

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

Circle Hospital (Bath) Limited t/a Circle Bath

Foxcote Avenue, Bath Business Park, Peasedown
St John, Bath, BA2 8SQ

Tel: 01761422222

Date of Inspections: 08 January 2014
07 January 2014

Date of Publication: February
2014

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

Care and welfare of people who use services	✓	Met this standard
Cleanliness and infection control	✗	Action needed
Safety, availability and suitability of equipment	✓	Met this standard
Requirements relating to workers	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	Circle Hospital (Bath) Limited
Registered Manager	Ms. Shelagh Anne Meldrum
Overview of the service	<p>The Circle Bath is an independent hospital on the edge of Bath. Services at the hospital include consultation, general surgery, physiotherapy, oncology and screening. The hospital treats adults and children over the age of three years. There are 30 overnight beds and 22 day surgery beds and the hospital is part of the NHS Choose and Book service for some procedures.</p>
Type of service	Acute services with overnight beds
Regulated activities	<p>Diagnostic and screening procedures</p> <p>Surgical procedures</p> <p>Treatment of disease, disorder or injury</p>

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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	5
More information about the provider	5
Our judgements for each standard inspected:	
Care and welfare of people who use services	6
Cleanliness and infection control	8
Safety, availability and suitability of equipment	10
Requirements relating to workers	12
Assessing and monitoring the quality of service provision	14
Information primarily for the provider:	
Action we have told the provider to take	16
About CQC Inspections	17
How we define our judgements	18
Glossary of terms we use in this report	20
Contact us	22

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 7 January 2014 and 8 January 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

We visited the Circle Hospital (Bath) over two days. We met with the hospital manager and then toured the hospital site in the company of the lead nurse and lead for governance. We talked with patients and their family and friends who were accompanying them. We met with a range of staff including the hospital manager, senior executive staff, nurses, consultants, healthcare assistants, administration, facilities and maintenance staff.

Patients told us the care and treatment they had received was "excellent", "very good", and "very caring." A patient said "I would give them ten out of ten." Patients told us staff were "quite exceptional" and all the clinical staff spent time with them answering their questions and explaining the procedures. A patient said "everyone's been fabulous."

We found patients' needs were assessed and their care and treatment was planned to meet these needs. This included taking account of values and diverse needs. The hospital delivered care and treatment in line with published research and guidance. Arrangements were in place to deal with unforeseen medical emergencies.

The hospital monitored the safety and quality of the service patients received. This was done through an effective system of governance. The comments, compliments and concerns of patients were taken into account in the way the service was delivered.

Equipment, fixtures and fittings at the hospital were safe and maintained as and when required. Equipment required to meet the needs of patients was available and staff were trained to use it correctly and maintain it to the required standards. People were supported by staff who had been recruited through effective procedures. Checks on staff employed at the hospital had been carried out as required, including consultants who were contracted to practise at the hospital.

Appropriate infection control policies and protocols were in place. The hospital was well maintained, but we found unacceptable levels of dust lying on bed frames. Some floors below patient beds were not as clean as they should have been.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients told us they had safe and effective care and treatment. We spoke with eight patients. They all said they were happy with their care and treatment. Comments about the staff included: "the staff are exceptional", "all staff have been very efficient", "the nursing staff are excellent", and "I cannot complain about a single thing." People said staff were "very caring" and a patient said the consultants were inclusive and approachable. One patient remarked that both the anaesthetist and consultant came to see them after their procedure to see if they were doing well.

Patients' needs were assessed and care delivered in line to meet those needs. We examined 26 sets of patient notes covering patients having a variety of surgical procedures at the hospital. We found the notes were comprehensive and clear. Patients were assessed for certain risks in theatre, such as developing a venous thromboembolism. When admitted to the ward, patients were further assessed for other risks such as pressure ulcers and any need for the use of bedrails. The risk assessments were thorough and completed when appropriate. Where a patient was assessed as having a hydration risk and needing a fluid-balance chart, we saw these were produced and completed correctly.

The provider may find it useful to note we were not able to see evidence of a patient being provided with anti-embolism stockings following surgery if these were indicated as an assessed preventative measure. The hospital had supplies of these products, but the notes did not clearly show if and when they had been used or provided to a patient. There was no area within the discharge paperwork to complete to advise patients about their ongoing use if these stockings had been provided.

People were protected from avoidable events occurring in surgical procedures. The hospital used the internationally recognised World Health Organisation (WHO) surgical safety checklist in all operating theatres. This procedure involved a number of steps to ensure every stage of surgery was checked as confirmed, ready and safe. Staff told us

about the process and how each member of the theatre team was involved. We saw examples in patients' medical records which had been fully completed. The hospital had different checklists as required for some surgical procedures, and a separate checklist for procedures involving children.

People were protected by the hospital having relevant information about them. We saw a number of patients had declared allergies or intolerances in their health questionnaires. Patients were asked to complete a questionnaire and answer detailed relevant questions about their current and past health. This included a declaration about any medicines, foods or other things they may be allergic to or intolerant of. We saw this information had been transferred to other critical paperwork, such as prescription drug charts and surgical data. Hospital information also included valid informed consent, and information about a person's next-of-kin. Staff checked and made sure patients were supported by a relative or friend when they were discharged.

Patients were given medical information about their ongoing care to take home following their discharge. The hospital provided patients with information leaflets about the procedure they had received. This information gave more details about the condition treated; how a patient might feel after an anaesthetic; post-operative advice about, for example, driving or going back to work; pain relief; and what to do if there were any concerns. Patient notes recorded medicines people were given to take home. The discharge paperwork recorded patients had been advised how and when to take these medicines, when they could resume certain activities, such as sports, and whether they had further appointments for follow-up or therapy at the hospital.

The hospital had arrangements in place for dealing with unplanned or unforeseen medical emergencies. This included a contract with the local acute hospital to transfer patients if necessary. The hospital had documents that would be prepared and sent with any patient who needed emergency transfer. The standard form included all the patient's personal information and detailed information about tests carried out and any procedures undertaken. A copy of the patient's notes would also be made and sent with the patient. The hospital had clear written instructions and arrangements for the nursing staff to follow should a doctor decide a patient needed to be transferred. Staff we met clearly understood these arrangements and their role in any emergency transfers. All clinical staff were trained in basic life support and the hospital had specialist staff on duty at all times trained to support children. The hospital was also arranging for all staff in any role to be trained in basic life support.

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

Our judgement

The provider was not meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed, but people were not cared for in a satisfactorily fully clean, hygienic environment in some patient areas and other areas.

This is a breach of Regulation 12 (2) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

People were protected from infection by staff adhering to the hospital's policies on hand-washing, uniforms, clothing and personal appearance. All the clinical staff we met were wearing clean uniforms or surgical scrubs. Staff had short clean finger nails and were not wearing inappropriate jewellery. This meant hand-washing would be more effective as there were no barriers to good hand-washing techniques. The majority of hand-wash basins we saw for staff to use had electronic no-touch soap dispensers, paper towels, no-touch taps, and foot-operated waste bins with well-fitting lids. The no-touch soap dispenser in the patient toilet on the ground floor was not working and there was no soap in one of the changing room toilets in the day surgery area. We saw staff had used this and not addressed the lack of soap. We saw hand gel available in people's bedrooms, day surgery bays, and other appropriate areas. We observed staff in the recovery area washing their hands thoroughly before and after approaching a patient.

The hospital audited various infection control protocols on a regular basis. Hand-wash and uniform audits were done regularly and results fed back to senior staff. We looked at a recent audit of personal appearance of staff. This included checking for inappropriate jewellery, and finger nails for wearing of false nails and varnish. The hospital would follow its disciplinary proceedings for staff who had not met the requirements for minimal jewellery and no nail adornments, or any of the other rules around dress and appearance. There were also walk-arounds conducted by different senior staff, for which staff had no advanced warning. Staff conducting walk-arounds would concentrate on specific or general areas and any areas of concern discussed with the lead for that area immediately.

People were protected from infection by staff wearing disposable personal protective equipment (PPE). Staff had available and wore disposable aprons and gloves when appropriate. Staff said this would be the case when, for example, they were taking blood

or urine samples from a patient, or delivering any personal care to patients. We observed this happening in practice. Staff confirmed to us PPE was available to them at all times and there was a back-up stock held when stocks in any discrete location were running low.

Cupboards and storage areas had closed doors to protect them from accumulating dust and dirt and to avoid the need for excessive cleaning. We found cupboards were generally clean and tidy and well organised. Most non-patient areas were tidy and well looked-after, although there was limited storage space for staff to keep their personal belongings. There was some cleaning equipment standing in a corridor and not stored away. The head of the sweeping brush which was standing on top of the mop bucket was full of dirt and dust residue. The cleaner's cupboard at the end of the inpatient floor was also not clean and there was excessive dust on surfaces. The clean and dirty utility rooms we saw were clean, well-organised, and tidy.

Most patient areas of the hospital were clean and well maintained. We did not examine the operating theatres on this visit as they were all in use, but we talked with the theatre manager. The manager told us about the cleaning regime. There was no regular deep-clean routine planned for theatre and this had been recognised. The manager was now arranging for the housekeeping team to carry out a deep clean routine for all theatres to take place every six months. Otherwise, cleaning schedules had been prepared by theatre staff for the housekeeping staff to follow. The theatre manager had recognised there was insufficient oversight of theatre cleaning and had recently asked to see the cleaning records. The manager was preparing to update them to ensure they followed the correct guidelines.

Although we found many good examples of effective cleaning, we found excessive dust on the underneath frame of one couch we inspected in the physiotherapy suite. The sink in that room was also not clean on the surface, and other surfaces were dusty and sticky in places. We found dust standing on the frames under beds in patient's bedrooms. We checked the plug-hole in one patient room and found it to have not been effectively cleaned. The floors beneath the beds in the three inpatient rooms we saw were dusty in places. The skirting boards were also dusty. The bed frames in the patient cubicles in day surgery were also dusty, although the beds and other surfaces were clean. Linen and mattresses we saw were clean and in good condition.

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

Patients we met said they believed all the equipment that had been needed was available. They said staff seemed competent and experienced at using equipment and did so safely. Staff confirmed they had all the medical and non-medical equipment they needed, and if any equipment failed, this would be repaired quickly. Staff said any procedures that would be put at risk from a lack of safe equipment would be cancelled or postponed until the equipment was repaired or replaced.

Equipment was properly serviced and maintained. We spent time with the manager of electro bio-medical equipment (EBME). Each piece of equipment within the hospital had been recorded and given an asset number. The records showed what the equipment was, what it was used for, where it was located, and details of when it was purchased. The hospital database record then showed when the equipment required servicing. This followed the manufacturer's instructions for servicing, or, if the usage of the equipment was high, or it was considered a critical piece of equipment, the EBME manager elected to service it more frequently than the guidance. No equipment was serviced less frequently than the best practice. We checked some specific equipment on the register. We saw when it had been serviced, and then checked the physical equipment to see the label confirming the servicing date.

Equipment was serviced at times that enabled the hospital to continue to run safely. The EBME manager showed us how equipment in specific departments was serviced by the hospital trained and experienced staff over several months. This was in order that no groups of equipment were taken out of service for testing all at the same time. For example, monitors in the recovery area were serviced individually over a three-month period. Managers of the departments were also aware when their servicing programme took place each year or more often, so they could ensure all the equipment they were registered as having in their area was accounted for and made available.

Staff knew how to use equipment and had been provided with up-to-date training and instruction manuals. Each department had files and information available both in print and via the internal computer system if they wanted any information about the equipment they used. The physiotherapy manager told us the equipment they had in their department was standard equipment for that service. All staff had been trained to use the equipment and were experienced with its regular use. They said the equipment was regularly serviced

and they received a good response from the organisation if anything needed to be repaired or checked for possible faults.

The life support equipment was appropriate for a hospital, well maintained and there was good provision. The resuscitation trolleys were all secure, the oxygen was full, and the suction and defibrillators were checked and working. The trolleys in all areas had been regularly checked. The recovery suite had monitors for each bay and all were within their service date. All the equipment we saw at the hospital was monitored and supervised if it was not locked away. Staff said they had all the equipment they needed and regularly checked it was where it should be.

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

The recruitment of staff was carried out to ensure staff were able to perform their roles effectively. The human resource (HR) function was provided by a shared service arrangement within the Circle organisation. HR personnel would work between the different locations on a regular basis providing support to the hospital manager and senior staff. The HR lead, lead nurse and governance lead described the recruitment process. When a vacancy arose for nursing, administrative or management staff, this would be approved for advertisement by senior staff. Advertisements were placed locally and nationally. This included the organisation's website, recruitment agencies, and local media. Applicants were required to complete an application form which was assessed, and a short-list of at least two candidates were invited for interview. Interviews were conducted with two members of staff who were either to manage the person or already carried out a similar role. Interview questions were decided in advance and notes of the candidates' responses were kept. This enabled the hospital to demonstrate the process had been fair and why one person had been selected over another. Doctors and consultants were granted admitting rights when vacancies within their specialty arose or the hospital introduced new services. Any doctor applying for practising privileges would be reviewed by a hospital committee, which was a sub-committee of the executive board, and which met monthly.

Identification and confirmation checks were completed. Candidates who were successful at interview were required to provide evidence of their identity, relevant qualifications, and references. Identity included a photographic document such as a passport or driving licence with a photograph. The person's address was checked generally with copies of documents from a list the organisation considered were acceptable, such as utility bills. Certificates of relevant qualifications were provided and placed on file. References were then obtained from the candidate's most recent employer(s) and/or someone who knew them personally.

Staff provided evidence of their registration with any professional body or regulator, if appropriate for their role. Consultants and doctors were required to provide evidence of their medical insurance and registration with the General Medical Council. Nurses were required to provide evidence of their registration with the Nursing and Midwifery Council and their ongoing membership status.

Checks were made of staff with external agencies. This included all employed staff having enhanced Disclosure and Barring Service checks (DBS - formerly CRB) before they commenced employment. DBS checks were required for doctors and consultants as part of their ongoing registration with the GMC. However, they were also required to complete a DBS check with the hospital. The provider's policy was for DBS checks to be renewed for all staff every five years. The hospital had a comprehensive record of all documentation required to be supplied by doctors and consultants. This showed when information had been provided and when it was due for updating. There were a number of consultants who had not provided updated medical indemnity insurance certificates, nor copies of their NHS appraisals. The hospital was aware of each document required and we saw evidence they were directly contacting the doctors concerned. The provider may find it useful to note there was no process in place for senior staff to follow if doctors did not provide this information when requested in a reasonable time.

Staff files demonstrated the required information had been obtained. We found from reviewing six sets of employee files the hospital had obtained all the information the provider required. The files were well organised. Each file contained an index and were divided into sections. A checklist of the documents required had been completed in those we reviewed and this confirmed all the documents had been obtained. The lead for governance had recently undertaken an audit of staff files to ensure they were in order. We reviewed six sets of consultant files. These included documents such as the doctor's CV and the contract to practise at the hospital. Qualifications and registrations with professional bodies were also documented. These files had also been audited by the governance lead and the new database created to gather all the relevant information in one place.

Assessing and monitoring the quality of service provision

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive and to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

The hospital had a corporate and clinical governance set-up to monitor the safety and quality of care and treatment for patients. There was an executive board overseeing the hospital which was made up of the hospital manager and senior directorate staff. The executive board exercised day-to-day control and management of the hospital.

The executive board was assured about how the hospital was operating through sub-committees, groups and forums. This included committees for, for example, medical gases, paediatric care, information governance, health and safety, facilities management, and the clinical governance and risk management committee (CGRMC) which met monthly. Standing agenda items each month included reviewing the risk register, incident log, the governance report which covered audit work undertaken, patient experience, complaints and any other business or annual reports.

The executive board was assured about the effectiveness of the systems and processes in the hospital due to regular audit routines. The audit programme was produced annually. All those areas we would expect to be audited in a hospital setting were reviewed. Areas had been risk assessed to decide how often the audit should take place. The audits were both clinical and non-clinical. Monthly audits included hand hygiene, the environment, controlled drugs and clinical records. Clinical audits included the resuscitation trolleys, returns to theatre, compliance with the World Health Organisation (WHO) surgical safety checklist, and emergency transfers. We saw evidence of how consultant information was being updated following an audit of records. There were also unannounced and regular walk-arounds at the hospital by senior staff. They talked with patients and staff during these visits and examined certain aspects of the hospital such as cleanliness, health and safety, fire risks, and the general environment. Pictures were sometimes taken to illustrate areas for improvement to directorate leads. The WHO checklist was audited on a sample of patients each month by staff in the recovery department, so any concerns were known immediately following surgery.

Where necessary, audits were carried out by trained and experienced experts. For

example, a full site health and safety audit was carried out annually by the lead for health and safety for the provider organisation, who was based at a different site. A full report was written for the hospital and this was presented to the CGRMC. An action plan from the report was produced. We saw the actions required of the hospital from the last audit in 2013 had been completed. If any of the actions were the responsibility of directorate leads, these would be completed and then further checked by the governance lead.

Assessing and monitoring the safety and quality of care from the patient's perspective were done well. This included the handling of complaints. We reviewed some of the few complaints made to the hospital and found they were all taken seriously; responded to in a timely way; and if they were upheld, changes were made to practice. For example, where a patient said the bays in the day case department were not warm enough, duvets were provided for all patients to use in future. All complaints were received by the hospital manager and manager of hospitality. They were reviewed by the CGRMC committee each month and their status updated until they were closed. The CGRMC and the executive board received and reviewed comments and compliments from patients at each meeting. These were shared with staff through newsletters, publication on notice boards, and personal congratulations to the staff involved.

Incidents occurring at the hospital were well reported. The electronic system for recording incidents had been introduced for just over a year, replacing the paper-based system. All the staff we spoke with understood the reporting system and how and when to use it. Incidents were received by the lead nurse and governance lead. They would be investigated as appropriate and only closed when the governance lead and hospital manager were satisfied they had been thoroughly addressed. Any actions from incidents were recorded. They would be discussed at the health and safety meeting if this was relevant, or by directorate leads, and then at the CGRMC and the executive board.

The hospital recognised its risks through maintaining a register of risks. We reviewed the current register and saw areas identified were being addressed; the deadline for removing or mitigating the risk was achievable; and the risks were rated to denote the level of potential harm. There were no serious or significant risks identified. The risk register was reviewed by the CGRMC, the executive board, and the provider's integrated governance committee.

The hospital had a number of processes for receiving feedback from patients about the service. There was an annual inpatient survey where all inpatients over a period of usually two to four weeks were asked to complete a survey covering 25 different questions. The hospital received 112 responses in November 2013. Almost all the responses to the questions were either 'excellent' or 'very good'. We saw where patients had made suggestions for improvements, such as clocks being provided in patient bedrooms, this had been addressed within a few weeks. There was also an outpatient survey and the hospital had an ongoing Friends and Family-style test. This asked patients to say what had been particularly good at the hospital, what they might like to change or was not done well, and would they recommend the hospital to family and friends. The responses were reviewed weekly and then posted onto the organisation's website. There were 'patient champions' in each part of the hospital. These staff would talk in more depth to two patients each month and feedback their experiences to the right person.

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 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control How the regulation was not being met: Some parts of the fixtures and fittings in the hospital had excessive dust from a lack of effective cleaning. Some cleaning equipment and storage areas were not as clean as they should have been.
Surgical procedures	
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 18 February 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.

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

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.
