Inspection Report

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

Plymouth Orthodontics Limited

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Tel: 01752662554

Date of Inspections: 28 February 2014
13 February 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Plymouth Orthodontics Limited
Registered Manager	Mr. Sanjay Kumar
Overview of the service	Plymouth Orthodontics Limited provides orthodontic treatment for children and adults under an NHS contract and to private patients.
Type of service	Dental service
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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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 announced 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 13 February 2014 and 28 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We sent a questionnaire to people who use the service, talked with people who use the service, talked with carers and / or family members and talked with staff. We reviewed information given to us by the provider.

What people told us and what we found

We spoke with five people receiving or accompanying relatives for treatment at the practice and looked at the Patient Feedback Survey undertaken by the dentist between November 2013 and January 2014. People told us "very happy here….personal and friendly", "I needed an emergency appointment when part of the brace broke and we got an appointment fairly quickly", "the dentist has a very clear and informative style of delivery". Survey comments included "All staff and dentist are very friendly and approachable", "It's very good!", and "everything is great".

Everyone said they were involved in their treatment plan and had been asked for their consent. Parents were involved to ensure choices about their children's treatment were being properly identified and they were assisted to make decisions in their child's best interest.

People's treatment needs were assessed carefully, and treatment was provided effectively by experienced and qualified staff. There were systems in place to provide care in the event of a medical emergency.

We found that people who used this service and staff were protected from identifiable risks of acquiring an infection because there were systems in place to keep the practice clean and hygienic including effective de-contamination of instruments in accordance with guidelines.

We found that staff were qualified and had the relevant skills and experience to carry out their jobs. They were registered with relevant professional bodies which meant they were able to carry out their respective jobs.

We found the quality of the service provided was audited and monitored by the provider to ensure it was safe, effective and well-led.

You can see our judgements on the front page of this report.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care. We spoke with five people receiving or accompanying relatives for treatment at the practice. They told us they found the staff were friendly and welcoming. They felt they and their relative were treated respectfully by the dentist and all the staff. People told us "the dentist is very friendly and answered all our questions" and "the dentist's strength is he explains things well". One parent told us that the dentist was "very good at speaking directly to [their child] and referring back to [the parent]". This showed the dentist included and involved the child as the patient, as well as making sure parents were informed and able to contribute to the consultation too.

The people receiving treatment at the practice all confirmed they had been involved in their treatment plan. They said they had been given "lots of information" by the dentist about how to care for an appliance and what they could and could not eat whilst wearing it. They told us they were asked for their consent before any treatment was undertaken. Parents accompanying children told us they had signed a consent form to confirm they agreed with the treatment plan and for their child to receive treatment by the dentist.

The dentist confirmed that parents accompanying children signed a consent form to confirm they agreed with the treatment plan and for their child to receive treatment by the dentist. We saw signed consent forms for treatment on patients' records including the NHS consent form if the patient was receiving NHS care and treatment. The dentist also showed us examples of full orthodontic assessments on patient records that he explained were taken at the first appointment for each patient. This was an electronic record. If any significant change for treatment occurred, the dentist added additional notes to the plan. He showed us how he recorded all the options he had discussed with the patient (and parent if appropriate).

We asked the dentist how they sought informed consent from their patients for treatment.

They told us they would talk through all the options of treatment and the benefits and risks of each option. The dentist said they included waiting a period of time before considering treatment as an option however they explained to the patient what may happen if the treatment was not carried out. The dentist said that treatment was only given when it was considered to be safe and appropriate for the individual and the dentist was confident the person was capable of making the decision for treatment. The dentist told us they were very conscious about risk and therefore ensured they had gained full patient consent before proceeding with any treatment. They told us that if people were self-referrals, they would discuss if treatment was appropriate, suitable and needed. The dentist also said they would always seek a second opinion if there were any doubts or concerns about treatment for a patient.

If they were concerned about a person's capacity to understand and make informed decisions, the dentist told us they would try to ensure that the correct people were involved in making decisions in the best interests of the patient.

The dentist told us they wrote to the patient's dentist to inform them of the proposed treatment plan. If teeth needed to be extracted before an appliance could be fitted, the general dentist would be told about this. It was also reliant on the general dentist to inform the orthodontist if there were any problems with extractions. The dentist said that whenever it was possible they tried to start treatment without the removal of any teeth however this was not always possible. If needed patients could be referred to the local hospital for extractions and the dentist was able to facilitate this.

The people we spoke with said that the dentist had given them time to think about treatment before agreeing to a treatment plan. They were also positive about communication with their own dentist by the orthodontist. The dentist told us that the key to successful outcomes of treatment was communication with their patients and with parents or accompanying relatives of children or adults receiving treatment.

Patients under the age of 18 years were assessed to see if they met the NHS criteria for orthodontic treatment. The practice offered private treatment for children who did not meet the criteria or who did not wish to wait, and also for adults needing orthodontic treatment. Fees for these patients were available on the practice website and were discussed by the dentist with people paying privately. At the time of our inspection visit fees were not displayed in the practice and the dentist agreed to arrange to make these available.

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.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare.

Reasons for our judgement

We spoke with five people receiving or accompanying relatives for treatment at the practice. They all gave us positive feedback and comments included "very happy here….personal and friendly", "dentist is very clear…verbal instructions about oral health and post treatment retainer clearly explained", and "pleased with treatment and care".

People confirmed they were asked about their medical history and it was checked for any changes on subsequent visits. We saw on patient records there were signed and dated medical histories. For the people who had been receiving treatment over an extended period of time, the medical history was updated annually and/or if there was any medical change between appointments. We also saw medical alerts recorded on patient records. This meant the dentist was alerted to take appropriate measures to prevent adverse reactions such as an asthma attack or an allergic reaction to latex.

We asked people about appointments. They told us that once they had started treatment, appointments were "fairly quickly". We saw that the dairy was open for appointments to be booked up to four months in advance. We found for standard referral NHS patients there was about seven months waiting time for the initial appointment and about two years waiting list for treatment; urgent referrals were booked as soon as possible. This wait was due to the NHS contract which once it was filled, the dentist could not take any more NHS patients. There was no restriction on the numbers of private patients. A dental nurse showed us how the treatment waiting lists were monitored. The dentist recorded clinical notes and set a recall date. For example, a patient seen on the day of our visit had a 12 months recall date set. This meant a letter would be sent to the patient in December 2014 with an appointment for February 2015. We found young people's ages were monitored and anyone reaching 17 years was given priority to be seen and treatment started before they reached their 18th birthday. This was important if they were to be treated as a NHS patient. Younger children started treatment in date order. If a patient was dissatisfied with the length of waiting time, they were offered a review and the option of being referred elsewhere was discussed.

For the young people we spoke with after school appointments were important and we observed staff were accommodating about booking these. Evening appointments were

also available for private patients who preferred these. One person told us "I needed an emergency appointment when part of the brace broke and we got an appointment fairly quickly". Breakages of fixed appliances were not charged for NHS patients, and private patients were charged only if it happened repeatedly. In these cases the appliance was removed and the patient discharged from treatment. We saw additional retainers were available for people to buy from the practice at NHS rates (the first one was provided free of charge to NHS patients) or at a private discounted fee. Dental hygiene products were also on sale at reception. These included mouthwash, toothbrushes, interdental brushes and "retainer brite". We saw on patient's records details about any leaflets given to the patient about oral health, and wearing an appliance or a retainer post treatment.

We looked at some examples of patient records. We saw these contained the letter from the referring dentist and letters to the referring dentist explaining proposed treatment plans after the first consultation. A full orthodontic assessment was completed at the first appointment with written clinical notes by the dentist as well as a record of options for treatment that had been discussed with the patient. Full orthodontic records, X-rays and study models (impressions of patient's teeth) were taken when the patient started treatment. For private patients, notes of the visit were recorded by the dentist including risks, treatment options, types of discomfort that the patient could expect, and the expected length of treatment time. This information was put into a letter and given to the patient as confirmation of the consultation. The patient was asked to read and sign the letter, and bring it with them on their next appointment as a copy for their patient record. On the second appointment, the dentist revisited all the options and treatment plan discussed previously. This appointment also included the completion of dental records, x-rays and taking study models. The appliance was then fitted on the third appointment.

The dentist was a registered specialist in orthodontics and also held a postions as an associate specialist at the local general hospital. The dentist said that their specialist knowledge was advantageous for patients because they were able to provide both the surgical care and orthodontic care. This meant there was continuity for the patient. We saw there was a clear audit of referrals sent from the dentist to the consultants of the hospital dental department. Referred patients were seen by a hospital dental consultant for assessment for treatment and then referred to a specialist surgeon. This may be the dentist particularly if a patient had requested this. The dentist told us patients generally wished to be treated as soon as possible and accepted the earliest appointment with any hospital dental consultant.

We found the dentist was able to seek a second opinion from other dental colleagues. We saw a patient record as an example. The patient's permission was sought before any information was shared including the use of photographs and study models.

The practice had an automatic external defibrillator (AED) as recommended by the Resuscitation Council (UK). We saw on staff training records and staff confirmed they all received training in cardiopulmonary resuscitation (CPR) and use of the AED annually. We saw procedures for staff about what to do in the event of a medical emergency. The medical emergency equipment, emergency drugs, first aid box and the oxygen cylinders were checked monthly by the dental nurses. The drugs were stored in separate wallets that were zipped and closed with tagged seals. We saw checks were recorded and included expiry dates of medicines so these could be ordered in advance of expiry.

We saw that the local rules for maintaining safe practice with respect to X-rays were in place, with an advisory service under contract. There was signage outside the X-ray room

to alert people if the equipment was in use. The dentist was the radiation protection supervisor. This meant he was responsible for checking the X-ray equipment and ensuring safe disposal of x-ray chemicals with a local contractor. Routine radiation equipment checks were completed every three months, the last check being 03/02/2014. We saw a radiation risk assessment was in place. X-rays were only taken by the dentist who was registered with the General Dentistry Council (GDC) and followed GDC core training requirements in radiation protection.

People told us that the dental nurses acted as chaperones during treatment to ensure people's privacy and dignity were respected. We observed that surgery was arranged so that accompanying adults of children could also be present during the treatment session. The chairs in the waiting room were all of standard height and without arm rests. This meant there was no choice of a higher level chair with armrests for anyone who may need this to ease sitting down and standing up. Access to the building was up a flight of steps. People were informed about this when they were initially contacted by the practice staff. This information was also displayed on the practice website and informed people that wheelchair access was not practicable due to limitations of the building.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed and were cared for in a clean, hygienic environment.

Reasons for our judgement

Everyone we spoke with who used this service told us the premises were always clean and tidy. No one we asked had any concerns about risk of infection or poor hygiene practices from the dental staff.

We saw in annual staff performance reviews that staff objectives included infection control training in 2014. We also saw evidence showing the dentist and dental nurses were vaccinated against Hepatitis B. This ensured the safety of the people using the service.

In November 2009 the Department of Health published a document called Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05). It set out in detail the processes and practices essential to prevent the transmission of infections and clean safe care.

The practice had a dedicated decontamination room where all the dental instruments were cleaned and the dental nurses were responsible for decontamination of instruments on a rotational basis. The dental nurse on duty showed us the decontamination procedures, including the packaging and storage of clean instruments. There was a separate sink for hand washing with liquid soap and paper towels. Before starting the decontamination process the dental nurse put on their protective gloves, apron, mask and visor. There was a flow of work from dirty to clean. Boxes were labelled to ensure dirty and clean instruments were stored separately. The boxes used to transport instruments were leak-proof, rigid and closed securely to protect instruments from damage and to protect the handler from injuries.

Dental nurses brought dirty items from the dental surgery in covered boxes, immersed in water with an enzyme cleaner. Any disposable instruments were disposed of in the clinical waste bin or bin provided for anything sharp. The reusable items were scrubbed under cold water with detergent to remove any visible debris. The temperature of the water was monitored to check it was not above 45 degrees Celsius. This was not recorded after each load however the dentist agreed to add this to the decontamination check lists. The instruments were rinsed in plain water before they were inspected under a magnifying glass to check they were clean. Any instruments still showing debris were returned to the

sink for a second scrub. The cleaned instruments were laid out on trays and these were loaded into the autoclave that was used to sterilise the instruments. Any hand-pieces were cleaned and lubricated before sterilisation. This is because hand pieces are hollow and require a different method of cleaning. A log was maintained of each use of the autoclave and the ultrasonic cleaner.

The clean instrument trays were removed from the autoclave and checked for damage or wear. The clean instruments were bagged and stamped with the expiry date by which they had to be used or processed again in accordance with revised HTM01-05 guidance issued in May 2013 in the clean area of the decontamination room. This process was carried out as it was needed throughout the day. Pouches were checked to ensure they were still in date. Any instruments that had not been used and were past the expiry date were returned to the decontamination room to be put through the decontamination process again. The pouched cleaned instruments were put into "clean" boxes and transported to the dental surgery where they were stored ready for use. We saw in the dental surgery trays with instruments not in pouches. The dental nurse explained there were always less instruments than would be required for each sessions however if any of the trays and instruments were not used, these were sterilised and pouched at the end of each day.

The dental nurses told us that anything being sent away to a laboratory, for example, dental impressions were rinsed, disinfected, date stamped and sealed before they left the surgery. Prostheses and appliances were subject to decontamination on their arrival at the practice from the laboratory.

One of the dental nurses told us that daily checks were completed each morning and at the end of each day in each surgery. These checks included purging water lines, dealing with clinical waste and disinfecting suction systems. Staff told us there were checks that supplies of disposable items such as gloves and face masks were sufficient. All stock was rotated to ensure it was used in date order. The dental nurses were responsible for cleaning their surgery between each patient, and at the end of each day. This included the dental chair, armrests, overhead lamp handles and all work surfaces. The dental nurses were also responsible for checking the decontamination room daily at the start and end of each day to ensure safety and cleanliness. This ensured staff knew what action to take to minimise the risk of infection.

The people were spoke with confirmed the dentist and dental nurses all wore disposable gloves and face masks during treatment of a patient. Also the patients were given protective eye wear and disposable bibs to protect their clothes during treatment.

We saw that clinical and hazardous waste was collected and stored safely in the surgery until it was taken outside to a lockable clinical waste bin. This happened daily. We saw certificates and arrangements were in place for the collection of clinical waste and sharps, and trade waste, by appropriate contractors.

The dental nurses were provided with their uniforms however they were responsible for washing them. They told us they could wear their uniforms home as long as they were not stopping off en-route. The provider may like to note that Chapter 6 of the HTM0105 6.33 states that clothing worn during the decontamination process should not be worn outside the practice and a similar approach is recommended for clinical clothing.

Supporting workers ✓ Met this standard

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

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. The number of patients seen by the dentist each session varied depending on the type of treatment and length of time needed for the appointment. On average there were between 20 and 40 appointments per day. At the time of our visit Plymouth Orthodontics employed three part time dental nurses to provide nursing and administration support to one part time dentist who owned the practice. There was a rotation of dental nurses between reception, administration, decontamination duties and dental nurse support in surgery with the dentist. This meant each dental nurse was able to cover each area of work to provide continuity and efficiency in work practice.

The dentist told us they had internal and external networks of clinical support. They had an annual appraisal which was conducted by another dentist who checked the dentist had kept up to date with their knowledge, and was someone who worked elsewhere with no conflict of interest with the dental practice. We saw a record of evidence that was kept by the dentist for the appraisal and this showed details of continual professional development, including study days and individual learning. The appraisal also included quality improvement actions where the dentist demonstrated their input into the profession, and feedback from patients.

We looked at all the dental nurse staff files. We found new staff completed an induction and orientation about working at the practice training period over four weeks. This was reviewed at the end of the period to assess if there were any additional training needs. All the dental nurses had undertaken training in mandatory subjects such as safeguarding of vulnerable adults, child protection, information governance for dental practices, and fire safety. We found the dental nurses had appropriate clinical qualifications for their profession and were up to date with their continuing professional development (CPD) for which they were personally responsible to maintain. The dental nurses were also responsible for their GDC registration and personal indemnity insurance. We found these were all in place and up to date for each staff member. These showed they were eligible to practice in their professional capacity.

We found that all staff employed at the practice had a formal annual appraisal completed

by the dentist. These included objectives for the 12 months following the appraisal. This meant professional development was supported and promoted to reflect any relevant regulatory or professional requirements. We found there were staff meetings twice yearly and minutes kept of these meetings.

The provider may like to note that we found no evidence and staff told us they had not had a workstation assessment. These are important to ensure health and safety at work requirements are being met, and any staff who need reasonable adjustments in order to carry out their role.

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.

Reasons for our judgement

We found that the people who used this service and their representatives were asked for their views about their care and treatment and these were acted on. Everyone we spoke with was positive about the staff and the service they had received. A Patient Feedback Survey was undertaken by the dentist between November 2013 and January 2014. Survey comments included "All staff and dentist are very friendly and approachable", "It's very good!", and "everything is great". We noted suggestions included more opening days, text reminders for appointments and magazines in the waiting room. People were also invited via the practice website to share their ideas and suggestions for improvement of the service.

We asked the dentist about how suggestions were addressed. The dentist had extended opening hours for private patients to provide early and later appointments however there were no plans to open the practice five days a week due to other commitments outside the practice. We were told magazines were not provided in the waiting room to avoid cross infection. We were also told that information leaflets were kept in the surgery. These were given to each patient by the dentist to ensure the patient had the correct leaflet for the type of appliance they had fitted, and the dentist was able to record on the patient record when these were given. The dentist however agreed to consider putting up pictures or posters in the waiting room to provide some distraction and make it look less stark and clinical.

The people we spoke with said they did not know how to make a complaint but they had not needed to do this. They also said that in the event they were unhappy about anything they would find out or speak to the receptionist.

The dentist advised us that no complaints had been received about treatment although concerns had been raised about the treatment waiting list waiting times. If people raised concerns with the dental nurses, they would discuss this with the dentist. Any relevant details relating to conversations with patients were recorded in the patient's record. This meant any queries could be addressed by the dentist with the patient and/or family at the next appointment. The complaints procedure was not displayed but the dentist agreed this would be put up in the waiting room following our inspection visit.

The surgery had a checklist that was completed daily by the dental nurses. These checks were completed at the start and end of each clinical session to ensure the proper preparation and cleanliness of equipment and the surgery. Similar checks were completed for the reception area and the decontamination room. These checks were audited by the dentist.

We found protocols and procedures were in place for the management of emergency drugs and equipment, and for the management of medicines that may be required by patients in association with their dental care.

We found equipment was serviced and checked as required. Clinical waste was stored safely and was collected by a clinical waste contractor from the practice every three weeks. The provider had an arrangement with the contractor that the frequency could be changed if necessary. Staff knew the procedures and guidance they had to follow to ensure people were protected from cross infection.

We saw fire alarm, emergency lighting and fire extinguishers were checked annually by an external contractor and the last check was 01/10/2013. Regular fire drills were carried out. We saw that the last one was on 28/10/2013 and the names of all the staff present were logged. We found that the dentist had confirmed with the local fire and safety support service that a log of oxygen was kept on the premises. There was also signage indicating oxygen was kept on the premises. This was essential for people's safety and protection in the event of a fire.

The CPR equipment was tagged in order to monitor if anyone tampered with it. This was checked weekly by the dental nurses on a rota basis. The first aid kit was checked routinely to ensure all the contents were in date. This included checking emergency drugs.

We saw that the quality of X-rays was regularly checked. This was to ensure that the radiography was precise and consistent because the dentist was knowledgeable and understood how to use X-ray equipment effectively. We also saw that X-ray equipment was routinely checked for quality, safety and performance by an external contractor.

The dentist told us that he continually audited his clinical records because he was reliant on his notes for each appointment. There was no formal audit process to verify this.

We found arrangements were in place to cover the dentist when he was on holiday. The recent employment of an additional dental nurse meant holidays and sickness were also covered for administration, reception and dental nursing duties.

The practice had a contingency plan in place to deal with emergencies. The dentist told us it was updated annually as it was part of the Information Governance (IG) toolkit review used at the practice.

We found the service was able to ensure communication, planning and recording were reliable and accurate. We found the dentist and the staff were all committed to providing a personalised service to everyone who used this practice.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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