Inspection Report

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

Willerby Hill

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Tel: 01482389216

Date of Inspection: 27 November 2012

Date of Publication: December 2012

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✗ Action needed
Staffing	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Humber NHS Foundation Trust
Overview of the service	Willerby Hill, which is the Humber NHS Foundation Trust (Humber NHS FT) headquarters, is also the site of The Humber Centre, Greentrees and South West Lodge. The site provides extensive in-patient support services to people with learning disability, mental health or behaviour that challenges the service, conditions. Derwent ward is just one of the wards that operate in the Humber Centre. It provides admission assessments for patients experiencing acute mental health conditions.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

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 27 November 2012, observed how people were being cared for and talked with people who use the service. We talked with staff.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

We visited Derwent Ward at The Humber Centre, where we spoke with four patients, three staff and the ward charge nurse. We were informed that the ward manager had left at the end of the summer. This vacancy was being covered by the ward manager of another ward in The Humber Centre. We did not meet this person.

We looked at some case files and looked around the ward. We visited this ward because we had received information that gave us cause for concern. These concerns have been mentioned and discussed in the body of the report.

We found that patients were satisfied with the overall services they received, but they had comments to make about poor interactions between patients and staff. One patient said, "It is ok here, it's a bit slow, but some of the staff are good. I don't like being here. You have to ask for everything." Another patient said, "It's more than satisfactory, you get what you need to get you well."

We found that the physical environment was not safe for patients with suicidal thoughts. We found that staffing levels were sufficient, but staff had experienced challenging situations from patients who had shown high levels of support needs.

We found that documentation was satisfactorily completed and that records were up to date. We found that some patients had not had leave and though we did not see any staff engaging in interactions with patients we were told that two staff had been spending time with them.

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 16 January 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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients' views and experiences were taken into account in the way the service was provided and delivered in relation to their treatment.

Reasons for our judgement

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. We had been informed that patients were not given choices to engage in activities because of a shortage of staff to accompany them.

We spoke with patients, staff and the ward charge nurse and we looked at patients' case files. We also observed patients and staff during our visit.

Patients told us they had activities to engage in. Patients said, "In your CPA (care programme approach) meeting you are asked what you want to achieve and you can say what activities you want to do. I've been to do education, the gym, to the bank and shop and I've done some cooking" and "I go to gym every day to do weights and run." Patients and staff told us there were weekly and monthly meetings, for individuals or groups, where they could talk about their support and treatment needs.

Staff told us about the ways in which patients were involved in their support and treatment: 'My Shared Pathway', the care programme approach, empowerment meetings and multi-disciplinary team meetings.

We saw some art work that patients had produced and we saw a patient on another ward painting some displays for the Christmas fair soon to be held at the Humber Centre. We also spoke with the head of a newly formed centralised activities team who explained the team was now working across all of the wards to assist with activities and with escorting patients on leave. Derwent ward's charge nurse also told us about these new arrangements.

Patients told us they did not always feel comfortable with staff and that staff sometimes interacted with them in a challenging way that made them feel vulnerable.

We saw patients' daily communication notes, which recorded their activities. This meant that patients had opportunities to engage in meaningful occupation.

Patients expressed their views and were involved in making decisions about their care and treatment. Patients were supported in promoting their independence.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. We had been informed that patients' risk assessment documentation had not been kept up to date and that new patients to the ward had not been admitted properly.

Patients we spoke with expressed mixed views of the ward. They said they had their own room, the food was okay and that they liked the accommodation, but they also said they found it difficult relating to staff and each other.

One patient said, "It is ok here, it's a bit slow, but some of the staff are good. I don't like being here, because people are not well. I've been on the other wards and they're all different. There are things to do here though. You can play bingo, play cards, do art work, or go to education, but it's all a bit slow. You have to ask to get anything."

This patient also said, "Some of the staff talk to you and are alright, some are a bit, well they say things that sometimes upset you. And I do get annoyed sometimes, so that makes me shout."

Another patient said, "It's more than satisfactory here, you get what you need to get you well. The rooms and food are ok. There's only one thing and I don't know how to explain but sometimes you can feel very lonely, as staff don't spend time with you, they are always in the office. And they sometimes make you feel uncomfortable, as they say things when you pass through to the courtyard. Sometimes patients can be talking and staff join in and it can make patients feel left out. Patients are vulnerable to sarcastic comments. It can be an intimidating place. There are activities for us to do if the staff are available, but you have to keep asking them for things."

A third patient told us, "You don't always get full explanations from staff, like why your medication's changed, or what's going to happen after here. I haven't been told about my rights. I have made an application for a tribunal though through my solicitor and I can talk to Cloverleaf if I want to. I like to go to the gym, do weights, go running, as I go everyday."

A fourth patient said, "I just want to leave before Christmas, I want my life back. The staff make lots of negative comments to me and they listen in to my conversations with other

patients. They 'butt in' when they have no right to. I just want to be with my family." This patient did not know about the possibility of receiving advocacy services and gave us permission to mention this to the ward charge nurse.

We spoke with the staff about providing support to patients and they told us they considered patients' privacy and dignity. They said they encouraged patients with their personal hygiene if necessary. Although we were told by the charge nurse and the staff that staff had engaged in high levels of observation of patients, to ensure their safety, and we saw them carrying out observations, we did not see any interaction from them. We saw one staff observing a patient using the telephone and another staff providing 'constant' observation of a patient, but we saw no engagement between staff and patients, except when staff gave out medication.

We spoke with the charge nurse about admitting patients to the ward and he explained that there had been a six month period when a doctor had not been allocated to Derwent admissions ward and staff had needed to locate a doctor each time a new patient was admitted. The doctors that attended had been 'rushed' in their completion of the documentation for admission and therefore for a while patients' documentation had not always been thoroughly completed. We were shown a mobility assessment form that had not been completed, as an example of this. The patient's mobility had not been an issue and so the form was not necessary, but the admitting doctor had not ticked the appropriate box that made this clear.

We were informed by the charge nurse that there was now a Senior House Officer allocated to Derwent ward and that admissions had been properly completed since then. The provider may find it useful to note that when a patient was not been admitted properly they were at risk of not receiving the right support and treatment to aid their progress to good mental health.

We looked at three patients' risk assessment forms including the Galatean Risk Screening Tool (GRiST), which had been completed for patients on admission to alert staff to the risks of patients harming themselves or others. We saw that they had been completed in a timely manner after admission and that for one patient the document had been updated twice, in August and November 2012, since the original completion in May 2012. We also saw that a Malnutrition Universal Screening Tool (MUST) had been completed for patients.

In one file there was a blank copy of the Liverpool University Neuroleptic Side-Effect Rating Scale (Lunsers) form. We were told that the patient had not been given any anti-psychotic medication so the form did not need completing, and that sometimes doctors recorded this information in their clinical notes. This meant that the Lunsers form was not always completed. We saw that patients had been placed on observations appropriate to their levels of risk and we saw one patient being constantly observed. Evidence that risk assessment documentation had been completed and patients were observed meant that patients were not at risk of self-harm or harm from others, or at risk of poor nutrition and taking anti-psychotic medication.

We found that patients were at risk of harm due to the environment. Details of the environment shortfalls are listed and explained in outcome 10 of this report.

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

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. We had been informed that the number of patient incidents had increased on the ward causing an increase in restraints and seclusion.

We spoke with people, staff and the charge nurse about incidents, restraints and seclusion and we looked at documentation, which recorded them.

Patients told us that seclusion had taken place for some patients in the near past and one patient said they had been in seclusion quite a number of times recently. This patient gave us their own explanation why this had happened and acknowledged they needed to shout less and not get so angry. Another patient said, "Staff don't always recognise when my condition is happening, but I do. And staff say I have to go to seclusion because of my behaviour due to the condition. But they don't listen when I tell them it is not happening."

Staff told us there had been an increase in seclusion for some patients and said this had not been as a result of staffing shortages. They said it had been because of patients' clinical health needs and changes in one patient's medication and therefore an increase in incidents involving them had arisen. One patient had been 'constantly' observed under the ward's 'open seclusion' procedures for a time, as their behaviour had been threatening towards other patients and staff. There had also been a high level of observations taking place, with another patient under 'constant' observation on admission and other patients on 15 and 30 minute observations. Staff told us they had completed 'management of actual and potential aggression' (MAPA) training and only used this when necessary.

We looked at a sample of incident, restraint and seclusion documents and saw that they had been completed appropriately and patients had received the clinician support necessary during and after an incident, restraint or seclusion had taken place. The records were consistent with information we'd received from the whistle blower, in that there had been a higher level of incidents and seclusion. This had all been documented. We did not find any evidence that lead us to believe patients had been restrained or secluded inappropriately. This meant that patients were not at risk of harm from inappropriate behaviour management techniques or inappropriate application of the

seclusion policy.

We did not assess outcome 7 in relation to staff understanding of their responsibilities to recognise, challenge and report safeguarding situations or abuse allegations, so staff were not spoken with about these safeguarding areas.

Patients who used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements.

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.

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

Reasons for our judgement

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. We had been informed that "Observations on potions was not done correctly, there were errors with medications" and that paperwork was not completed.

We spoke with the charge nurse and discussed this information. Together we decided that the issue about 'observation' pertained to observation of patients and was not related to medication. Observations have been discussed in outcome 4.

We looked at the medication records for two patients and we saw staff administering medication to patients. We saw that medication was being administered, recorded and signed for appropriately. We saw that patients still came to the small side office to receive their medication, as was mentioned during previous inspection visits from the Mental Health Act Commissioner and Compliance Inspectors and as recorded in their reports. See outcome 10 of this report. However, we saw that one staff took one patient's medication to them somewhere on the ward.

We found no evidence that patients were not receiving the correct medication at the right time and we found no evidence that records and paperwork was not being completed properly. We had one query about medication. The query was that for one patient we were unsure which medication was being used for a particular condition, but the charge nurse resolved the issue for us and explained what we needed to know.

When we asked patients if they had any concerns one told us they had not been fully informed about their medication and would have liked a more detailed explanation about why changes had been made. They gave us permission to pass this on to the charge nurse, which we did.

Medicines were handled appropriately. Medicines were prescribed and given to patients appropriately. Medicines were safely administered.

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients who used the service were not protected against the risks of unsafe or unsuitable premises. Patients had experienced an environment that had been identified as unsafe but had not been changed sufficiently or in a timely manner, to ensure their safety during times of acute mental illness.

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

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. However we looked at this outcome as part of our ongoing monitoring of The Humber Centre and the safety and suitability of the environment.

We had visited Derwent ward on 2 December 2011 when we pointed out that medication was being administered from a hot and unsuitable office, and it was undignified to receive medication while standing in the corridor. However, we were later informed by Humber NHS FT that temperatures in this office had been checked and did not pose a storage risk to the effectiveness of medication. We saw that patients continued to receive medication from this office while standing in the corridor.

We also pointed out that there were ligature risks on this and other wards in the Humber Centre. The Mental Health Act Commissioner (MHAC) had visited Derwent ward on 22 May 2012 and the Commissioner had asked for an action plan with regard to removing ligature points.

During today's visit we looked round the ward and discussed with the charge nurse and the modern matron our continued concerns with the safety of the environment. They told us that environmental risk audits had been completed and details of ligature risks had been recorded by Humber NHS FT on 16 May 2012. A Patient Environment Action Team (PEAT) visit to the ward had also been carried out, which recommended changes were needed to remove all ligature points. Information about ligature risks from taps and pipes in toilets and bathrooms, and from windows, night lights and sink taps in patients' bedrooms had been passed to a Business Unit Team meeting that had been held on 26 June 2012.

The MHAC had received an action plan on 10 July 2012, which told them that Derwent ward's ligature audit was still in draft form and would be discussed at the meeting on 26

June 2012. There was no information as to the outcome of this meeting and discussion which had been held nearly two weeks before receipt of the action plan.

In the meantime, a patient had died as a result of ligature activity on 17 June 2012, which was a month after the draft audit report had been compiled and nine days before the Business Team Meeting was held to discuss ligature points. We were informed that a coroner's inquest into this death was to be held in January 2013.

We have requested from Humber NHS FT that they send us certain information in relation to their audits, meetings and the incident in June 2012. We have not done this using our powers under section 64(1) of the Health and Social Care Act 2008, as we have confidence in the provider meeting our request.

The provider had not taken steps to provide treatment in an environment that was suitably designed and adequately maintained. Patients were at risk of serious harm from the environment.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet patients' needs.

Reasons for our judgement

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. We had been informed that there were staffing shortages, which meant patients had not been able to take their section 17 leave and incidents on the ward had increased.

We spoke with staff, the charge nurse and with the modern matron and we looked at staffing rosters.

We had been informed by the charge nurse and the modern matron who called in to see us during the inspection that the ward manager had left in the summer. We saw that the charge nurse was completing tasks associated with the manager role. We were told by staff that they valued having the charge nurse on the ward as they were a great support to them and provided the leadership the ward and staff group needed.

Although we were informed that a ward manager on another ward was covering the vacancy on Derwent ward we did not see the person, but we saw from the roster for that week that they were on duty 09:00 to 17:00 Monday, Wednesday, Thursday and Friday with annual leave on the day of our visit, Tuesday. The charge nurse told us that Humber NHS FT had put out an advert for the vacant post, but had withdrawn it and made the decision that there was no longer a vacancy to fill. We later received information from Humber NHS FT that the post had been advertised and candidates had been short-listed, but because none of them arranged to be interviewed and Humber NHS FT was considering a service re-design, Humber NHS FT decided to postpone the filling of the vacancy. They told us this had been re-advertised.

The charge nurse had adopted a role of responsibility that his remuneration did not recognise. Staff told us they were happy with the arrangements and management that we spoke with at the end of our visit did not express any dissatisfaction with them. The charge nurse was being encouraged to continue in this role. However, we were later informed by Humber NHS FT that the role had been allocated to other team leaders in the service, and that the charge nurse had agreed this arrangement.

Staff told us they had experienced some difficult situations over the last six months and had seen some upsetting and traumatic incidents where patients had self-harmed, one resulting in a death. They gave these incidents and having dealt with an increased

number of other incidents with newly admitted patients, as the reasons for an increase in the staff sickness rate during August and September 2012. Staff acknowledged that incidents on the ward had increased over a period of time from June to October 2012

We looked at the staffing rosters or 'off duty' lists and we were told by staff that there was an undertaking to ensure that two trained nurses and three nursing assistants were on duty each day, with one trained nurse and three nursing assistants at night.

We saw that the rosters for week commencing 8 and 15 October 2012 and week commencing 19 and 26 November 2012 had many changes to staffing shifts. During the two weeks in October six staff had between 2 days and 12 days sickness each, while during the two weeks in November one staff had 9 days sickness and was due to be off for the rest of the second week.

We could not determine from the rosters that there had been the staffing complement as indicated and have therefore requested from Humber NHS Foundation Trust that they send us the actual individual hours worked by all staff on the ward during the four weeks mentioned in the previous paragraph. We have also requested details of the staffing structure and any vacant positions for the ward. We have not done this using our powers under section 64(1) of the Health and Social Care Act 2008, as we have confidence in the provider meeting our request.

There were enough qualified, skilled and experienced staff to meet patients' needs. This was the case on the day we visited Derwent ward but we needed evidence that it had been the case over the last few months.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

We visited Derwent ward in response to information we had received at the end of October 2012, through our whistle blowing system at the Care Quality Commission. We had been informed that some records had not been completed properly or kept up to date.

We spoke with the charge nurse about records maintained on the ward. We saw a sample of these records to provide us with evidence records had been maintained. Records protected patients against the risk of unsafe or inappropriate care and treatment arising from the lack of proper information about them.

We saw records that included assessments of patients' needs (their GRiST, MUST and Inpatient Initial Assessment). We saw records that included patients' care plan details (care programme approach, behaviour management plans and reviews of care). We also saw records that included patients' history of health issues, medication requirements and monitoring of mental presentation.

We looked at records for medication administration, observation, restraint and seclusion. We saw that records were appropriately maintained. Patients' personal records including medical records were accurate and fit for purpose.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: The provider had not ensured that patients having access to premises where the regulated activities were carried on, were protected against the risks associated with unsafe or unsuitable premises, by means of suitable design as written in regulation 15(1)(a). All ligature points that had been identified in audits had not been removed.

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 16 January 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.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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