Inspection Report

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

Derriford Hospital

Derriford Road, Crownhill, Plymouth, PL6 8DH

Tel: 01752202082

Date of Inspections: 26 April 2013
24 April 2013
23 April 2013
22 April 2013
19 April 2013
18 April 2013
17 April 2013
16 April 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	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cooperating with other providers	✔ Met this standard
Management of medicines	✔ Met this standard
Requirements relating to workers	✔ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Complaints	✔ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Plymouth Hospitals NHS Trust
Overview of the service	Plymouth Hospitals NHS Trust includes an integrated Ministry of Defence Hospital unit. The hospital offers a full range of general hospital services to around 450,000 people in Plymouth, North and East Cornwall and South and West Devon. Care is also provided at a separate off site Child Development Centre. Further details can be found on the hospital's website at: http://www.plymouthhospitals.nhs.uk/ourorganisation/Pages/Home.aspx
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely 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 16 April 2013, 17 April 2013, 18 April 2013, 19 April 2013, 22 April 2013, 23 April 2013, 24 April 2013 and 26 April 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 given to us by the provider. We were accompanied by a pharmacist and were accompanied by a specialist advisor.

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

This inspection was brought forward due to concerns about "Never Events" at Derriford Hospital. No further "Never Events" have occurred since the time of inspection.

At the time of our inspection the hospital was under severe operational pressure and for a period of time was on 'black' alert.

We spoke with over 90 patients and visitors and over 100 staff. We followed seven patients in their journey from admission to discharge and found that staff co-operated with other providers.

Comments from patients and relatives were positive and there were procedures to deal with complaints. Patients told us "staff are excellent", "you really can't fault the nurses, nothing is too much trouble".

Patients and people acting on their behalf were not always provided with treatment choices in relation to resuscitation.

Staffing levels and training to provide specialist skills to meet patients' needs were not always in place on the wards except on the maternity unit. Staff worked in difficult circumstances with professionalism and resolve to provide the best standard of care they could.

Patients were protected against the risks associated with medicines because the trust had arrangements in place to manage them safely.

The hospital had systems in place, including recruitment practices, to protect patients against the risks of inappropriate or unsafe care. Shortfalls had been identified in surgical procedures in theatres but this review of risk and monitoring had not developed adequately. This placed patients at risk of not receiving appropriate care and treatment.

The management and storage of records did not ensure patient confidentiality was maintained.

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

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

Respecting and involving people who use services ✖ Action needed

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 not meeting this standard.

The registered provider had not made suitable arrangements to ensure that service users were enabled to make, or participate in making, decisions relating to their care or treatment. This was in relation to end of life choices for the regulated activities diagnostic and screening procedures, surgical procedures and the treatment of disease, disorder or injury.

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

Reasons for our judgement

Patients who used the service were, on the whole, given appropriate information and support regarding their care or treatment.

Patients told us they understood the care and treatment choices available to them and they felt included in decisions about their care. Patients and their relatives told us they had received clear explanations and appropriate information from doctors and nurses regarding their planned and changing care and treatment. Patients told us "they are all great on the ward, really friendly, the surgeon was particularly good", "A&E were superb, I couldn't have got better care, all the nurses were very kind".

We saw staff treating patients and relatives with consideration and respect. We overheard a nurse speaking calmly, kindly and respectfully to a man who had some confusion. The nurse approached him by saying "Hello sir, I have come to help you" and we saw the man respond well to this approach.

On wards we heard staff speaking in quiet confidential tones to ensure that privacy and dignity were maintained as much as possible. Curtains around beds were closed when necessary to ensure people's privacy was maintained. Patients told us that all staff always respected their privacy and treated them with dignity. Throughout the inspection we saw staff speaking respectfully to patients. We spoke to three carers for patients who lived in care homes within the community and who were supporting patients on the wards. They all said that, from the point of admission, they had observed staff treating patients in a dignified and respectful manner.

On the maternity unit staff told us it was sometimes difficult to maintain privacy as the labour suite triage area had three bays separated by curtains only. Staff said that any spare consulting rooms were used to try to improve the privacy for patients.

We saw that patients had their privacy protected during all stages whilst in the operating theatre areas. All the staff ensured patients were covered with blankets and drapes when being transferred from the bed to theatre table and whilst being prepared for the operation. Staff were respectful, reassuring, and took time to ensure patients understood what was happening to them.

On admission through the emergency department or directly to a ward, a care plan started to be developed which identified the patients' care needs. This took into account any important views and expectations and planning for their discharge home. We saw this plan changed day to day depending on people's changing health needs. As patients moved through the hospital, staff communicated patients' needs well to ensure a continuity of care. Where a patient was unable to make a decision for themselves, either because they lacked capacity or due to an emergency situation, we saw in patient files that their next of kin or representative had been consulted.

We looked at care records which contained information about how people's diverse needs were to be met. The information included details of their mobility, medical needs and dietary requirements. However we saw that two patients who were receiving end of life care were moved from one ward, where the beds were needed for new admissions, to another ward by staff in the night because beds were required in the medical assessment unit for new admissions. These patients were very near the end of their lives and this move did not support what their families or staff wanted for them.

For those patients with a learning disability we saw they had information supplied about their specific needs. These additional notes travelled with them and had been received by the hospital but not consistently used by staff to support their care needs. The records received from the care homes they lived in were essential for staff on the ward to support the patients appropriately. The hospital notes for the patients we saw with learning disabilities focussed primarily on their health needs. They did not, in all cases, include important information to ensure that their wishes and preferences were known and taken into account.

In public areas there were displays and information about various aspects of care, including learning disability and dementia, getting help for carers and information about other support facilities available. These were in place to support patients and carers to access help in the hospital and community.

We saw a range of information about healthcare services available within the main reception area. Some of this was available in easy read formats using a combination of photographs, pictures and symbols. There were also easy read documents relating to specific health conditions and treatment such as breast screening and cervical cancer.

We saw patients were offered choices about what they would like to eat and drink. We saw that for some people with a learning disability this information was written down and available within documentation brought with them. However the quality and availability of this information varied between wards. Two patients we met were being supported by carers from their care home. Information about their care and needs had been provided by the home and staff were available to support hospital staff if necessary. However some patients we met did not have this support and information about their needs/likes/dislikes

was limited. One staff member we spoke with said she did not know the patient liked sugar in their tea. The patient was unable to tell them this verbally and written information from the care home had not been provided. The patient had been on the ward for three weeks and a health care assistant we spoke to said they had only just found out this information from a visitor.

We saw that ward staff were provided with information and training to raise awareness around issues relating to mental capacity and best interest decisions. Records confirmed that, when someone with a learning disability was admitted onto a ward, the learning disability liaison nurses advised ward staff to contact them if they needed to discuss any best interest issues. Ward staff were provided with a 'capacity checklist' and guidance on what they needed to do if they felt that any patient lacked capacity to make a decision.

We looked at the forms used to inform staff of the patients' end of life choices and choices for resuscitation should they have a cardiac arrest. We saw that the treatment escalation plans (TEPs) used to record the decisions about medical treatment and resuscitation had not all been fully and, in some cases, accurately completed. We saw that for one patient who had capacity, a decision had been made on their behalf not to resuscitate them. This decision had not been discussed or agreed with them. We raised this issue with staff on the ward. We looked the next day and this had been amended to advise staff to resuscitate them. Full completion of these documents is necessary to identify if the patient has capacity to be involved in the decision making process and the medical rationale for making the decisions. These forms were also seen to be incomplete for those people with a learning disability. We saw that information had been recorded on a patient's admission form but had not been transferred over on to the TEP form. This meant that important choices and preferences may not have been accurately recorded and as a result patient's preferences may not be considered.

We saw that this issue did not affect the midwifery and maternity unit or out-patient areas and was for the regulated activity of treatment of diagnostics and screening, surgical procedures and treatment of disease, disorder or injury.

We spoke with staff on the paediatric ward. We were told that patients with a learning disability and physical disability aged between 16 and 21 were often admitted to the paediatric ward. Staff felt that this was often inappropriate as these patients were not treated as adults.

All areas of the hospital were accessible for people with walking aids with lifts available between floors. We saw that long corridors had regular seating for people with limited mobility. Despite this, patients and relatives/visitors told us that, for people with mobility issues, walking the long distances was difficult and affected their wellbeing.

We were told that patients' choices and preferences regarding spiritual care were respected. The trust had a department for pastoral care which supported religious activities across a range of faiths. Faith leaders and volunteers from different religions and denominations were available for the support of patients/relatives.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights for the regulated activities of diagnostic and screening procedures, maternity and midwifery services and the treatment of disease, disorder or injury.

The registered provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. This is for the regulated activity of surgical procedures.

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

Reasons for our judgement

All patients and visitors praised the care, support and treatment they had received in all areas of the hospital we inspected.

One patient said "staff have been really reassuring." Another patient said "They have looked after me very well and explained everything to me in a way which I could understand" and "they have been superb to me, they have been kindness itself ". For some patients a carer had accompanied them from the care home they lived in. One carer we spoke to said "all the staff have been very helpful and appropriate. They have provided us with good information about what is happening and spoken to the patient very respectfully". Every relative we talked with spoke in positive terms about the care and kindness shown to both their relative and themselves.

We were told by some patients in the out-patient clinics that they had not always received appointment letters in a timely way. This affected their ability to plan their clinic appointments and some appointments had been missed. In some cases patients had not received the letter advising them of the time and date of their appointment. The first information they received was a telephone call the day before advising them of the next day's appointment. This caused difficulties for patients with regard to planning and transport. Patients told us that sometimes they had to cancel their appointments as a result and this delayed their care and treatment.

Patients who came into the Emergency Department were initially seen and reviewed by a nurse who assessed their needs. Patients arriving by ambulance were seen by a senior

doctor for an initial assessment of their condition. We saw that the emergency department had bays for serious medical emergencies, and a resuscitation area, as well as bays and treatment areas for less complex cases. We saw that patients were supported here with dementia and end of life care. We saw that, even when the unit was very busy, staff sat with those patients until family members could arrive or admission took place.

People were admitted to wards when needed which were either five or four bedded bays or single rooms. We saw that a range of assessments were used in order to identify risks to patients' wellbeing in such areas as falls, pressure areas, continence and behaviour. People's weights were monitored and Malnutrition Universal Screening Tool (MUST) assessments were used. We saw that therapy plans were in place for people who needed treatment and advice from a physiotherapist or occupational therapist.

On the Medical Assessment Unit (MAU) we spoke to patients both on the unit and those who were receiving ambulatory care. Ambulatory care means that they came to the unit for treatment but were able to go home and return the next day and this avoided admission to hospital. They all told us they were happy with the treatment they had received. On the MAU there were consultants on duty each day supported by other medical staff. Regular ward rounds took place each day to assess each patient and decide what tests or treatment was needed before concluding whether the patient could be discharged or transferred.

We looked at care records for the patients we were pathway tracking through the hospital and found that they contained up to date information about risks, care and treatment. Patients' notes were kept in two separate files with care plans being kept at the patient's bedside to inform nursing staff and further historical information such as previous admissions and treatment kept in another file.

We saw that patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Records were basic but identified people's preferences and personal wishes and developed as the length of admission progressed. We saw that records for the patients we pathway tracked were updated throughout the day. This showed that care and treatment was planned, provided and monitored. Staff told us that the constantly updated records ensured that they knew what was happening and that people were supported in the right way.

Throughout the inspection staff were all kind, considerate and helpful. One patient told us, "They spoke to me not just to each other". We saw that all staff communicated well between departments when handing over information about patients.

We went to wards which provided care to elderly patients. We saw that a record was maintained of those patients who moved to those wards from other wards or units in the night. Staff told us that this had a disruptive effect both on the patients being moved and on the other patients in the ward. Lights had to be switched on, beds moved, and there was extra noise. There was also disruption caused by those patients who had become confused and unsettled by being moved.

We saw that some patients on the adult wards were discharged at night. However, we were advised that those patients were awaiting transport. We noted that time of discharge could be as late as 10.00pm to 11.00pm. We were aware of one discharge to a care home at 00.30am. Discharges at night can pose a risk that the care needed at home may not be available. Staff on one ward told us that discharges in the evening were not usually appropriate and were carefully considered before taking place.

The hospital's admissions process included a 'flagging' system to alert the liaison nurses that a patient with a learning disability had been admitted. At this point the liaison nurses would meet the patient and establish if any reasonable adjustments needed to be made and to offer support and advice to staff within the hospital. All the staff spoken with were aware of these arrangements and said that they were able to contact the learning disability nurses at any time for support and guidance. This ensured that the specialist team were fully aware of any important issues and were able to comment and be involved in discussions regarding treatment and discharge planning.

There were inconsistencies around the quality and accessibility of information about those patients with learning disability needs. We saw that one patient required total support with all personal care needs. The staff we spoke to were very familiar with the patient and had built a positive relationship with them due to the frequency of their admissions. However the patient was not able to communicate their needs and wishes verbally and information about how they needed to be supported was not available in a written format. Staff spoken with said that, although they knew the patient well, staffing arrangements on the wards were likely to change on a regular basis and, without written information, the patient's needs could be missed or misunderstood.

Some people had additional notes which travelled with the person detailing their specific care needs These included triggers for behaviour and personal choices that could not be easily communicated. The staff did not always use this information when it was available which meant that patients were at risk of not receiving the care they needed.

Derriford hospital had reported eight "Never Events" since July 2012 of which seven of those had taken place in theatres. These included four incidents of wrong site surgery. Previously the trust had been in breach of Regulation 9 of the Health and Social Care Act 2008 because they had not effectively implemented the World Health Organization (WHO) checklist.

We visited theatres and saw that the trust used the Surgical Safety Checklist recommended by the WHO and the National Patient Safety Agency (NPSA). The Trust were using a photocopy of this checklist for each person which meant that staff were consistent in the checks they performed. All safety checks seen were completed clearly, stated out loud, and contained all the elements included on the WHO checklist. This meant patients had satisfactory safety checks prior to, during and after their surgery. We saw examples where staff of all grades obtained the attention of staff who were not paying attention. This was good practice.

However, despite this implementation, "Never Events" continued to occur in theatres from 2012 to 2013. The registered provider, whilst addressing the "Never Events" and investigating as they occurred, did not ensure that an effective change took place to prevent further events. This is for the regulated activity of surgical procedures only.

The surgical safety improvement programme provided to us by the trust had identified the issues staff raised with CQC. However changes to practice had not taken place and staff confirmed they remained under pressure and risks to patient safety remained.

In one theatre staff had been provided with a list which lacked detail. For example we overheard a member of staff say "It does not even say whether it's a local or general anaesthetic and it's a different order completely from yesterday." We heard another member of theatre staff say "So which list are we using?".

The management of surgery times was seen to put staff under pressure and created a risk of inappropriate or unsafe care and treatment. There was no clear mechanism in place to monitor or analyse who scheduled the surgery. Some staff said lists were drawn up by secretaries, consultants, or a mixture of both, depending on the speciality. We were told that some specialities, but not all, worked closely with team leaders to discuss the compilation of lists for the following week, aiming for realistic listings. Some staff spoken with told us that list scheduling was poor and the activity of slower surgeons was not adequately reflected in list content.

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 were 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

The provider had made suitable arrangements to protect the health, welfare and safety of patients in circumstances when responsibility for care and treatment of patients was shared. This was because the provider worked in co-operation with others.

Staff told us that referrals were made internally in the hospital to a range of healthcare professionals such as dieticians, occupational therapists or physiotherapists, to enable patients' independence and mobility. They told us that some wards had designated therapists who worked on the ward and some wards could access them separately.

Most of the patients with dementia were admitted to wards from the Medical Assessment Unit. Once someone was admitted to the ward the team estimated a discharge date and the multidisciplinary team worked towards achieving this so that patients were not kept unnecessarily in hospital. The records showed us that, for all discharges for patients into the community including those organised by the learning disability liaison nurses, staff worked hard to ensure that discharge planning was appropriate and met patients' needs. We saw that the hospital staff requested packages of care for those patients who needed support at home. We saw that checklists were completed that included follow up appointments and contact with any relevant residential care homes to advise of changes in care. Staff told us that later evening discharges were avoided whenever possible. Those patients with a distance to travel were discharged as early in the day as possible to get them home at a reasonable time of day.

On the maternity unit we saw community midwives accompanying women onto the unit. The midwives had carried out the woman's ante natal care, came to the hospital with the woman to deliver the baby, and then carried out the post natal care back at home. This service was available to women and babies who had been assessed as suitable for this type of service. This demonstrated a continuity and consistency of care between being in the hospital and being in the wider community. The midwife with responsibility for safeguarding vulnerable women and children told us how they worked closely with social services in Devon and Cornwall to provide support to vulnerable families.

For those patients with a learning disability and their supporters there was a 'flagging'

system. This ensured that the learning disability liaison nurses were made aware of any patients admitted to the hospital with a learning disability. Discussion with staff on the wards indicated that this system worked well and ensured that the patient had consistent support from this department as they moved through the hospital. We saw minutes of group meetings, which included plans for a 'Blue Light' day. People with a learning disability would be able to meet and receive information about a range of different agencies including the Samaritans, British Red Cross and the ambulance service. The purpose of these events was to provide people with a learning disability with information about their health needs and the services available to them both in the hospital and the wider community.

The learning disability nurse we spoke with said that, despite the 'flagging' system, there were times when important information was not passed between wards. The learning disability nurses said that, to address these issues, they continued to visit the wards regularly. They supported the ward staff, provided training sessions, and raised awareness throughout the trust of issues relating to learning disability and vulnerable adults. One staff member spoken with said "We can still get better but communication within the hospital and other agencies has significantly improved". The learning disability team worked closely with external partners such as GPs and commissioners to raise awareness of health issues, to prevent admissions into hospital and to support people when an admission was necessary.

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

We met with two pharmacists from the hospital. We visited five medical wards, three surgical wards and the Emergency Department. We spoke with nine other members of staff. We spoke with four patients about their medicines and saw some patients being given their lunchtime medicines on one of the wards visited. We looked at 27 patients' medicine records and reviewed information supplied to us by the trust.

Medicines were kept safely on the whole. In two of the nine areas visited some medicine cupboards were found unlocked. However in one of these areas the storage areas were behind a continuously staffed station. The trust was auditing the storage of medicines on a monthly basis and we saw data that demonstrated they had achieved 86% compliance with the trust's own standards. There was an action plan in place for those areas where the trust's standards were not being met.

The pharmacy department monitored the temperatures of the medicines refrigerators on a daily basis and could therefore demonstrate that these medicines were safe to use.

Medicines were prescribed and given to people appropriately. We looked at the prescription and administration records for 27 patients on the wards visited. There was a suitable document in use for the prescribing of medicines and for recording the administration of medicines. All wards received a regular visit from a pharmacist who reviewed the medicines upon admission, ordered newly prescribed medicines, and provided clinical advice. A snapshot medicines intervention audit was conducted for one week every six months which recorded on average over 1000 interventions made within each of those weeks by pharmacists. The information had been analysed and a training package for junior doctors had been developed for commonly occurring themes. This demonstrated that the trust had systems in place to ensure the safe prescribing of medicines.

The trust recorded incidents involving medicines on a computerised database. This included those examples when people had not received their medicines as prescribed. Those incidents that may have caused severe (0.4%) or moderate (8%) harm were followed up in accordance with trust processes and action taken where necessary. The learning from these incidents was communicated to all clinical areas on a regular basis.

Medicines were safely administered. We saw nurses giving people their medicines in a safe and respectful way. People told us that they were happy with how their medicines were looked after.

There was a system in place for the self-administration of medicines which included a risk assessment for the person and for surrounding people. On the wards visited one person was self-administering their medicines but there was no risk assessment in place for this person. The provider may find it useful to note that this ward was not following trust procedure.

Appropriate arrangements were in place in relation to recording of medicines. We saw that prescription and administration records had been completed to show what medicines people had been given. These demonstrated that people were given their medicines as prescribed for them. When a person was not given their prescribed medicine a code was used to explain why.

Appropriate arrangements were in place in relation to ordering medicines. The wards kept stocks of medicines which were regularly topped up. If people brought in their own medicines staff assessed whether this was suitable to use and if they were still needed. The trust was monitoring the waiting time for discharge medicines as they had a target time of 90 minutes from when the prescription was received by the pharmacy department. This showed the trust was meeting its target for over 80% of the discharge prescriptions dispensed. The trust had put processes in place on the wards, such as ready labelled discharge medicine packs, to ensure that people did not have to wait for an excessive length of time for their discharge medicines to be dispensed.

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

There were effective recruitment and selection processes in place.

At this inspection we looked at the recruitment processes for both doctors and nursing/care staff employed by the trust. We saw in all cases that effective recruitment procedures had been put in place to ensure that staff recruited were appropriate and that patients would be safe in their care. We saw that each staff member had a photograph, evidence of conduct in previous employment, evidence of qualifications and a full employment history. This information was there to demonstrate their previous experience to ensure that the staff were suitable for the work involved. We saw that the relevant criminal record checks had been completed to ensure that patients would be safe.

Any staff who were registered with a professional body to undertake their role were monitored to ensure that their registration was current and maintained for the job undertaken. There were systems in place to identify any lapses in registration and ensure that prompts and actions were taken to ensure the safety of patients who used the hospital.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

In order to safeguard the health, safety and welfare of service users, the registered provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activities of diagnostic and screening procedures, surgical procedures and the treatment of disease, disorder or injury.

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

Reasons for our judgement

There were not enough qualified, skilled and experienced staff to safeguard the health, safety and welfare of patients. Training to ensure the right skills were in place to meet patients' needs was ongoing but suitably skilled staff were not always available for the various specialities within the hospital. We saw staff working in difficult circumstances with professionalism and resolve to provide the best standard of care they could.

Every patient and relative spoken with were complimentary about the staff who cared for them. They told us that "If everybody worked as hard as they do here, the world would be a better place - but they are so busy you do have to wait ". At the time of this discussion the patient pressed their call bell to ask for assistance to the toilet. The call bell was answered ten minutes later. Staff apologised for the delay.

Another patient told us "The staff were lovely – no complaints - could do with more staff, they are always so busy". A visitor to the hospital told us "they are all so professional all of the time and they all work so hard".

Over the two week period we spent at the hospital we visited 34 different wards and departments for varying periods of time. Staff told us the difficulties of not having a full staffing contingent at all times and the pressure this put them under to meet patients' needs. This view was not expressed to us in the maternity and midwifery unit.

The hospital had planned for a certain number and skill mix on each ward/unit and those numbers and skill mix has not been achieved.

We visited the same four wards each day to follow patients' care and gain a greater picture of the staffing availability. We saw that staffing levels fluctuated and on some occasions the staff worked without sufficient staff numbers available. Staff shortages were caused by

staff being off sick, not available or on training courses. Staff told us how worried they were about this situation because it impacted on patient's care, welfare and safety.

On some wards the level of staff needed had been achieved by resourcing staff from other areas of the hospital or by using agency staff or staff from the bank of hospital staff. We saw that, whilst the numbers of staff may have been achieved to meet patients' needs, the skills needed on those specialist wards could not always be provided because the staff had not received the training for that specialism. Staff told us that, whilst they managed this problem as best as they could, it increased the pressure on them and sometimes patients had to wait for care.

On one ward the normal staffing contingent was five nurses and five health care assistants for the morning. On one occasion during our inspection we found there were three nurses and three health care assistants. This meant that patients with high dependency needs were supported by a nurse from each end of the ward giving half of their time. The previous night shift for that ward had also been short of one nurse with the normal staffing level of three nurses reduced to two. Staff said they considered this situation was unsafe.

Another ward we visited should have had four nurses each morning. However we saw that this was made up to four by the nurse whose role was to complete administrative tasks. This put staff under increased pressure and increased risk for the patients of not receiving the care and treatment they required. The same ward was staffed with four nurses to cover the ward and four patients with high dependency needs. However we saw that on that ward the same level of staff were nursing six patients with high dependency needs. This did not safeguard the health, safety and welfare of patients in those areas.

We saw departments and wards that routinely had depleted staff numbers. Staff told us that they often stayed on after their shifts to make sure that patients received the care they needed.

For patients with a learning disability several of the staff had built positive relationships with patients who had frequent admissions to the ward. One health care assistant we spoke to said "We all know how X likes to be supported, we know when they are feeling happy or sad, and they would usually have the same staff supporting them". We asked the staff if they considered the staffing levels were sufficient to meet the care needs of people with a learning disability. We were told "All of the patients on the wards have acute and complex care needs, the pressure on these wards can mean that people with additional needs, such as a learning disability, do not have their needs met sufficiently".

Theatre staff told us there were "often issues of skill mix" and specialist staff availability during operating time. Skill mix refers to the staff trained for specific theatre specialities or areas such as recovery. We were told that new staff were expected to rotate in all areas of the theatres. On the day of our inspection theatre staff told us they had been concerned that skill mixes were unsuitable for the afternoon theatre list. We saw a theatre team briefing document which recorded "? issues with skill mix later in the day- no senior staff on duty to resolve this issue." Staff told us that they were moved between surgical lists to improve skill mix but this move also diluted the skill mix of those team members remaining. Staff said this had been flagged up to the hospital management but had not been resolved.

We were told of other examples of staff shortages in theatres. One member of staff said there had been a lack of availability of recovery staff the night before our inspection. This had led to a non-recovery scrub member staying behind with an anaesthetist to recover the last patient on the list. In the day case theatre unit we saw that the staffing number of

six recovery staff to six theatres was only managed by five recovery staff which meant that staff had to double up their roles to cover one recovery bed.

A member of theatre staff said "Everyone has been so busy that meetings have taken a hit too." They explained that the usual information sharing meetings had not been taking place. We were told that the monthly department meetings had not been attended by all staff as they had been "rostered" to work because of trauma theatre work and catching up with the backlog of work.

We were made aware from the management of the hospital, and staff on the wards, that a recruitment drive was taking place and staffing levels had improved. However staff training on wards was delayed because of the shortage of experienced staff to assist with training new staff. This meant that, whilst staffing numbers had improved, skills were not adequate. This put staff under increased pressure and did not safeguard the health, safety and welfare of patients.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had an effective system to monitor quality and manage risks for the regulated activities of diagnostic and screening procedures, maternity and midwifery services and the treatment of disease, disorder or injury.

The registered provider had not protected service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, because there were no effective systems in place to regularly assess and monitor the quality of services provided; to identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk; and to analyse incidents that resulted in, or had the potential to result in, harm to a service user from the carrying on of the regulated activity of surgical procedures.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

The hospital had systems to protect patients against the risks of inappropriate or unsafe care and treatment which operated at management and ward level. These systems were in place to identify, assess and manage the risks relating to the health and welfare and safety of patients. They were also there to regularly assess and monitor the quality of the service being provided.

We saw that accidents and incidents were recorded and reported using a computerised system. We saw staff on the wards submitted information about pressure damage and falls. This was then gathered by the patient safety team. The issues identified were investigated and reported back to the Trust Board meeting. We saw the records of the meetings where the incidents were reviewed, discussed and monitored and any further actions agreed. We saw that, in some areas, governance and monitoring of service quality was working correctly and had developed and changed practice. There was evidence that changes in care were seen in the management of skin pressure damage and falls management as a result of monitoring by the hospital.

Following a series of reported "Never Events" we looked at this area in detail. "Never Events" are defined by the NHS National Patient Safety Agency as "Serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented."

Derriford hospital had reported eight "Never Events" since July 2012 of which seven of those had taken place in theatres. These included four incidents of wrong site surgery. The management of the hospital had followed the required reporting and action protocol and had investigated and produced the 72 hour reports required. These reports identified details of the incidents and the initial investigations and actions taken. There had also been a surgical safety improvement programme produced to identify overall issues raised as a result of those investigations and actions to be taken to prevent further occurrence.

However the repeated "Never Events" that had taken place in theatres demonstrated that practice changes implemented as a result of "Never Events" and auditing of their success had not been robust enough to prevent further incidents taking place in this area of treatment and care.

We looked at the surgical safety improvement programme and saw that several areas of practice in theatres had been identified for action. Not all of these actions had been completed. We saw that, whilst areas had been identified for improvement, the surgical safety improvement programme did not show that these improvements had been achieved by their due date. We looked at the timescale from July 2012 to April 2013 and saw that repeated "Never Events" had continued to take place which showed that the plans put in place following each "Never Event" had not been effective to reduce any further risks of these incidents taking place. We saw that for the "Never Events" that had taken place, Surgical Safety Checklists had not been accurately completed and sites for surgery not suitably marked on three occasions.

The management of the hospital had identified the need to revise and disseminate the Correct Site Surgery Policy March 2013. However "Never Events" relating to this issue had been taking place from July 2012 to March 2013.

The systems in place were effective to investigate, record and report. However learning from them was not implemented in an effective way to prevent reoccurrence.

We asked theatre staff why they thought the "Never Events" had occurred at the hospital. All answers related to "poor scheduling", "poor morale", "lack of beds", "poor communication" and "additional pressure." One member of theatre staff said "There has been a real problem with scheduling. Day case patients are usually OK because they have a bed." Another member of theatre staff said "The trouble is there is so much swapping and changing that mistakes are bound to happen."

The surgical safety improvement programme provided to us by the trust had identified the issues staff raised with CQC. However changes to practice had not taken place and staff confirmed they remained under pressure and risks to patient safety were still in place.

Many staff talked of the "frustrating" scheduling issues within the theatre departments. Scheduling is the organisation of which patient needs surgery, in what theatre, and at what point during the day and by whom. We were told that the issues were to do with "unrealistic" schedules. For example on the day of our inspection one theatre list contained details of seven operations due to take place that day. Surgical times had been included and totalled five hours and forty five minutes. Staff explained that the operating time each day was eight hours. This meant that staff had two hours fifteen minutes to anaesthetise seven patients, transfer the patients to recovery, and clean theatres in between each surgical case. Staff said this was "not enough time" and "a regular occurrence." One member of staff said "scheduling did not include anaesthetic time or time for unexpected incidents."

By not monitoring accurately the scheduling of surgery the hospital had failed to identify, assess and manage risks relating to the health, welfare and safety of patients.

We asked whose responsibility it was to schedule theatre lists. We were told it was either the surgeon or secretaries. One member of staff said "The surgeons are sometimes unrealistic in their expected surgical times". On the day of our inspection we saw the first patient took half an hour to have their anaesthetic. This delay was unexpected. The surgeon said the operative procedure would take 10 to 12 minutes. The operation took 25 minutes. This meant that the list took longer than expected. A member of staff said "You see, this happens regularly and causes delays which mean staff cut more corners." This demonstrated that staff felt under pressure to achieve unrealistic goals.

Further monitoring systems in place in the hospital showed us that the trust audited all records and held specific 'Patient Safety and Quality Meetings'. These were held every month and were attended by senior management staff and senior nurses. The meeting minutes showed that action plans were developed as a result of the various audits completed.

The ward staff audited all aspects of treatment and care. Audits included daily skin checks, weekly pressure sores, monthly falls, and nutrition and weight checks. We heard that incidents of pressure damage were closely monitored through the quality assurance committee and information used to check good practice had been maintained. We were told that through auditing results, 'intentional rounding', which means that staff assist patients who have a vulnerability to skin damage to change position regularly, had highlighted a need for earlier rounding to take place.

The Learning Disability team undertook a weekly audit of 10 patients on a ward. This gave them important information about patients' needs and helped them consider if the needs of people with a Learning disability/dementia were being appropriately met. We were told about changes that had taken place within the Learning Disability department as a result of internal reviews/complaints and other events. This included a review of policies and procedures relating to consent. We saw that checklists were now in place to ensure that staff understood how to assess a patient's capacity and what they needed to do if they felt a patient lacked the capacity to make a decision about their treatment or care.

At our previous inspection in September 2012 we made a compliance action around the management of records to include their accurate completion and security. The hospital management provided CQC with an action plan which advised that compliance would be achieved by February 2013. We saw that the monitoring and auditing of records and their content and security had been monitored. However changes in practice to ensure accuracy and security had not been achieved. Records were not kept securely and systems in place may compromise the confidentiality of patients at the hospital. Records relating to patients' choices and preferences for action to be taken should they have a cardiac arrest were not consistently and accurately completed.

We saw that the pressures of demand on services at the hospital and the impact of delays on discharge meant that the timescales monitored by the hospital were sometimes breached. For example, the timescale of four hours for patients to leave the emergency department was seen to be breached because of the unprecedented but ongoing demand on the service. We saw the actions taken by the hospital staff at these times to work in a way to promote patients being seen and assessed quickly and efforts made to find beds in the hospital. We spoke to staff in the hospital departments which took planned admissions and saw how these pressures delayed the services they provided. Monitoring of these

delays takes place and some changes have been made to address the difficulties.

The trust routinely audited the performance of its services with its medicines management policy and procedures. The results of these audits were reported to various governance groups within the trust and action plans were produced to address any issues identified through the audits.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

We saw that there was a Patient Advisory Liaison Services (PALS) team in place to support patients, carers and relatives in quick resolution of issues or assistance with submitting a complaint. Information included on the trust website explained how to complain or contact PALS for assistance. Translation, interpreter and signing services were also available when needed.

The management of the hospital had systems in place for receiving, handling and responding to complaints. All complainants could expect to receive an acknowledgement within 48 hours and a full response within an agreed timeframe. We were advised by the management of the hospital that there had been delays in how complaints had been managed. Data from the hospital for March 2013 indicated that the time allowed for receiving and acknowledging a complaint was met for 100% of cases and 83.5% of complaints were responded to within timeframe. A recent change of practice was that information about every complaint was supplied to the head of Nursing and the Quality Assurance/Patient Safety Team to audit and promote changes in practice when needed.

Serious and significant complaints were subject to a formal root cause analysis approach investigated by an independent investigator for serious complaints. Reports were reviewed and agreed by the Director of Nursing. The hospital had regular committee and Board reporting on complaints and PALS which included Personal Care Group monthly, Safety and Quality Committee monthly and the trust Board quarterly reports.

Patients and relatives in all of the areas we visited, with the exception of out-patients departments, were confident that they knew how and where to complain. We saw signs and information on corridors to advise people of the Patient Advice Liaison Service (PALS) and how to raise any concerns. We saw that PALS was available throughout the working week and that advisors visited wards, spoke with people by telephone, and responded to any letters.

We received one verbal concern from a patient which was addressed immediately by the ward sister. We received information about all of the complaints received since our last inspection. This included what action had been taken by management of the hospital to address any issues identified.

The provider took account of complaints and comments to improve the service. Learning

outcomes were fed back to the teams concerned.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The registered provider had not ensured that all patients' records were stored securely. This related to the regulated activities of diagnostic and screening procedures, surgical procedures, and the treatment of disease, disorder or injury.

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

Reasons for our judgement

At our previous inspection in September 2012 we made a compliance action around the management of records to include their accurate completion and security. The hospital management provided CQC with an action plan which advised that the actions needed to meet compliance would be met by February 2013. During this inspection we found that the actions included in this plan had not been met.

Staff records relevant to the management of the service were accurate and fit for purpose. Patient records were not kept securely and systems in place may compromise the confidentiality of patients at the hospital.

We saw that each person had a plan of care from admission through to discharge. These records contained appropriate information and documents relating to the care and treatment of patients. As we followed patients on their journey through the hospital, we checked those records daily and saw that they accurately reflected the care and treatment those patients received.

Patients in theatre areas had a document detailing their care during their theatre journey. These documents required signatures at all stages of the surgical process. For example swabs, instruments and sharp instrument counts, medical personnel present, and whether supervision was provided. At this inspection we saw these records were completed.

We saw that monitoring and medicines records were held on each patient's bed. Historical and current medical records were stored in cupboards near the nurse's station/desk. On some wards, but not including the maternity or out-patient departments, records were laid on the nurse's station/desk and so were accessible to patients and visitors when no staff were in that area. We saw that lockable trolleys to store records securely had been put in place. However in some areas these cupboards were not locked and some had the key pad access number available on the cupboard. This enabled anybody to access the cupboards and subsequently the records stored in them. One ward staff showed us that

the locks were no longer suitable to lock both sides of the cupboard doors. This did not ensure the security of records and the confidentiality of patients' information.

We saw that electronic check in systems had been implemented in out-patient clinic areas and also the Royal Eye Infirmary. We saw that information, such as patients' names, addresses and dates of birth, was easily visible to other people in the waiting area. This may have compromised the security and confidentiality of patients who had checked in by this method. On some wards we observed that telephone conversations made by staff about patients could be clearly heard by patients and visitors in seating areas. This did not ensure the confidentiality of patients' information.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The registered provider had not made suitable arrangements to ensure that service users were enabled to make, or participate in making, decisions relating to their care or treatment. This was in relation to end of life choices. Regulation 17(1)(b)
Regulated activity	Regulation
Surgical procedures	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1)(b)(i)(ii)(iii)

This section is primarily information for the provider

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered provider had not taken appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff employed for the purposes of carrying on the regulated activities. Regulation 22
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered provider had not ensured that all patients' records were stored securely. Regulation 20(2)(a)

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 13 July 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 other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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