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

Whipps Cross University Hospital

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

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### Overview of the service

Whipps Cross University Hospital is part of Barts Health NHS Trust. The hospital provides a range of general inpatient, outpatient and day case services, as well as maternity services and a 24-hour Emergency Department and Urgent Care Centre. During this inspection we looked at care in the emergency department, outpatients and care provided on Bracken ward and Blackthorn ward (elderly care wards).

### Type of service

Acute services with overnight beds

### Regulated activities

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury
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 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 22 May 2013 and 23 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health and talked with local groups of people in the community or voluntary sector.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

Emergency Department
Patients were spending too long in the emergency department at Whipps Cross University Hospital. The nationally agreed target is that 95% of patients should be seen within four hours. However, the hospital had not met this target since November 2012. Between January and March 2013 there had been 31 occasions when patients had to wait more than 60 minutes from the time the ambulance arrived at hospital until both clinical and patient handover was completed, although we were told that emergency attention was provided on the trolley when required. This meant ambulance patients were waiting longer to be seen.

During the inspection we found that some patients had to wait longer than they should expect. Walk in patients were seen promptly for an initial assessment, but the time to treatment and consultant sign off were inconsistent. One patient in particular had to wait over four hours to be admitted and there was some confusion about this patient's referral.

We were concerned that some patients who had been in the emergency department for prolonged periods of time were not always offered adequate nutritional support.

Elderly Care
Patients did not always receive appropriate care and treatment and staffing arrangements were sometimes deficient. On a number of occasions we found that there were not enough staff on duty. On the day of our visit, two wards were short by one qualified nurse. There were inadequate arrangements in place when key staff members were absent for a long period of time.
Care plans were not always updated as people's needs changed. Risk assessments for falls, moving and handling and Malnutrition Universal Screening Tool (MUST) were used but not always reassessed. We found that there had been a number of falls on one ward and there were five hospital acquired pressure sores on two wards. Essential checks for patients with naso-gastric tubes were not carried out and this was not in line with the trust's policy.

Patients sometimes had to wait to get support to eat their meals. We observed that some patients were not helped to eat when they needed it and that although they were given water, it was sometimes placed out of their reach.

The elderly care department did not have enough equipment which meant that some wards had to share equipment.

At our last inspection in November 2012, we found that appraisals, supervision and team meetings for nursing staff were inconsistent. At this inspection we found that the support provided to staff was inadequate. Some staff had not had an appraisal for over a year. Staff meetings were irregular and supervision was mainly informal, inconsistent and not recorded. We found that there were inadequate arrangements in place to ensure that appraisals and supervision continued in the absence of key staff.

Outpatients
Patients were provided with appropriate information and involved in their care. Their diversity, values and human rights were respected.

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 06 August 2013, 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 Whipps Cross University 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

Respecting and involving people who use services  ✔ Met this standard

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

Our judgement

The provider was meeting this standard.

Patient's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Outpatients

Patient's diversity, values and human rights were respected. We observed staff being respectful. All consultations were done in private rooms with doors closed. There was a dignity champion nurse who tried to ensure that all patients were treated with dignity and respect. Provisions were made to book an interpreter or use language line to communicate with patients who could not speak English. We found that staff could speak different languages, and others were able to use sign language, which also helped when treating patients with communication deficits.

There were procedures in place to treat people who were partially sighted. We found that there was also a service for patients with mobility problems.

We found that there was adequate seating in waiting areas. Children were given drawing packs to entertain them whilst they waited. Staff and patients told us that letters usually told patients that they would not be seen at their exact appointment time. We looked at three appointment letters, which confirmed this. It would be useful for the provider to note that patients misread appointment letters as they assumed they would see a consultant.

Patients were given appropriate information and support regarding their care or treatment. Nurses told us that people were given a choice of appointment times. All treatment options were discussed with the patient and sometimes videos were shown of the treatment they would receive so they could make an informed choice. It would be useful for the provider to note that, although information leaflets were available, these were not always available in other languages.

On the day of our visit all the people we spoke to had waited an average of 45 minutes before they were seen. We observed that staff updated the clinic board regularly to inform people if a clinic was running late. Staff also apologised and explained to patients if there was a delay. We were told that patients could get car park vouchers for people who had to
wait past their ticket time. However, the people we spoke to on the day were not aware that this service existed.

Patients expressed their views and were involved in making decisions about their care and treatment. We were told and saw evidence that confirmed that ‘patients experience’ evenings were held specifically for patients that had complained. Weekly patient surveys were completed. There was an Outpatients Transformation Project where patients were asked what they thought about the changes regularly. As a result of patient feedback, staff told us that the breast clinic opening hours had been extended and two locum consultants had been employed in order to reduce waiting times.
Care and welfare of people who use services

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

Our judgement

The provider was not meeting this standard.

Patients did not always experience care, treatment and support that met their needs and protected their rights.

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

Emergency Department

The emergency department consists of a majors department with 22 cubicles, a resuscitation area with six bays, a paediatrics department and a minor injuries department. Patients arrive by ambulance or are referred by the urgent care centre, which is run by another provider and located on the same site. On this visit we concentrated on patients in the majors department and resuscitation area. The department was attended by an average of 13224 patients between November 2012 and April 2013. An average of 2779 patients a month who attended the department were admitted over the same period.

We visited at 0930 on the 22nd of May and at 2030 on the 23rd of May. We spoke with senior managers, consultants, a registrar, senior nurses, nurses, agency staff, an alcohol liaison nurse, a pharmacist, patients and carers. Patients said staff had provided them with care that met their needs. However, most patients said they had to wait a while to be seen.

Patients who arrived in the emergency department were seen by the assessment nurse who completed triage notes, carried out baseline observations and took bloods. Patients were prioritised according to arrival time though the condition of the patient was also used to prioritise care. We found most nurses worked according to arrival time and when priority changed it was not always communicated. We observed an instance where a dehydrated patient was overlooked.

Nationally agreed emergency department quality indicators state that 95% of patients who arrive by emergency ambulance should have their full initial assessment completed within 15 minutes. No patients should wait for more than 20 minutes. The hospital has had difficulty achieving these timescales. We reviewed information recorded by London Ambulance Service and were concerned that ambulance patients were not always assessed in a timely manner. There had been 31 black breaches (cases where it had taken more than 60 minutes from the time the ambulance arrives at a hospital, until both clinical and patient handover had been completed) between January-March 2013. However, we were told that emergency attention was provided to patients on the trolley when
required.

Nationally agreed emergency department quality indicators state that 95% of patients should be seen within four hours and no patient should be in the department for more than 12 hours. We are aware that during the last six months many NHS trusts have had difficulty meeting this indicator. We reviewed the trust's performance between November 2012 and April 2013 and found that the trust had not been achieving the 95% ED 4 hour performance target since November 2012. Performance was below 95% consistently between December 2012 and March 2013. These meant patients were waiting longer to be seen.

Other clinical quality indicators reviewed for patients seen between November 2012 and April 2013 were within parameters set out by Department of Health Accident and Emergency Clinical Quality Indicators: Best Practice Guidance for Local Publication 2011. These included unplanned re-attendance rate (re-attendance within seven days of original attendance including referrals made by another professional), and the left without being seen rate (percentage of people who leave the department before receiving treatment) was below 5% with exception of December 2012.

Care and treatment was planned but not always delivered in a way that was intended to ensure patient's privacy, safety and welfare. We were concerned about how "corridor patients" (these were patients who were placed on trolleys when there were no available cubicles) were cared for. On the day of our visit we saw corridor patients despite empty cubicles. We observed a doctor carry out initial observations and ask questions in the corridor outside other patient's cubicles.

Care and treatment reflected relevant research and guidance. The early warning score (EWS) was used to determine the frequency of observations as per NICE clinical guideline 50 (Acutely ill patients in hospital Recognition of and response to acute illness in adults in hospital July 2007). We found that patient records we reviewed showed observations were done according to the patient's condition. 47% of nursing staff in Majors had attended EWS system this year as part of mandatory training. We saw that all trolleys had pressure-relieving mattresses, in order to minimise pressure damage.

Walk in patients were initially assessed and then directed to a waiting area. The time to initial assessment was prompt, however, the time to treatment and time to consultant sign off was inconsistent. During the day visit we found that this waiting area was full for most of the afternoon. One patient in particular had to wait over four hours to be admitted and there was some confusion about this patient's referral.

There were procedures to deal with emergencies. Staff were aware of the procedure to follow in an emergency and were up to date with basic life support training and advanced life support training. We saw a training matrix that showed that 26% of medical staff had completed the basic life support, 92% of nursing staff had completed basic life support training in 2013 and there was a plan in place to ensure all staff completed training before the end of the year.

Elderly Care
We found that although nurses assessed patients' needs when they were admitted onto wards, care plans were not always updated as patients' conditions changed. Dementia screening and pressure ulcer prevention strategies were implemented. Risk assessments for falls, moving and handling and Malnutrition Universal Screening Tool (MUST) were used but not always reassessed.
Senior staff told us that if someone was at risk of falls, they could request for one to one staff until the person had settled. We reviewed falls data collected between 17 February 2013 and 5 May 2013 and found that there had been one fall on Bracken ward but 11 falls on Blackthorn ward. The matron was aware of this difference and said that most falls in Blackthorn ward had occurred at night. We were told that in response to this data there were plans to appoint a falls champion to each ward, although this had not been implemented at the time of the inspection.

We found that senior staff had palliative care training and would guide junior staff when the need arose. Patients living with dementia were expected to have a behavioural chart in their care plan to monitor their behaviour. However, these were not always in place.

We found that patients were checked for pressure sores on admission. Body maps were completed and updated each time there was a change. Pressure relieving equipment was ordered and arrived in a timely manner. Despite all these checks, we were concerned that on Bracken ward there were two grade one hospital acquired pressure sores and one grade three hospital acquired pressure sore. Blackthorn ward had one grade one and one grade three hospital acquired pressure sore.

We found that care plans were generic and were not always reviewed after admission. Other records such as hourly rounding (patient comfort checks that were to be done every hour) and the daily care records were completed most of the time. It would be useful for the provider to note that hourly rounding was not always possible and, when it did happen, it was not always recorded in a timely manner. We saw staff sit down to write several hours' worth of information from memory.

Patients had observations completed according to their needs. However, escalation was not always evident and follow up observations were not always completed as outlined in NICE clinical guideline 50 for acutely ill patients in hospital. One relative on Blackthorn ward told us that they felt "staff communication was very poor" and that they had not been consulted about or asked to input into their relative's care.

Outpatients
Care and treatment was planned and delivered in a way that was intended to ensure patients safety and welfare. We found that all patients' personal details, medical history and other treatment and follow up were readily available and updated during each visit. Staff told us that children and those who came in by ambulance were prioritised.

Patient care was planned in a way that protected patients from unlawful discrimination. We found that all staff were given booklets which explained the policies and procedures within outpatients. There were provisions to cater for all types of patients without discriminating. These included access for people with mobility difficulties, an interpreter for people with communication deficits and consideration for people other sensory impairments such as partial sight and those requiring hearing aids.

There were appropriate arrangements in place to deal with emergencies. Resuscitation trolleys were available in each department and checked daily. All staff were aware of how to call for help in a medical emergency.

Most patients were satisfied with the care they received. We found that 87% of 682 patients who had completed feedback cards between 2012 and 2013 would recommend the service to friends and family. The patients we spoke to confirmed that they had been given an option to choose a different appointment. However, patients would sometimes opt
for the nearest appointment time even though it was not convenient. We reviewed waiting
time data and choose and book data and found that people kept appointments they chose
for themselves.
Meeting nutritional needs

Food and drink should meet people’s individual dietary needs

Our judgement

The provider was not meeting this standard.

Patients were not always protected from the risks of inadequate nutrition and dehydration.

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

Emergency Department
We found that people were not always offered something to drink or eat even when they had been in the department for a long time. People we spoke with at the start of the inspection told us they had not received or been offered anything to eat or drink. Some of these patients had been in the department for an average of three hours. On the first day of our visit we saw that the refreshments trolley serving tea and coffee went round regularly. Later in the day/afternoon we saw a member of staff offering people a choice of tea, coffee and sandwiches.

During our evening visit we were concerned that one patient who was waiting to be seen had not had any food or drink since early afternoon. Nurses had administered treatment but had not offered them any food. We had to ask staff to provide drinks to some people who had been waiting a while. We spoke to the sister in charge about our concerns who said that sometimes hot meals were ordered for those who were in the department longer than four hours. However, the drinks trolley only went round if staff were available.

We found that only 47% of nurses in majors had attended mandatory nutrition training. Nurses told us that they would refer any patients on enteral feed to the dietician and would weigh patients if appropriate. We were concerned that staff had different ideas about their role and responsibility to provide food and drink especially for patients who stayed in the department a long time or had been referred from the urgent care centre. We found that although there were vending machines available, not all patients could access these due to limited mobility or not having brought in any money to purchase any food or drink.

Elderly Care

We found that patients were not always supported to eat their meals in a timely manner. Food was served when staff were ready to assist patients with eating. However, some patients had to wait for their meal while others were being assisted in order to ensure that they were served a hot meal. We observed that one of the support staff did not allow people sufficient time to make a choice for themselves about their preferred dessert option.
One patient spent ten minutes trying to eat their meal which had been set on a table too far away for them to reach properly. We saw a lot of the food had fallen into their lap and staff only intervened and adjusted the table when we asked them to. Staff told us that meal services took a long time because many patients needed assistance. Some help was given by family members and we were told that volunteers helped with the lunch service three times a week on Bracken ward.

We observed that every patient (unless categorised as nil by mouth) had a jug of water by their bedside which was topped up regularly. However, sometimes the water was not always placed within reach of the patient. We observed that some patients who were on nutritional supplement drink had these left opened on their bedside table. We noted that those on Bracken ward were placed out of the patients reach.

One patient said, "If you want a drink you can help yourself to a glass of water, there is always water available. Sometimes the food may not be very hot but they have a lot of people to serve. It's never cold." Another patient said, "The food isn't too bad. It's hospital food. You get a choice of food and it's hot enough but the portions are small."

Patient's food and drink met their religious or cultural needs or preferences. Staff told us they spoke to relatives about food choices and patients preferences if patients were not able to do so themselves. Patient's dietary needs were displayed on the board in the office, in patient's records and were highlighted at staff handovers. The menu catered for varied cultural and religious diets including Kosher and Halal.

Weekly weights and nutrition screening were completed for all patients. Those who were found to be at risk were referred to the dietician appropriately. Patients with swallowing difficulties were referred to the speech and language therapist. However we found and were told that advice from the speech and language therapy was not always followed consistently.

We reviewed two records for patients on enteral feeding and were concerned that the pre-feeding checks to ensure the nasogastric tube (a tube that is used to feed people that goes through the nose into the stomach) was in the right place, were not done in accordance with the trust policy. This could put patients at risk if feed went into organs other than the stomach. Fluid balance charts and malnutrition universal screening tool (MUST) scores for these patients were not always completed properly.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment. This was because the provider worked in co-operation with others.

Reasons for our judgement

Outpatients
Patient's health, safety and welfare was protected when more than one provider was involved in their care and treatment. This was because the provider worked in cooperation with others. Staff were able to tell us which professionals they worked with on a daily basis and told us communication was always key in order to make a smooth patient journey. Information was shared between the department and GP's and other agencies using set forms as outlined in the trusts information sharing guidelines.

Staff told us that that they had good working relationships with care homes, district nurses and GP's they worked with. We reviewed information we had collected from care homes in Waltham Forest and found that they received adequate information regarding outpatient appointments.

We reviewed referral lists for new appointments and found that there were several patients already at the 13 week breach date. The figures fluctuated throughout the three month period data we reviewed. It would be useful for the provider to note that there seemed to be an increase in 13 week breaches for oral surgery, ear and nose surgery, orthopaedics and chest medicine.
Cleanliness and infection control  

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Outpatients

Patients were cared for in a clean and hygienic environment. On the day of our visit the waiting area and the consulting rooms were clean and fully equipped. Staff adhered to bare below elbows and wore clean uniforms.

We found service stickers on all equipment were in date. All equipment we examined was clean and had dated cleaning stickers. The nursing staff completed all equipment cleaning, whilst domestic staff cleaned the floors and toilets. All toilets were clean and we were shown a cleaning schedule that confirmed that the toilets were checked and cleaned every hour.

We looked into several consulting rooms and found that there were sufficient supplies of gloves and other protective clothing. There were stickers reminding people to wash their hands. Each room had hand washing facilities and paper towels. Sharps bins were not overfilled and were correctly assembled and labelled. Once two thirds full they were closed, signed, dated and taken to the collection area.

There were provisions to ensure that waste was disposed of appropriately. Waste had three separate types of bin in the department. Clinical waste, general waste and recyclables. Staff were aware of how to segregate and dispose of waste appropriately in the bins provided. We found that the domestic staff emptied the bins daily.

Staff told us that they attended annual mandatory infection control training and were aware of the infection control guidelines. The infection control link nurses confirmed this and also said there were quarterly updates. Staff told us they washed hands or used hand gel before treating each patient. We saw that hand gels were available and were used by the staff we observed.

We found that several audits were completed in the department. These included weekly hand hygiene audits, hygiene code audits and an annual audit conducted by the infection control team. We reviewed the weekly hygiene code audits and found that they were signed once staff had completed the cleaning tasks. The hand hygiene audit conducted in
April 2013 showed that 99% of the time staff washed their hands before and after patient contact.
Management of medicines  
Met this standard  

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Emergency Department
Appropriate medicine management arrangements were in place. Medicines were stored securely and safely. The medicines we viewed were in date. Staff had access to the British National Formulary and pharmacist advice when in doubt. Staff told us they adhered to the trusts medicine administration policy and specific protocols for different types of medications.

We saw there was a system in place for disposing of expired, soon to expire and unwanted medication. Staff told us that they also checked intravenous fluids when they restocked supplies to ensure that none were out of date. We saw evidence of medicine audits and a pharmacist described how they monitored stock and disposed of medicines.

We reviewed a training matrix and found that 27% of nurses in majors had attended mandatory training for medicines. Whilst 29% had attended Medical gas safety training in 2013, there were plans in place for the rest of the staff to attend.

Both nurses and doctors were aware of the need to check patient's pain score and offer analgesia as required. We saw nurses recording medications after they had been administered. We also saw nurses double checking intravenous fluids and medications with another nurse before administering them as per the Trusts Intravenous drug administration policy.

Elderly Care
Patients told us that staff gave them their medicines. One patient said, "The nurses store your medicine for you and bring it to you when it is time for you to take it."

Medicine was administered appropriately by trained nurses. We observed a nurse administering both oral and intravenous medication. The nurses checked that they had the correct person and the correct medication before administering. There were no medicines left at bedside tables. When administering intravenous infusions, we observed nurses double checking with another nurse before administering the medication.
Staff told us that nursing staff ordered medicines. One nurse told us that the night staff checked the medicines to see if any had expired or were no longer required. Should this be necessary, we were told that nurses log it and send it back to the pharmacy in a pharmacy box as per the trust's medicine policy.

Controlled drugs were stored appropriately. The medicines were checked every day after handover. During this check, the expiry dates and how the medicine was stored was checked and recorded by two nurses.

Staff told us that medicines were sent back to the pharmacy if the patient no longer required them. Staff told us that if medicines went missing they would complete an incident report and inform the pharmacist. There were procedures in place to ensure that people were discharged home with a supply of prescribed medicine.

Staff told us that when patients refuse medicine, it was noted on their chart and the doctor was informed. Staff told us they would try to find out why medicine was being refused and would get the doctor to prescribe an alternative wherever appropriate. We saw that drug charts contained appropriate codes when patients had refused medication.
Safety, availability and suitability of equipment  Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

Patients were protected from unsafe or unsuitable equipment. However, there was not enough equipment, which meant that several wards had to share equipment.

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

Elderly Care
We found that nurses did not always have access to some equipment they used on a regular basis. Staff told us that their work would be made easier if they had more ultra-low beds, ECG machines (machines used to measure rate and regularity of the heart beat) and bladder scanners. On both wards we visited staff said they had to go looking for the bladder scanner or the ECG machine as it was shared among several wards.

One staff member told us that, "as far as I am aware, there are only three bladder scanners in the whole hospital. A staff member has to go and find it. This can make it difficult for the remaining staff on the ward if one staff member disappears to go and find equipment because you are usually already under-staffed."

Staff also told us that they "share an ECG machine with two other wards. A member of staff has to go and find it, sometimes you have to wait for it because it is being used and other people are also waiting to use it."

We were concerned that there were no bath or shower facilities on Bracken ward. We were told that the only bathroom on the ward had been condemned and all patients were given personal care at their bedside. This left patients with no choice regarding their personal hygiene needs and added to the risk of patients developing skin infections.

Other equipment such as blood pressure monitoring equipment and blood glucose monitoring equipment were readily available. Staff told us that pressure relieving mattresses usually arrived within two hours of being ordered. Staff told us that they received training on how to use any new equipment that was introduced on the ward. However, we did not see any record that staff had received any new equipment training.

Outpatients
We found that staff had been trained on how to use equipment they used on a regular basis including hoists, bladder scans and blood pressure machines. They told us that any
faulty equipment would be repaired or replaced by medical electronics. We also saw that portable appliance test (PAT) stickers were on all equipment that we looked at during our visit.

We observed that each consulting room had its own equipment. Couches were in a good state of repair. There was adequate seating for patients though at times it became crowded.
## Staffing

<table>
<thead>
<tr>
<th>Action needed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>There should be enough members of staff to keep people safe and meet their health and welfare needs</strong></td>
</tr>
</tbody>
</table>

### Our judgement

The provider was not meeting this standard.

There was not always enough qualified, skilled and experienced staff to meet patients' needs.

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

#### Emergency Department

There were usually enough staff on duty in the emergency department to provide people with the care and treatment they needed. We observed after 13:00 there was an influx of patients arriving by ambulance. There appeared to be enough skilled and experience staff on hand to manage patients arriving by ambulance to A&E. However, we found walk-in patients in the waiting area had to wait several hours before being seen by a nurse or member of staff as ambulance patience were prioritised.

There were 13 nurses on during the morning shift. We reviewed the rotas and allocation sheets and found that theses staffing numbers were maintained. There was always a nurse coordinator on every shift. However, both doctors and nurses felt that the skills mix varied between shifts as both nurses and doctors had different levels of skills, experience and competence.

We observed that people could get the attention of the nurses when required most times. Doctors were on the floor but were in assessments in the afternoon. However, when nurses escorted the patients to wards or when cubicles were full patients sometimes had to wait longer for assistance.

We reviewed mandatory training records for both nursing staff and medical staff and found that nurses were split into groups and attended their training as a group. Training included safeguarding, infection control, health and safety and moving and handling. The records we reviewed showed that there was a plan in place to ensure that all mandatory training would be completed before the end of the year.

We reviewed doctor's rotas and agency records for the past three months and found that there was cover most of the time. We saw that doctors worked in four hour blocks in the different sections of the department. A permanent consultant had started in February whilst two locum consultants had also been recruited on a temporary basis. We saw in an
action plan that indicated more interviews had been planned for June. There was 
consultant cover 0900-2200 Monday to Friday and 1700-2200 on Saturday and Sunday.

Elderly Care

Patients had mixed reviews about the staffing on both wards. Some knew the names of 
their nurses. One patient said, "There are plenty of nurses around they don't always come 
immediately when I call them but then they are always busy." Another patient said "There 
seems to be enough staff day and night. I see the same staff nearly every day. They know 
I don't like milky tea. Those that don't know give me tea the way I ask for it."

We found that staff were up to date with mandatory training or were scheduled to attend 
training this year. Each ward had two link nurses for tissue viability, moving and handling, 
infection control, diabetes and incontinence. We were told that link nurses developed 
specific skills, which they would pass on to other nurses on the ward. We found that link 
nurses were not always available to attend training sessions or complete relevant audits in 
their clinical area.

One nurse said, "There is generally not enough staff. People get the care they need but 
we do not have time to complete all the paperwork. The problem is the staff ratio is not 
reviewed when there is a change in the dependency level of patients on the ward." Some 
staff thought care could be improved if they had the right number of staff all the time and 
better access to the equipment such as an electrocardiogram machine (machine to 
monitor the heart) and bladder scanner.

We reviewed rotas for both wards and looked at quality audits results and found that there 
were times when the wards were not appropriately staffed. Between February and April 
2013, we found that there were not enough staff on duty on 22 shifts on Blackthorn ward 
and three shifts on Bracken ward.

We were concerned that both Bracken and Blackthorn wards had vacancies and were 
short by one qualified nurse on the day of our visit. We found that between February and 
April 2013, Blackthorn ward had an average of 38 unfilled shifts per month whilst Bracken 
ward had an average of 7.6 unfilled shifts per month. This could compromise quality of 
care delivered and reduce staff morale.

Although the matron had completed the necessary requests to recruit to cover the 
vacancies, we were concerned that on Bracken ward there were no provisions made to 
cover for one junior sister who was on maternity leave. Similarly on Blackthorn ward the 
junior sister was acting up to cover long-term sickness. This could leave staff unsupervised 
and meant that senior nursing staff were counted in the numbers, reducing the time they 
spent development and improving the quality of care.

Staff thought there were enough doctors on shift during the day and out of hours. One 
consultant covered Bracken ward and two consultants covered Blackthorn ward. We were 
told they could be accessed via their bleep system if necessary. Each ward had Specialist 
Registrar cover. Junior doctors were also available and reviewed patients daily during the 
week. During out of hours and at weekends, patients had to wait long as staff would have 
to call the on call doctor to review sick patients.
Supporting workers

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

Our judgement

The provider was not meeting this standard.

Patients were cared for by staff who were not always supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate 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

Elderly care

We reviewed appraisal records held on one of the wards and requested appraisal information from the trust. We were concerned that only the ward sisters had had an appraisal. None of the nursing staff had been appraised in 2013 on both wards. Some staff had not had an appraisal since 2011. Both ward sisters had not yet had follow up meetings to check on objectives set following their appraisals. None of the staff on Bracken ward had been appraised or had received supervision in the last year. Only five staff had completed the appraisal process in 2012 on Blackthorn ward. We were told this was due to lack of senior sister cover following sickness and maternity leave.

On both wards, none of the nursing staff had received any formal one to one supervision. A ward sister told us that supervision meetings were meant to take place every month but they did not have time to complete formal supervision. They told us that they had an "informal chat" with staff whilst on duty, but did not record this. Staff told us that they had group feedback sessions only when something went wrong.

We found that there had been no staff meetings on either wards. There were, however, plans for a staff meeting to be held on 6 June 2013 and monthly thereafter. Sisters attended monthly sisters meeting to discuss good practice, how to improve the ward, and to share information with other departments.

Nursing staff had mixed views about the support they received, but told us that they were able to raise concerns with their immediate manager. Both sisters we spoke to felt supported by the matron and felt able to raise issues with them. They acknowledged that, there was new management in place but, felt nothing would change until vacancies were filled.
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 patients receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients using the service and others.

Reasons for our judgement

Emergency Department

We found there was a system in place to regularly seek the views of people and persons acting on their behalf. We found there were comments cards available in ED. There was a comments box where completed comment cards were placed after they were filled out. However, patients we spoke with were not always clear that they could give their views and opinions. One person we spoke with told us they could complain to one of the nurses if need be.

We saw cleaning audits which were completed between February and May 2013 and found that the department scored above 96% most of the time. High dusting was consistently lacking in 4 audits. Other shortfalls or repairs were fixed in subsequent audits. We reviewed hand hygiene audits. The department scored 100% in April 2013 February 2013, January 2013 and December 2012.

There were policies and procedures in place to ensure the quality of the service could be assessed and monitored. These included monthly senior team meetings, daily emergency department performance meetings and, clinical improvement group meetings. We reviewed minutes from such meetings and found that there were action plans to address any concerns about quality of care delivered.

We were concerned that, the trust had notified us of a number of potential serious incidents (SI) had occurred between October 2012 and March 2013. Of the 18 potential serious incidents, six related to breaches of the London Ambulance Service 60 minute turnaround time, three were felt not to merit escalation. Four were of particular concern and potentially related to death caused by mismanagement.

However, the trust had been proactive in implementing an action plan whilst waiting for the investigation and root cause analysis to be completed. On the day of our visit the action plan was in progress and was aimed at addressing themes identified following the potential incidents. Themes being addressed included capacity in the emergency
department, supervision of junior medical staff, education and training of medical and nursing staff. Other concerns being addressed included communication with and access to in patient teams and the interface with urgent care provider.

Staff were aware of conflict resolution methods and 48% of the nursing staff in majors had attended mandatory conflict resolution this year. We reviewed complaints made in the department between February 2013 and April 2013. There were 13 complaints in total and all had an identified investigator and a response due date as outlined the trusts complaints policy. We found that the complaints identified the following themes: lack of care, incorrect diagnosis and, inappropriate discharge.

Elderly Care

Patients were given a feedback card on discharge which asked whether or not they would recommend the ward and the reasons why. We asked for these results for the last three months and found that there were two compliments on Bracken ward and one compliment on Blackthorn ward between February and April 2013.

Staff were aware of the complaints policy and told us that they did not have any formal training but, had read the policy when they joined the Trust. If concerned about a patient's care, the senior nursing staff said they would speak to the matron or the head of nursing. We reviewed complaints data from February 2013 to April 2013 and found three complaints on Blackthorn ward and one complaint on Bracken ward. All the complaints had an appointed investigating officer and a response due date in line with the trust policy.

Direct observations, and out of hours spot checks were done on the care of the elderly wards.

We found that staff were aware of the incident reporting procedure. The senior sisters were aware of the governance structures and told us that they would act on feedback on the incident or complaint from the matron or risk management. If the incident was serious they would attend a serious incident meeting and plan for intervention to avoid future occurrence.

Outpatients

We looked at a summary of feedback given by 86 patients who visited outpatients in 2013 and had completed patient feedback cards. We found that the department had an average net promoter score of 80%. Five areas scored 100% whilst three areas scored below a 100%. We also reviewed feedback left by 275 patients between May 2012 and April 2013 using the mobile Kiosk Survey(electronic surveys filled in at mobile kiosk points). People were generally satisfied with the information and involvement. However, people were not always satisfied with the information they got about medication. The Trust had shared results with staff and tried to improves concerns raised by patients.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>How the regulation was not being met:</td>
<td></td>
</tr>
<tr>
<td>The provider had not taken proper steps to ensure that each patient attending the emergency department was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care that met the individuals needs and, where appropriate, treatment to ensure the welfare and safety of patients.</td>
<td>Regulation 9 (1)(b)(i)(ii)</td>
</tr>
</tbody>
</table>

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<td>Diagnostic and screening procedures</td>
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</tr>
<tr>
<td>How the regulation was not being met:</td>
<td></td>
</tr>
<tr>
<td>The provider had not taken proper steps to ensure that each patient on the elderly care wards was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care that met the individuals needs and, where appropriate, treatment to ensure the welfare and safety of patients.</td>
<td>Regulation 9 (1)(b)(i)(ii)</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Regulation</td>
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<tr>
<td>----------------------</td>
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</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Meeting nutritional needs</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider did not ensure that patients attending the emergency department are protected from the risks of inadequate nutrition and dehydration, by means of the provision of a choice of suitable and nutritious food and hydration, in sufficient quantities to meet patients' needs. Regulation 14 1(a)</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Meeting nutritional needs</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider did not ensure that patients on elderly care wards were protected from the risks of inadequate nutrition and dehydration, by means of the provision of support, where necessary, for the purposes of enabling patients to eat and drink sufficient amounts for their needs. Regulation 14 (1)(c).</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Safety, availability and suitability of equipment</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered person did not always ensure that equipment was available in sufficient quantities in order to ensure the safety of service patients and meet their assessed needs. Regulation 16 (2)</td>
</tr>
</tbody>
</table>
### This section is primarily information for the provider

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Staffing</td>
</tr>
<tr>
<td><strong>How the regulation was not being met:</strong></td>
<td></td>
</tr>
<tr>
<td>The provider did not always ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.</td>
<td></td>
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<tr>
<td>Regulation 22</td>
<td></td>
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</tbody>
</table>

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 06 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Supporting workers</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>The provider did not have suitable arrangements in place in order</td>
</tr>
<tr>
<td></td>
<td>to ensure that persons employed for the purposes of carrying on</td>
</tr>
<tr>
<td></td>
<td>the regulated activity were appropriately supported in relation to</td>
</tr>
<tr>
<td></td>
<td>their responsibilities, to enable them to deliver care and treatment</td>
</tr>
<tr>
<td></td>
<td>to patients safely and to an appropriate standard. Nurses did not</td>
</tr>
<tr>
<td></td>
<td>always receive appropriate training, supervision and appraisal</td>
</tr>
<tr>
<td></td>
<td>Regulation 22 (1)(a)</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>✔ Met this standard</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>✗ Enforcement action taken</td>
<td>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.</td>
</tr>
</tbody>
</table>
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:

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

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

<table>
<thead>
<tr>
<th>Phone:</th>
<th>03000 616161</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
<tr>
<td>Write to us at:</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td></td>
<td>Citygate</td>
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<td></td>
<td>Gallowgate</td>
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<td></td>
<td>Newcastle upon Tyne</td>
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<td></td>
<td>NE1 4PA</td>
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<tr>
<td>Website:</td>
<td><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></td>
</tr>
</tbody>
</table>

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