

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

Liverpool Women's Hospital

Crown Street, Liverpool, L8 7SS

Tel: 01517024038

Date of Inspection: 09 April 2014

Date of Publication: June 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓	Met this standard
Staffing	✗	Enforcement action taken
Supporting workers	✓	Met this standard
Assessing and monitoring the quality of service provision	✗	Enforcement action taken
Complaints	✗	Action needed

Details about this location

Registered Provider	Liverpool Women's NHS Foundation Trust
Overview of the service	Liverpool Women's Hospital is one of two in the country that specialises in providing healthcare for women and their babies. The hospital provides a range of services including gynaecology services, maternity services, neonatal care and a reproductive medicine service. Each year, the trust provides care and treatment to around 30,000 patients from Liverpool and the surrounding areas.
Type of services	Acute services with overnight beds Doctors consultation service Diagnostic and/or screening service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies 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 to check whether Liverpool Women's Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints

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 9 April 2014, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, reviewed information sent to us by other regulators or the Department of Health and reviewed information sent to us by other authorities. We talked with other regulators or the Department of Health, talked with other authorities and were accompanied by a specialist advisor.

What people told us and what we found

We had previously inspected this service on 7 and 8 July 2013. During this inspection we found there had been some improvements in how women and their babies were cared for and in how staff were supported. However, there were other areas where the trust failed to meet essential standards of quality and safety. Part of this inspection was undertaken outside of normal working hours. We started the inspection at 6am to see how women and their babies were cared for during the night shift.

We spoke with ten women and four relatives during our inspection who all spoke positively about their experiences at the hospital. Their comments included:

"It has been brilliant; they told you what was happening,"

"There are no words to describe how grateful we are,"

"They made my stay a happy one,"

"They explained everything to me."

Staff at all levels were better supported to undertake their roles through training and appraisal, and staff morale throughout much of the maternity directorate had improved. However, maternity staffing levels were still sometimes inadequate, which meant that the trust was not always able to provide safe and effective intrapartum (care during childbirth) and post natal care to women and their babies.

There were systems in place to assess risk and quality within the trust, but the quality of

these systems was not adequately managing risks to staff and patients. Improvements were also needed in the way in which the trust handled complaints.

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 09 July 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Liverpool Women's Hospital to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We had previously inspected this service on 7 and 8 July 2013 when we found non-compliance with this outcome for which a compliance action was issued. During the previous inspection we found that staffing shortages were having a negative impact on the patient experience, particularly in the Midwifery Assessment Unit, where women were not receiving appropriate care and support in a timely manner.

During this inspection we found that there had been significant improvements within the Midwifery Assessment Unit. Staff we spoke with told us the service had been reorganised and improved and staffing levels had increased, with staff rarely re-deployed to other areas. Some comments made by staff were:

"It's a great place to work now – there's a real team here";

"This time last year the answer machine was always being put on because there weren't enough staff to answer it. That's changed; a midwife is allocated to answer the triage phone– we seldom have to put the answer machine on now."

At the time of our last inspection 61% of women were being triaged at the Midwifery Assessment Unit within the target time of 30 minutes. The most recent data available at the time of our inspection indicated that an average of 92% of women had been triaged (the process of determining the prioritising patients' treatment, dependent on the level of need) within the target time over the latest three month period.

We also saw evidence that an escalation process had been put into place for women who had been waiting for two hours to see a doctor. Staff told us the systems generally worked well and we saw evidence that the trust audited the triage times regularly in order to highlight any issues and take remedial action where necessary.

The trust had recognised that the induction of labour service required improvement. We were informed that a multi-disciplinary team was being arranged to take forward this piece

of work. This will improve the patient experience and their outcomes, once completed.

During our last inspection we observed staff exchanging information about women during the handover process in a semi-open area, where confidential information was clearly visible on a whiteboard. This whiteboard has now been re-located and all the handovers we witnessed were carried out in a way which protected patient confidentiality.

Staffing

✘ Enforcement action taken

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.

There were insufficient qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We had previously inspected this service on 7 and 8 July 2013 when we found non-compliance with this outcome for which a compliance action was issued. During this inspection we found that there had not always been sufficient numbers of staff on duty to provide safe and effective care

During this inspection we found that there had been some improvements in staffing levels, and work had been undertaken by the trust to ensure that staff were taking adequate breaks. However, there were still areas of concern regarding staffing levels and we had concern about the impacts this was having on the care provided to women and their babies.

Since our last inspection the trust had employed 12 more whole time equivalent midwives. During our inspection we saw evidence that the trust had provided one to one intra partum care in only 77.4% of cases. In order to provide safe and effective care, all women should receive one to one intra partum care.

Audit data for six months from September 2013 – February 2014 submitted to CQC as part of this inspection indicated that a quarter of the women on the Midwifery Led Unit who requested an epidural were declined for either workload or staffing related reasons. Midwives told us that some of these women had clearly stated in their birth plans that epidural was their pain relief method of choice. Staff on the Midwifery Led Unit spoke to us of their disappointment in not always being able to transfer women across to the delivery suite so that they could receive their pain relief method of choice. Some women had also experienced delays in the induction of labour and elective procedures (procedures that had been scheduled in advance, such as caesarean sections) as a result of shortages of midwives. Midwives we spoke with confirmed this. The trust informed us that each delay in elective procedures was assessed and discussed with the woman by a senior doctor and midwife in the hospital, with a plan put in place to manage their care.

Five full time healthcare assistants had been appointed in February 2014 and were due to commence employment in the trust in May 2014. These additional staff are expected to relieve staffing pressures on delivery suite and the post natal wards, where healthcare assistants reported to us that they could be moved around three times in one day to cover staff shortages. Some comments made were:

"We would love to spend more time with the mothers and babies but it is really difficult when we are so busy,"

"We need more healthcare assistants, there aren't enough of us."

Throughout the maternity directorate, individual wards and departments were now required to demonstrate when staff had taken rest and meal breaks and to record when the workload had been too heavy for them to take their breaks, or when they have taken a shorter than allocated break. This information had been monitored by the ward managers and matrons and had been escalated, when appropriate, through the trust's incident reporting system. This meant that there was a mechanism in place for communicating this risk to the senior management team.

We looked at copies of off duty rotas and audit information presented to us by the trust. From this information we found that staffing levels were consistent with those which the trust assessed as being adequate throughout February 2014. However, during one week in March, 19 shifts did not have the required numbers of staff identified by the trust as being necessary to run the service effectively, while other weeks had occasional shortfalls in staffing levels. The trust informed us this was due to short and long term sickness absence. Half of the shifts on one post natal ward were below the trust's own agreed staffing levels during this week, which meant that women and their babies were not always fully supported during the post natal period.

The management of sickness absence within the maternity directorate had improved considerably since our last inspection. Ward managers had received support from the new Human Resources business partners to manage sickness absence within their own areas. Midwives we spoke with reported an improvement in the previously high levels of sickness absence, which had in turn had a positive effect on the staffing levels throughout the directorate.

Prior to our inspection we received information of concern regarding the midwifery staffing levels on Jeffcoate Ward, particularly at night. We had been informed that if the workload was heavy then midwives were re-deployed to the Midwifery Led Unit, which is adjacent to Jeffcoate Ward. This meant a healthcare assistant could be left caring for post natal women and their babies. The duty rotas for Jeffcoate ward and the Midwifery Led Unit were combined. This was despite them being two separate areas, one caring for women in labour and the other caring for low risk post natal women. It was not possible from looking at copies of the off-duty to confirm this practice and no-one we spoke with told us this usual practice. During the out of hours period of our inspection, Jeffcoate ward was adequately staffed by two midwives and a healthcare assistant.

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We had previously inspected this service on 7 and 8 July 2013 when we found non-compliance with this outcome for which a compliance action was issued. During this inspection we found that a third of staff had outstanding mandatory training and a third had not received an appraisal in the last year. We also found that staff felt unsupported and not listened to.

During this inspection we found that morale had improved within the hospital, with the exception of the areas where staffing levels were still low, or where staff were frequently moved from their regular place of work to cover staff shortages elsewhere.

Information received from the trust confirmed that a training plan was in place and all staff had either completed, or had a scheduled date for mandatory training during 2014. We spoke with 13 midwives during our inspection who told us that the new system of mandatory training was working well. They told us the training was booked in advance and staff were rarely removed from a block of training once it had been booked. This had happened frequently prior to the implementation of the new system.

Although the number of completed staff appraisals had not yet reached the trust standard of 95%, the numbers of staff who had now received an appraisal had increased to 83% by March 2014 and many of the outstanding appraisals had been scheduled to take place in the next two months.

We spoke with nine midwives about the level of support and supervision they received. Midwives confirmed that the numbers of Supervisors of Midwives (SOMs) had increased and they had good access to their SOM, both within working hours and outside of normal working hours using the on call SOM. We were also informed that choice of SOM was now more appropriate to the areas in which the midwives worked. An example of this was a hospital midwife who had been supervised in the past by a community midwife and had been able to transfer SOMs to one who worked in the hospital.

All staff we spoke with told us that staff meetings took place regularly and that they had an opportunity to contribute to the agenda. They told us that their opinions were listened to

during staff meetings and that their line managers were accessible and approachable. However, the provider may find it useful to note that healthcare assistants informed us that they could not always attend meetings due to staff shortages.

The trust had organised a series of 11 staff 'drop in' sessions with members of the executive team in attendance during February 2014, to listen to staff concerns and listen to ideas from staff on what the trust could do to enable them to feel more supported. Following these sessions, the trust issued a briefing to staff which contained feedback from the sessions and commitments the trust made to address the concerns raised. The briefing stated that some staff had raised issues around bullying, which they did not feel had always been appropriately addressed and also of being fearful of addressing concerns with their immediate line manager. Staff did not raise these issues with us during the inspection and we did not see any evidence to support these concerns. The trust has committed to ensure that they have "robust processes in place to deal with bullying and harassment, and that communications around those processes clearly differentiate between what is appropriate management and inappropriate behaviours." They have also committed to "invest in the development of managers and leaders throughout the organisation."

Assessing and monitoring the quality of service provision

✘ Enforcement action taken

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 did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

This outcome was included in the inspection as CQC received information of concern regarding the way in which risks within the trust were identified and managed. For the purposes of this inspection, we focused on the management of serious incidents and risks and specialist governance advice and support was provided.

The trust had a combined Risk Management Strategy & Policy dated July 2013. The current document contained information for staff which was ambiguous and unclear about how and where a risk assessment should be undertaken and recorded. We were informed that this is currently being reviewed and that a revised version will be available around May 2014.

The risk registers provided to CQC demonstrated an inconsistency in risk ratings and lack of focused management of risks. Some risks were entered on the risk register in 2006 and were still being updated. There appeared to be no check or challenge process to test whether this was appropriate and no end point for risks, all of which are normal practice as part of the management of risk within an NHS organisation. A number of examples were discussed with the relevant member of staff with regards to poor risk descriptions (the condition, cause and consequence of risks was not clear), inconsistency in risk rating and delay in action being taken. They agreed that, other than committees, there was no formal challenge process for the management of risks.

The Board Assurance Framework (BAF) was similar to the risk register in terms of risk description and actions being planned or taken. A BAF is a comprehensive method for the effective and focused management of the principal risks to meeting an organisation's objectives. We could not find any evidence of active monitoring by the Board of Directors of the principal risks to the organisation throughout the year. The trust had commissioned external support to help it develop the BAF further for 2014/15.

The Board of Directors has a Governance and Clinical Assurance Committee with delegated responsibility for governance and assurance. This Committee receives minutes from the Clinical Governance Committee, Information Governance Committee, Corporate Risk Committee and the Policy Assurance Committee. There was no evidence of how potential risks or issues were escalated, as the Governance and Clinical Assurance Committee minutes merely state that the minutes of the named committees have been received and noted. There is no standing agenda item for the escalation of risks from these committees or to the Board of Directors. It is important that there is a process for escalating key risks to appropriate members of the executive team so that they are aware of these risks and can oversee the mechanisms in place to deal with them.

There were robust systems for reporting incidents and 'near misses' across the maternity directorate. Comprehensive staff information posters regarding incident reporting were prominently displayed in all ward areas we visited. Staff were confident in reporting incidents and 'near misses' and were supported by managers to do so. Some of the staff we spoke with told us that regular feedback was given and there were examples of learning from incidents being applied and evaluated. Other staff, particularly healthcare assistants, told us they did not receive regular feedback from incidents.

To improve the feedback and sharing lessons from serious incidents, the Trust had introduced a 'Serious Incident Investigation Feedback Form'. This is a one-sheet summary of the incident, investigation findings, actions taken and how the chance of it happening again can be reduced. This appeared to be a useful summary for staff, although some did report that the bulletins were trust wide and therefore not always relevant to their particular area of practice. To support this, the trust reported feedback sessions with staff involved in the incident. However we spoke with one midwife who described a lack of effective communication and support after being involved in an incident, which was clearly distressing for them.

There was a time delay in reviewing incidents once they had been reported. The latest report to the Maternity Risk Management Committee stated that as of February 2014 there were still 130 unreviewed incidents, with the oldest incident being from March 2013. This is an ongoing problem for the maternity directorate and had been regularly documented in the minutes of the Maternity Executive Committee. We asked the trust about the risk of serious incidents being missed. The trust was confident that this would not be the case with other communication mechanisms in the organisation, but there was no evidence to support this.

No reports were available to demonstrate the review and in-depth analysis of incidents to identify themes, trends and areas for improvement. We were informed that this was due to a problem the trust has with its risk management system and the information that they are recording in it. It is important that an organisation has a risk management system which is fit for purpose so that risks can be managed efficiently and effectively.

The Trust has implemented the Friends & Family test. The system it is using for this enables individual members of staff to be identified for both good practice and areas for improvement. This is accessible for staff and is being used, along with complaints, to support reflective practice with staff.

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

There was no effective complaints system available.

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

This outcome was included in the inspection as governance information requested from the trust, prior to our visit, highlighted concerns with the way in which complaints were handled.

The trust had acknowledged concerns with its complaints handling process and had recently changed the line management structure and personnel within the team in order to address this. Complaints response times had been consistently poor against the Trust's own standards. The latest data reported to the Board of Directors was from February 2014 and indicated that only 64% of complaints had been responded to with the timescales set by the trust. The trust told us that this issue was now resolved. We were unable to assess this, or whether the improvements will be sustainable, as the current complaints were not yet due for completion at the time of our inspection.

There was no information for patients displayed on wards or in communal areas throughout the trust informing patients and visitors about how to make a complaint, should they wish to do so. None of the staff on the wards we visited could produce any information for patients on how to make a complaint. We spoke with nine patients during our inspection about the complaints process, none of whom knew how to make a formal complaint to the trust. Staff members also appeared uncertain of the formal complaints process, but all staff we spoke with would try to resolve issues at ward level. Whilst resolving issues as quickly as possible at ward level is good practice, no record of the minor issues raised or actions taken had been kept. This minimises the opportunity for identifying themes and sharing learning.

The Patient Advice and Liaison Service (PALS) is often an important point of contact for expressing concerns about the patient experience and receiving information on how to make a complaint. The PALS service is particularly important for people with poor literacy skills who need to make a verbal complaint which they may not feel able to make to the people directly involved. There was no signage to the PALS office on the main signage boards at the entrances to the hospital and on the day of our inspection the PALS office was closed due to staff training. A member of the executive team told us that the trust encourages face-to-face meetings with complainants and that this works well.

Complainants are provided with a CD recording of the meeting. Whilst formal evaluation of the complaints process is not undertaken from the complainants' perspective, we were told that some complainants have become involved in helping the Trust improve services or reviewing information.

We had arranged to go through a random selection of complaints files to review the process, quality of complaints response, action planning and implementation/monitoring of actions from complaints. However, a relevant member of staff felt that there was no need to do this, as they were confident that they would not meet the required standard, particularly with regard to action planning. This is an area the Trust is working to improve.

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	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints How the regulation was not being met: The provider did not have an effective system in place for identifying, receiving, handling and responding appropriately to complaints made by the people who used the service or persons acting on their behalf. Regulation 19 (1) (a) (b) (c) (d).
Family planning	
Maternity and midwifery services	
Surgical procedures	
Termination of pregnancies	
Treatment of disease, disorder or injury	

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 09 July 2014.

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.

This section is primarily information for the provider

✘ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 01 September 2014	
This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Maternity and midwifery services	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010
	Staffing
	How the regulation was not being met: Sufficient numbers of suitably qualified, skilled and experienced staff were not on duty at all times in order to safeguard the health, safety and welfare of people who used the service. Regulation 22.
We have served a warning notice to be met by 01 September 2014	
This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision
Family planning	
Maternity and midwifery services	
	How the regulation was not being met: Appropriate systems and processes were not in place to identify,

This section is primarily information for the provider

Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	assess and manage risks relating to the health, welfare and safety of people who use the service. Regulation 10 (1) (b).
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For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

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

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

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

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

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

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

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

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

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


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


How we define our judgements

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

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

 **Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

 **Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

 **Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

Phone: 03000 616161

Email: enquiries@ccq.org.uk

Write to us
at: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Website: www.cqc.org.uk

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