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

Cumberland Infirmary

Newtown Road, Carlisle, CA2 7HY
Tel: 01228523444

Date of Inspections: 13 March 2013
Date of Publication: April 2013

Date of Inspections: 12 March 2013

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

- Care and welfare of people who use services: Action needed
- Staffing: Action needed
- Records: Action needed
### Details about this location

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<tr>
<th>Registered Provider</th>
<th>North Cumbria University Hospitals NHS Trust</th>
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<tbody>
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<td><strong>Overview of the service</strong></td>
<td>The Cumberland Infirmary is located in the city of Carlisle. It serves the north of the county of Cumbria. The provider, North Cumbria University Hospitals NHS Trust, also has a hospital in the west of Cumbria at Whitehaven.</td>
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<tr>
<td><strong>Type of services</strong></td>
<td>Acute services with overnight beds</td>
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<td>Diagnostic and/or screening service</td>
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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'.

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 March 2013 and 13 March 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, talked with staff and reviewed information we asked the provider to send to us. We were accompanied by a specialist advisor.

What people told us and what we found

People using the service (patients) told us that they thought the staff at the Cumberland Infirmary were professional and hard working. However they told us that they did not always receive support with their personal care:

"They are very short staffed, I have to wait for help."

"The staff are lovely, very helpful and kind."

"Nothing is too much trouble for the staff, they are very caring. My care has been excellent, I have nothing but praise."

"They are run off their feet."

Staff we spoke with said that they were concerned about staffing levels. Some staff felt hopeful about the future and believed that the senior management were working hard to rectify problems, others felt things were not progressing as swiftly as they might. One staff member said:

"I can't give proper care as I have no time."

"Staffing levels have been horrendous due to vacancies."

We found that patients had not received care, treatment or support that met their needs in a timely manner. There were not enough qualified, skilled and experienced staff to meet people's needs. People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. However we spoke with senior managers at the site and they were able to demonstrate that plans were in place to rectify many of the issues around staffing within the hospital.
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 22 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

### More information about the provider

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

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

**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**

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**Our judgement**

The provider was not meeting this standard.

Patient's did not experience care, treatment and support that met their needs and protected their rights.

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.

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**Reasons for our judgement**

We measured this outcome by speaking with people who used the service (patients) and their relatives. We observed patient care, reviewed patient notes and spoke with staff including doctors, nurses, healthcare assistants, pharmacists, physiotherapists, occupational therapists and housekeepers. We spoke with over a hundred people and visited sixteen wards at the hospital. We spoke with staff and patients at night and during the day. Patients told us:

"They are very short staffed....I have to wait for help."

"The staff spend all their time apologising."

"The staff are very nice and patient with people."

"The nurses are very nice."

We spoke with staff who told us:

"We cannot give the care the patients need, it's not safe and the care we do give is rushed, staff are exhausted from housekeepers to sisters."

"People work beyond their job description to support people and be there for patients and families who are distressed."

We had received information prior to the inspection visit that patients were experiencing long delays at the point of their admission and were having to wait for several hours in the accident and emergency department. We spoke with staff from the accident and emergency department and they confirmed that this was sometimes the case. During our
inspection we observed that the accident and emergency department had seven patients waiting for a bed. Of those seven only two patients had a bed identified on a ward for them to go to. The remaining five patients were waiting for a bed to be identified. This meant that patients had to wait for long periods of time in the accident and emergency department prior to being admitted onto an appropriate ward where their needs would be met. During their wait they occupied cubicles within the department and accident and emergency staff cared for them until they were admitted onto the appropriate ward. This meant that when there were delays in patients being admitted to wards the accident and emergency department was expected to provide a service to the waiting patients whilst continuing to provide an accident and emergency service.

Patients we spoke to told us that they were often moved from ward to ward to help make room for other admissions. For example one patient had been moved three times during their stay in hospital and at the time of our inspection staff were debating a fourth move to another ward. However the patient remained where they were when it was decided that a further move could be detrimental to their health. Another patient told us that they had been moved three times in two weeks and another commented that they were relieved to have been moved recently as the ward they currently on "Seemed to have more staff." Patients we spoke to told us that being moved around was unsettling and they often had to repeat information about themselves several times.

We observed the day to day activity on another ward. We spent from 08.45 to 09.30 in a four bedded bay with four patients. The ward consisted of twelve beds eight of which were in two four bedded bays and four of which were in single rooms. There was physical evidence that the patients had had breakfast and each patient had been provided with a jug of water. However the jugs had been placed out of their reach. None of the patients received any personal care in that time. We noted that five staff on duty were working from the top end of the ward down to the bottom end. One of the patients said "It is always after nine...long past breakfast when they get down here...they are willing but busy." A patient told us that they often had to wait to be helped to go to the toilet. The patient went on to say that this made them feel unhappy. Another patient said that they had not asked for a bath or a shower since they had been admitted as they felt that staff were too busy though other patients told us that they had showered every day. We spoke with one patient who told us "I have to wait for help" and that they had only had one wash since their admission (three days prior to our inspection) and had not had a shave or cleaned their teeth at all.

We observed one patient been woken up and taken for an x-ray. They were wheeled to the x-ray department in their bed but no effort was made to support them in washing or to promote their dignity, though staff did fasten the patient's pyjama jacket prior to leaving the ward.

Most relatives spoke very highly of the staff. We spoke with three families who all agreed that they had been kept well informed about their relatives though they had noticed staff were very busy. One relative told us "My [relative] smells of urine all the time. I have volunteered to wash them myself as the staff are so busy."

We observed that the sixteen wards and departments we visited were clean but somewhat untidy with equipment left in corridors. We noted that some urine bottles were left on bed tables next to drinks and that there were a number of half empty drinks cups in some of the wards.

We requested additional information from the trust about how they were dealing with these
issues. They told us the chief executive and members of the senior management team had been conducting weekly patient safety rounds. They had listened to patients and staff about their experiences and concerns and were working to make improvements which included ensuring that staffing levels were appropriate. The trust had also devised a monthly ward health check and regular audits to monitor patient outcomes. The trust acknowledged that there was some disparity between what we found and the information they had gathered and, as a result of our discussions, put measures in place to improve in this area. This included plans to focus on key nursing outcomes particularly the "6c's" care, compassion, courage, communication, competence and commitment.
**Inspection Report**

**Cumberland Infirmary**

April 2013 www.cqc.org.uk

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**Staffing**

**Action needed**

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

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**Our judgement**

The provider was not meeting this standard.

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

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

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**Reasons for our judgement**

We measured this outcome by speaking with people who used the service (patients) and their relatives, we observed patient care, reviewed patient notes and spoke with staff including doctors, nurses, healthcare assistants, pharmacists, physiotherapists, occupational therapists and housekeepers. We spoke with over a hundred people and visited sixteen wards. We visited the wards and the departments and spoke with staff and patients at night and during the day.

We asked patients if they were being well looked after, patients told us that:

"They are very short staffed, I have to wait for help."

"The staff are lovely, very helpful and kind. They help me when I need it."

"Nothing is too much trouble for the staff, they are very caring. My care has been excellent, I have nothing but praise."

"Nurses are very patient they have some difficult people to deal with on this ward. They are very good and if you need help they do not leave you long."

"They are run off their feet"

We asked patients if they were receiving help with their personal care, one patient said they had not asked for a bath or a shower "Because staff have problems with other difficult and demanding patients." We spoke with other patients, some had not had help to shave and others had not received support in having a wash. One patient told us that they had not been able to wash for two days, another patient had not had their teeth brushed for three days.

We asked staff, some of whom were visibly upset, if there were enough staff to meet patients needs in a timely manner. Staff told us:
"I can't give proper care as I have no time."

"Staffing levels have been horrendous due to vacancies."

"We have relatives getting upset because patients are in wet beds, but I can't get to them, I just can't."

"We are so short staffed we have no time to give quality and safe care, we're rushing from one task to another and cannot sit with the patients to make sure they have what they need. I have no time to answer really important questions which the relatives ask, they think we are avoiding them but we're just so busy. Admissions and discharges are not carried out properly. We cannot continue at this pace, something has got to change, it's just not safe."

A ward sister told us "I have the authority to get extra staff but can't get any."

Staff explained that they were busy most of the time and often did not get appropriate breaks. Many staff said that patients being treated at the Cumberland Infirmary were highly dependant and that the staffing levels needed reviewing as basic care was being missed. Staff were clear that they had informed their senior managers about these problems and senior managers were trying to resolve the issues. Many staff that we spoke with told us that they felt things were beginning to change for the better though some said they thought their concerns were not always considered.

We spoke with doctors who told us that, on the whole, there were enough medical staff at the Cumberland Infirmary to provide appropriate cover. However many felt that the junior doctors worked long hours, one doctor said "I would rather make sure the patients are safe and sorted out before I leave." Staff told us that there were not enough pharmacists to cover the wards and that this meant that doctor's prescriptions were not always being double checked.

On one ward we saw a member of the housekeeping team who was giving out coffee throughout the morning. This particular member of staff also assisted at lunchtime and was efficient at helping people to drink and eat. They told us that they had been trained in supporting people with swallowing problems. In another ward however we observed one healthcare assistant trying to support two patients at once with their meal. We asked why this was and were told that there were not enough staff available to give one to one support to people who required assistance whilst eating.

We spoke with a senior surgical nurse about plans around the future staffing of the hospital wards. They showed us a report which demonstrated that staffing levels had been reviewed across the surgical wards at the Cumberland Infirmary and plans were in place to increase the amount of nursing staff. A similar review had been undertaken on the medical wards with the same outcome. Senior staff confirmed that there had been an increase in the acuity of patients across the hospital. This meant that patients admitted to the hospital were very unwell and required higher levels of care. We noted that the trust had used the northwest safer care acuity tool as part of their most recent staffing level reviews, the aim of which was to ensure that "nursing establishments [were] fit for purpose." Senior staff told us that there had been difficulties in recruiting to their current vacancies. It has to be noted that recruitment is a Cumbria wide problem and it is something which the local clinical commissioning group (CCG) is aware of. The CCG is working with the trust to look at ways to improve this situation.
The trust told us that vacancies were being advertised locally and nationally. They had engaged with the local university and spoken with current nursing students about working at the Cumberland Infirmary. The Chief Executive had given clear instructions to recruit as many staff as were required as soon as possible. Both prior to and following our inspection we noted that the trust placed advertisements on a national website for a variety of posts including nurses, nurse practitioners, healthcare assistants, dieticians, consultants and doctors. We noted that the trust had began to establish a pool of nursing staff that could be deployed to wards that required extra staff on a shift by shift basis. They had also employed agency and locums to ensure key areas were covered.
Records

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 were not maintained.

We have judged that this has a major 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

To measure this outcome we looked in detail at patient records on three of the wards we visited and discussed them with staff.

We looked at the records for a patient who had been assessed as having a high risk of developing pressure ulcers. Pressure ulcers, also sometimes known as pressure sores or bedsores, are a type of injury that affects areas of the skin and underlying tissue. They can range in severity from patches of discoloured skin to open wounds. According to the notes the patient had developed the first signs of a pressure ulcer though this had not been graded. There was a care plan in place to prevent further deterioration and barrier cream was being applied to the affected area. However there was no treatment chart or wound assessment chart to accompany the treatment being undertaken.

We looked at another patient's record who had also developed a pressure ulcer. They had a care plan in place stating there was a risk of a pressure ulcer developing but the fact that they had an active pressure ulcer requiring treatment was not recorded. There was no body map indicating the location of the ulcer and no wound assessment or evaluation chart indicating whether the ulcer was improving or deteriorating. There was no treatment chart guiding staff as to what dressings the ulcer required. In addition several entries to the patient records stated "All pressure areas intact" which was incorrect. We found similar examples of this in other patient records. This meant that staff were making inaccurate entries in patient records.

We looked at the records for another patient whom we observed to have a single pressure ulcer. We found that the records did not reflect the patient's needs. There was no wound assessment or evaluation chart to inform staff as to how the pressure ulcer presented. There was no description of the wound bed, or leaking fluid levels which would alert staff to whether the wound was improving or deteriorating. Absence of the treatment chart may have meant staff could have been unaware as to what dressings had been prescribed and used. We asked staff what dressings were being used and were told the information was contained in the patient records, however we were unable to locate this information. We
found a body map in the notes with an X marking two places where the patient's pressure ulcer was located. The notes indicated that there was only one pressure ulcer. This meant that either the position of the patient's wound had not been correctly identified or that there were two pressure ulcers. This error could have resulted in the patient not receiving the correct treatment on the correct area of their body. We noted that the same patient had been commenced on a fluid balance chart as staff felt the patient was at risk of dehydration. However their chart revealed that on various days they had consumed limited amounts of fluid. We noted that staff had recorded what fluid had been served to the patient and not what the patient had consumed. This meant that the documented amounts of fluid taken may have been inaccurate. This error could have led to the patient becoming dehydrated or malnourished which, along with good assessment and monitoring, are recognised as being key to the prevention and care of pressure ulcers.

We looked at a further set of patient records which showed they had developed a pressure ulcer whilst in hospital. We saw that the pressure ulcer had initially been graded incorrectly. Pressure ulcers are graded from one to four in order of severity, one being the lowest grading and four the highest. The records we looked at indicated that the pressure ulcer was initially graded as a two but had been re-graded to a four when examined by a tissue viability nurse. This meant that there was a delay in the patient receiving the correct treatment.

All of the patient records we looked at did contain a variety of appropriate assessments of patient's needs. For example manual handling assessments, nutritional assessments and falls intervention assessments. But we found examples of assessments that had only been partially completed. We noted that all of the assessments had evaluation dates in place the majority of which were overdue, some by as much as 19 days. We looked at care plans for patients and saw that many of them were of a standard pre written format. This meant that it was difficult for staff to personalise them to individual patient's needs and wishes. We noted in many of the patient records we looked at not all of the care plans had been written in and some were only partially completed.

We found one example of a 'do not cardiopulmonary resuscitate' (DNR) form that had not been completed properly. A DNR form records the advance wishes of a patient in relation to being resuscitated in the event of a cardiac arrest or similar cardiac emergency. The form we looked at was divided into seven sections. Three of the sections were incomplete including the summary of communication with the patient, the summary of communication with the patient's relatives and the names of the members of the multi-disciplinary team who contributed towards the decision. We did find a brief summary of the discussions that had taken place recorded in the patient's records. However this may not have been accessible in an emergency. This meant if the patient required resuscitation it may have been unclear as to what their wishes about this were. We brought this to the attention of staff during our inspection.

We asked staff why records were not being kept accurately, one staff member told us that they concentrated on hands on care. Another said that they did not have enough time to write in the records. Senior managers told us that they were aware that records were not up to the required standard and that the newly appointed clinical records committee was taking a structured approach towards improving documentation.
**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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td><strong>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
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<tr>
<td></td>
<td><strong>Care and welfare of people who use services</strong></td>
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<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
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<tr>
<td></td>
<td>Patients had not received care, treatment or support that met their needs in a timely manner.</td>
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<td>Diagnostic and screening procedures</td>
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<td><strong>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
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### Health Act 1983

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<th>Diagnostic and screening procedures</th>
<th><strong>How the regulation was not being met:</strong></th>
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<tr>
<td>Maternity and midwifery services</td>
<td>There were not enough qualified, skilled and experienced staff to meet people's needs.</td>
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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 22 May 2013.

CQC should be informed when compliance actions are complete.

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

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of 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.
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.
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:

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

**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)**

<table>
<thead>
<tr>
<th>(Registered) Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>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'.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Responsive inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is carried out at any time in relation to identified concerns.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routine inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Themed inspection</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is targeted to look at specific standards, sectors or types of care.</td>
</tr>
</tbody>
</table>