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

### North Middlesex University Hospital NHS Trust

Sterling Way, Haringey, London, N18 1QX  
Tel: 02088872000  
Date of Inspections: 06 September 2013  
05 September 2013  
Date of Publication: October 2013

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

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<tr>
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<td>Met this standard</td>
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<tr>
<td>Care and welfare of people who use services</td>
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<tr>
<td>Cleanliness and infection control</td>
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</tr>
<tr>
<td>Supporting workers</td>
<td>Met this standard</td>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>Met this standard</td>
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<th>Registered Provider</th>
<th>North Middlesex University Hospital NHS Trust</th>
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<tr>
<td>Overview of the service</td>
<td>North Middlesex University Hospital serves a population of more than 500,000 people living in the London Boroughs of Enfield and Haringey and surrounding areas including Barnet and Waltham Forest. The hospital has approximately 350 beds and provides a range of specialist care. The maternity service delivered 3800 babies in 2012. This is due to rise by a further 700 deliveries with the implementation of a local reconfiguration of maternity services and the opening of a new maternity unit in November 2013.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Acute services with overnight beds</td>
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<td></td>
<td>Urgent care services</td>
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<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
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<td>Family planning</td>
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<td></td>
<td>Termination of pregnancies</td>
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<td></td>
<td>Treatment of disease, disorder or injury</td>
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</table>
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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 5 September 2013 and 6 September 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

We carried out an inspection of the maternity unit at the hospital with a team of three inspectors and a specialist midwife advisor. We spoke with midwives, doctors, maternity support workers, a supervisor of midwives and the Head of Midwifery and Gynaecology. We spoke with 16 women and their partners, in the ante-natal clinic and in the post-natal ward, about their experiences of the maternity service. Most women told us their privacy and dignity had been respected by staff and they had received sufficient information to enable them to make choices about their care and treatment.

Most women were positive about the care they had received. For example, one woman told us "the doctor has also been very helpful" and another woman said, "it has been a great experience." Staff were described as "very welcoming," "very courteous" and "professional." Everyone we spoke with, who had delivered their baby, said they would consider having a baby at the hospital again in future.

We found all areas of the maternity unit to be clean and well-maintained. Midwives received appropriate training and support to enable them to provide the care and treatment that women needed. The maternity service was well-led and responsive to the needs of a diverse local population. Systems were in place to assess and monitor the quality of service that women received and ensure care was provided safely and effectively.

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

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.

Women's privacy, dignity and independence were respected. Women's views and experiences were taken into account in the way the service was provided and delivered in relation to their care and treatment.

Reasons for our judgement

We visited all areas of the maternity unit including the ante-natal clinic, triage, labour ward and post-natal ward. We spoke with women and their partners who were attending ante-natal appointments or triage and those women who had delivered their babies and were on the post-natal ward. Most women told us they were happy with their experience of maternity services. Staff were described as "very welcoming," "very courteous" and "professional."

Women understood the care and treatment choices available to them. A partner told us that the information provided was clear and that risks were explained. There was always an opportunity to ask questions. The partner said that detailed information about the benefits and risks of screening tests had been given and they had been given time to reflect and make a decision. When they decided not to go ahead with the test they felt their choice was respected. Another woman confirmed that "the risks of a caesarean section have been explained to me."

Women's privacy and dignity were respected. Women and partners told us they were able to discuss personal information in private and all consultations took place in a room with the door closed. We noted that the day assessment unit opened up directly onto patient bed areas, however privacy and dignity was maintained with a curtain pulled across and a very clear 'no entry' sign.

Women expressed their views and were involved in making decisions about their care and treatment. Women said they were given time to express their views and ask questions. For example, one woman said, "we've asked so many questions and they have all been answered." Another said, "staff answer all our questions, even the simple ones." Most women and partners we spoke with felt they had been listened to by staff and explanations had been given in a way they understood.

Women were given appropriate information and support regarding their care and
treatment. Most told us they were given appropriate and useful advice by midwives at different stages of their care. Many had attended ante-natal and parent craft classes and had visited the unit prior to the birth of their baby. Women told us they had been provided with information on issues such as smoking cessation, alcohol consumption, exercise and medicines while they were pregnant. After their baby had been delivered women told us they had been given information on a range of topics including breastfeeding and common health problems in babies.

The diversity, values and human rights of women were respected. Turkish interpreters were available in the hospital when needed as this was a commonly spoken language in the local community. Interpreters could be obtained for speakers of other languages and midwives had access to telephone interpreting. One woman in the ante-natal clinic, who spoke little English, told us told us "when I talk to the doctor I have an interpreter." Another woman said, "I can talk to the interpreter if I need to." Turkish interpreters assisted with parent education classes and ante-natal clinics. Staff told us they could obtain written translations of information leaflets, although a Hungarian woman told us she had been provided with information in English which she had found difficult to understand in places.

Staff, including at senior management and trust board level, demonstrated their knowledge of the needs of women in the local community. Maternity services were flexible and service design and delivery had taken account of the diverse needs of women from different communities and cultures using the service.
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 was intended to ensure women and babies’ safety and welfare.

Reasons for our judgement

We visited all areas of the maternity unit and asked women and their partners about their experiences of care and treatment. Most people were positive about the care they had received. For example, one woman told us “the doctor has also been very helpful” and another woman said, “it has been a great experience.” One partner told us of previous good experiences at the hospital, he said, “we had a good team for the first two births and some staff are still around.” Everyone we spoke with, who had delivered their baby, said they would consider having a baby at the hospital again in future.

Most women, who had already given birth or were close to delivery, told us they had had the opportunity to discuss their birth plan with the midwife or doctor. One woman told us “I understand my birth plan.” Another woman told us that although she had opted for a natural birth in her birth plan there had been changes in her condition and she understood she may need an assisted birth. She said the risks and benefits of this had been explained to her. A third woman was not aware of a documented birth plan but said she had had many discussions about the options available during ante-natal appointments. However, the provider may wish to note that, in the maternity notes of four post-natal women we reviewed, we could not find clear documentation of discussion of the birth plan. The section of the pregnancy notes called ‘preferences for birth’ had been left blank. We discussed this finding with the Head of Midwifery and Gynaecology who said they would look into the matter immediately.

Feedback from women obtained by the trust in August 2013 showed that most women were satisfied with their care and treatment and 96% said they would recommend the service to others. All the women we spoke with who had already delivered their baby told us that they had received one-to-one care from a midwife once they were in established labour. The maternity performance report for July 2013 showed that 96% of women had received one-to-one care once in established labour.

Women said had been given information on pain relief in the antenatal period and this was implemented during delivery. Most women told us that the pain relief administered during delivery was adequate. Partners we spoke with told us they had also felt involved in the birth and were able to be present at the delivery.
The Head of Midwifery told us that the maternity unit had high rates of normal deliveries and of breastfeeding, compared with other maternity services in London. The unit had achieved Baby Friendly accreditation at stage 1 for breastfeeding (implementing Unicef Baby Friendly best practice standards is a way of improving breastfeeding rates) and was preparing to go forward to achieve stage 2.

The maternity service had specialist midwives in the antenatal clinic who were equipped to meet the needs of women with particular conditions, such as diabetes. The unit had a ratio of midwives to births of 1:29, which was in line with recommended levels, but was in the process of recruiting more midwives in advance of a move to a new purpose built maternity unit on the hospital site in November 2013. We saw that a large number of prospective midwives had attended the unit, to undertake competency tests, as part of the recruitment process on the day of our inspection.

There were nine consultant obstetricians each with a speciality focus, such as teenage pregnancy, sickle cell, diabetes, multiple pregnancy, endocrine and thyroid disorders, substance misuse and mental health. This meant they were able to develop the specialist skills needed to meet the needs of high risk women.

Midwives we spoke with felt able to challenge medical opinion if they needed to and they were clear about their professional responsibilities. Consultants were described as very responsive and midwives said they always attended the unit when asked.

We reviewed the maternity notes of four women who had been discharged from the unit on the day before our visit. We noted that although most documentation had been completed appropriately the computer generated discharge summaries that were to be sent to the GP and health visitor contained information that did not always correspond with the handwritten maternity notes. The Head of Midwifery and Gynaecology explained that a problem with information technology had been identified, including a failure to generate information correctly. A new system was being introduced in November 2013, which was expected to improve the quality of discharge information. In the interim, in addition to the computer generated discharge summaries, the community midwife wrote separately to the GP and health visitor to ensure accurate information was shared. The women's hand held records of care and treatment were also available for other health professionals involved in their care.

There were arrangements in place to deal with foreseeable emergencies. We reviewed records of checks of resuscitation equipment available in the unit. These showed that the equipment was being checked on a daily basis. All midwives told us they received annual training in adult and neonatal life support techniques. Staff we spoke with confirmed that they knew how to respond to emergencies.
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.

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

Reasons for our judgement

All women and partners we spoke with told us they thought the maternity unit was clean and saw doctors washing their hands between patients and using gloves.

Staff told us personal protective equipment, including gloves and aprons, was always readily available in all clinical areas. We saw that gloves and aprons were available and staff wore appropriate clothing. Equipment we saw on the unit was clean and dust-free. Staff confirmed that equipment was cleaned both before and after use. We observed that the toilets in the unit were clean and had soap and paper towels available.

There were sufficient hand washing facilities and paper towels available on the unit. Hand gel dispensers were working and appropriately placed at the entrance to the wards and clinic. We saw that yellow bins for the disposable of needles and sharp medical devices were not over-filled. Single use disposable linings were used for all water births and we saw a lining put in place as a pool was being prepared for a birth. Audits of hand hygiene on the unit showed 100% staff achievement of expected standards of hand washing.

Appropriate guidance on infection prevention and control was provided to staff, patients and visitors. The trust had an infection prevention and control annual plan in place, the implementation of which was being monitored by the infection prevention and control committee. A recent progress report showed that a number of infection control policies had been reviewed and approved since April 2013. Information on infection prevention and control was available to women and visitors on the maternity unit. Infection prevention and control policies were cascaded via the matrons and managers to all staff and were accessible on the trust intranet.

There had been no recorded cases of MRSA or clostridium difficile on the maternity unit. Infection control was a regular item on the agenda for monthly maternity board meetings. Minutes of recent meetings indicated there were no concerns about infection prevention and control on the maternity unit but this was being regularly monitored by the infection control team.
Supporting workers

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

Met this standard

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The majority of women and partners we spoke with told us they felt confident in the skills of midwives. They were positive about the way they had been cared for and treated. For example, a woman said, "the midwives have all been very caring." Another said they felt they had become "very close" with their midwife during delivery.

New staff underwent an induction period where they shadowed other staff before being considered competent to work independently. The induction covered the roles and responsibilities they were to undertake. Staff we spoke with confirmed they had undergone induction training and confirmed this was the case for all new staff. New staff were assigned a preceptor who signed a checklist to record when they had achieved the required clinical competencies.

Staff received appropriate professional development. Staff we spoke with told us they had undergone recent training pertinent to their role including in child protection, cardiotocograph (CTG) monitoring and interpretation, pain relief, neonatal resuscitation and emergency skills and drills. All midwives received training in the use of inflatable pools used for water births. Maternity staff were undertaking evidence based multi-professional training for obstetric emergencies to the PROMPT (PRactical Obstetric Multi-professional Training) standard, as a way of improving perinatal outcomes, the knowledge and skills of staff and team working. Training records showed that 78% of midwives had completed PROMPT training with the rest due to have completed training by the end of November 2013. This helped ensure staff were able to deliver care to women safely and to an appropriate standard.

We noted, from trust training records, that 66% of maternity staff had completed annual mandatory infection control training. An action plan had been put in place to ensure all staff had completed the training by the end of March 2014.

Staff told us they kept up to date with new trends and developments in maternity and midwifery, such as in diabetes care. They described protocols they had helped to develop, based on NICE guidelines.

There were arrangements in place to support staff to deliver care and treatment to an
appropriate standard. All midwives had an allocated supervisor of midwives and had access to a supervisor on a 24 hour basis. Supervisors of midwives followed up on incidents and identified the training needs of midwives. All midwives we spoke with said they had received an annual appraisal, from both a supervisor of midwives and their line manager, in the last year and had a professional development plan in place. The trust provided evidence to show that 87% of midwives had undergone an annual clinical review. In most cases where reviews were outstanding, dates for completion had been booked. The service had a supervisor to midwife ratio of 1:14, in line with national recommendations.

Staff felt listened to by managers and no one told us they had experienced any bullying or harassment at work. Consultants, midwives and doctors all described good team work in the unit and said they felt well supported by colleagues and managers. Midwives said they were provided with opportunities for a debrief after incidents.
Assessing and monitoring the quality of service provision

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 received. Risks to the health, safety and welfare of women and others were identified, assessed and managed effectively.

Reasons for our judgement

Learning from previous experiences was apparent in the approach to women's care and treatment. For example, a partner explained to us an incident that had occurred during the birth of their previous child which meant that the pain relief provided to his wife was not as successful as hoped. He told us they had been called in to meet with the consultant, midwife and an anaesthetist, on the day of our inspection, to review plans for the current birth in order to avoid a reoccurrence of the situation.

Women, their representatives and staff were asked for their views about their care and treatment and they were acted upon. Electronic patient experience trackers were used to record women's views about their care on the maternity unit. A few women we spoke with on the post-natal ward confirmed they had been asked for their views. Action plans were formulated in response to feedback aimed at bringing about improvements in care and treatment. We reviewed reports of feedback from patients obtained via electronic trackers in maternity for the month of August 2013 and found most women had been satisfied with their experience of care particularly in the areas of receiving one-to-one support from a midwife during established labour and the amount of information provided.

The maternity unit had introduced CARE (standing for Care, Respect, Attitude and Explanations) rounds as another way of obtaining feedback from women. Senior staff on the unit were allocated four beds each on the post-natal ward and spoke with women about their experiences. The results of the CARE rounds were displayed on the ward for staff, women and visitors to see. The results from 2013 showed that the majority of women were satisfied with the way they had been cared for.

The Head of Midwifery and Gynaecology described how changes had been made to allow partners to stay on the post-natal ward overnight to support women. Partners included whomever women chose to stay with them. This change had been made in response to feedback from women.

A scheme called 'Mums for Mums' had also been introduced on the post-natal ward following feedback from women. More than sixty volunteer 'mums' from the local
Community had received two days training in baby care and breastfeeding and volunteered a few hours a week to support women on the ward. Thirty volunteers were currently active in the unit and we were told that a number had gone on to paid employment in the trust.

There was evidence of learning from incidents and investigations and appropriate changes were implemented. The Director of Nursing reviewed all incidents that occurred in the hospital on a daily basis. Staff told us they knew the type of incidents they needed to report and how to report them. They said that incidents were discussed at team meetings to ensure learning took place.

Staff provided examples of changes made in response to learning from incidents. For example, there had been a number of incidents where poor cardiotocograph (CTG) interpretation had been identified as an issue. A CTG is used to monitor fetal heart beat and contractions of the uterus. In order to improve CTG monitoring and interpretation a coloured sticker, which followed NICE guidelines, had been introduced on the unit recently. The sticker was used to clearly record CTG interpretations hourly. Midwives were required to record whether the reading was reassuring, non-reassuring or abnormal. The subsequent action to take, in terms of escalation of concerns, was made clear on the sticker. Staff told us this was having a positive effect on care already.

We saw there was a section on the sticker for another staff member to provide "fresh eyes" and give a second opinion on the interpretation, in line with research findings showing that a "fresh eyes approach" can enhance the accuracy of CTG interpretation. We saw that the stickers were being completed hourly and were used in the records of women we reviewed, although we noted that the "fresh eyes" section of the form had not always been signed. We fed this information back to senior trust managers who said they would investigate the matter further.

Learning from incidents was communicated to staff via a quarterly newsletter called 'Pregnant Pause'. We saw that feedback from patients was communicated to staff and information about serious incidents and learning was recorded under the 'risky business' section of the newsletter. Trends in incidents had been identified, compared with previous years, and shared with staff as a way of reducing the number of incidents that occurred.

Midwives told us that perinatal mortality meetings were held every two months along with a monthly labour ward forum, open to all staff, where learning from incidents and adverse events was discussed. Minutes from recent Labour Ward Forums showed that risk management issues were discussed. However, it was noted that although the perinatal mortality meeting was protected learning time for doctors it was often difficult for midwives to attend. Reports of serious incident investigations were kept in clinical areas where staff were able to read them.

The trust took account of complaints and comments to improve the service. For all complaints the Head of Midwifery visited women at home to discuss their concerns. Since the introduction of the CARE rounds, two years ago, complaints on the unit were said to have decreased by 50%.

The conclusions of local and national reviews carried out by expert bodies were taken into account and changes made to the care provided to women where appropriate. The Head of Midwifery and Gynaecology explained how recommendations and learning from the Francis Report had been discussed in a meeting with all midwives. Midwives told us that following discussion of the report training called 'In your shoes' had been introduced where a group of women who had given birth on the unit had been invited back to speak with
consultants, midwives and health care support workers about their experiences. This was described as very useful and informative for staff. Staff told us they felt able to raise any concerns they had about the quality of care and treatment provided and were confident they would be listened to by managers.

There was a clear committee structure in place to support the trust board and ensure lines of communication between the board and frontline maternity services were effective. The maternity board reported to the trust board and meetings were held monthly. The maternity board was usually chaired by the Chief Executive of the trust and attended by the Medical Director and other senior staff. A monthly maternity scorecard was used to monitor performance across a number of key performance areas covering clinical activity, clinical outcomes, incidents, complaints and patient satisfaction, and workforce. Any concerns about performance were flagged for discussion at the maternity board meeting. When a measure was identified as high risk this meant immediate action needed to be taken to maintain safety and quality. The trust benchmarked performance in maternity against that of other local services.

Staff we spoke with in maternity were enthusiastic and positive about the imminent changes in service and planned move to a purpose built maternity unit on the hospital site in November 2013. Staff told us they had been involved in service design and development and women had been consulted about colour-schemes and decor in the new unit.
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>
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<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>
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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:

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<td>Supporting Staff - Outcome 14</td>
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<tr>
<td>Assessing and monitoring the quality of service provision - Outcome 16</td>
<td>10</td>
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<td>Complaints - Outcome 17</td>
<td>19</td>
</tr>
<tr>
<td>Records - Outcome 21</td>
<td>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.
(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.