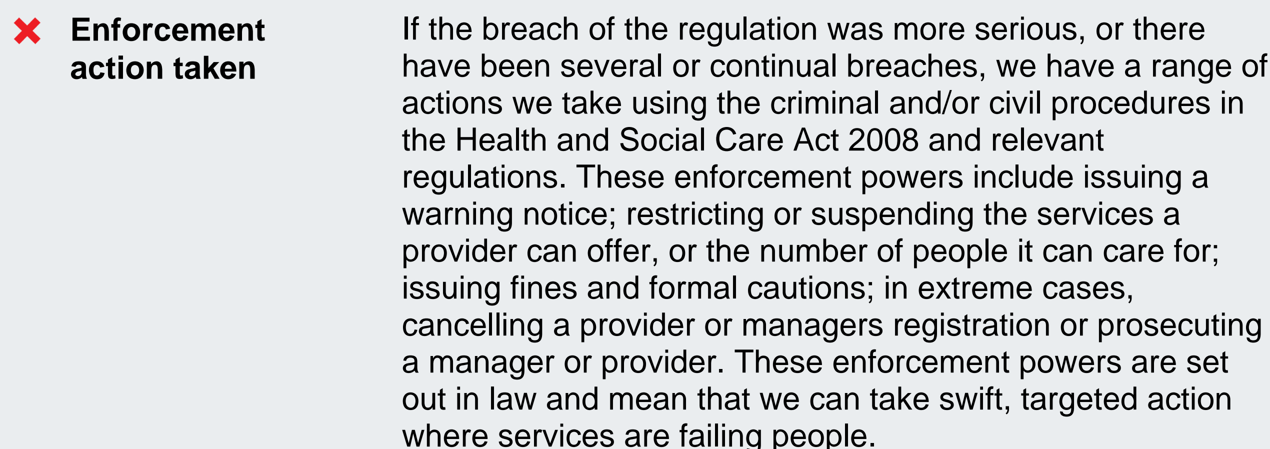
We reach one of the following judgements for each essential standard inspected.



✓ **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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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