Inspection Report

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

Leighton Hospital

Middlewich Road, Crewe, CW1 4QJ

Tel: 01270255141

Date of Inspection: 05 December 2012

Date of Publication: January 2013

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mid Cheshire Hospitals NHS Foundation Trust
Overview of the service	Leighton Hospital is a medium sized district general hospital located on the outskirts of the town of Crewe. It is the management base for Mid Cheshire Hospitals NHS Foundation Trust who are a provider of acute hospital services in south east Cheshire.
Type of services	Acute services with overnight beds Rehabilitation services Urgent care services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

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

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 reviewed all the information we have gathered about Leighton Hospital, looked at the personal care or treatment records of people who use the service, reviewed information sent to us by the provider and carried out a visit on 5 December 2012. We observed how people were being cared for, talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

When we carried out our unannounced visit to Leighton Hospital we mainly visited Wards 2 and 21b.

All the patients to whom we spoke were complimentary about the care that they were being given. One said "Service is good, nurses are good and they can't do enough for you. They keep checking to make sure you are alright". Another said "these professionals are a credit to their profession".

When we observed care on the wards we saw patients were treated properly and when we asked patients about this they told us they were treated with dignity and respect.

We examined a sample of patients' records and found that they were properly assessed and planned to needs of the patients on the wards. We also saw that arrangements for people's discharge was done in conjunction with staff from the local authority's other NHS trusts and voluntary bodies.

We discussed the arrangements for the safeguarding of vulnerable adults and while they met the requirements of regulations we noted The Trust had plans to improve training for staff.

We looked at the management of drugs on three wards and found that arrangements for the handling and recording of medicines were not consistently adhered to.

We asked about the Trust's arrangements for monitoring it's quality of care through ward level audit and examination of mortality figures and found they were working well.

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 14 February 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

When we carried out our unannounced inspection we visited Ward 2 and spoke to staff about the arrangements for the assessment and planning for people's care when they first arrived on the ward. It was explained that assessment was done as soon as possible after patients arrived and in any case within 24 hours. We also understood that assessments done as part of emergency admissions in other parts of the hospital would be repeated on arrival on the ward. Reassessments were done either as required or to a schedule. For example everyone was weighed at least once a week and pressure area assessments to protect people from the risk of bed sores were done every day. If someone had a fall then other assessments such as mobility and falls risk would be redone.

Because of previous concerns about the development of pressure sores in the hospital we asked for more information about this aspect of care and it was clear that staff were familiar with the Trust's Pressure Ulcer Pathway, how to assess pressure score risk using a method known as the "Waterlow Scale" and when and how to get advice from tissue viability specialists. We were told that tissue viability support was available over the telephone as well as through visits and we saw that there was a named tissue viability link nurse who attended meetings and cascaded information to other ward staff.

We spoke to four patients on Ward 2 and all were complimentary about the care that they were receiving. One person said "Service is good, nurses are good and they can't do enough for you. They keep checking to make sure you are alright". Another said "these professionals are a credit to their profession, nothing is too much trouble". A third patient said of the staff, "I feel totally safe. They explain everything to me – they are like angels" and "It's a wonderful place; they take care of me and care about me".

Patients on Ward 2 also told us they were treated decently by staff. One said "they are always nice and polite" and another when asked whether they were treated with dignity and respect replied "very much and every time".

We also visited Ward 21b and again staff told us that risk assessments were done promptly on admission and reassessed as needed or to a schedule. Staff on this ward

which looked after older people who were vulnerable to pressure sores were particularly knowledgeable on the subject and were able to speak confidently about what to look out for and what to do if a problem was suspected.

We looked at a sample of patient records on both wards and found that they corroborated what we were told by staff. We saw that risk assessments were completed in a timely fashion following admission and the notes recorded any reassessments that took place. When risks were present these were addressed in care plans and we noted that for pressure sore prevention there were specific care plans that referenced guidelines from the National Institute for Health and Clinical Excellence (NICE).

Patients on Ward 21b were also complimentary about the care they were being given. One person said "Staff are very nice, all lovely really, very kind" and "They are polite and kind and gentle".

On both the wards we observed care being given and in general this was unhurried and attention was paid to patient's privacy by, for example, the use of curtains around the bed. We saw patients treated in a respectful and dignified way and staff were working to maintain people's independence.

When we visited the two wards we looked at how staff assessed their own performance and addressed any shortfall. We were shown how each ward completed a monthly audit of its performance against quality and care indicators and that this information was displayed on notice boards in a public area for patients, visitors and staff to see.

On Ward 21b we looked at recent figures and asked senior ward staff about them. We noticed that in October 2012 there had been a low score for cannula site care, (The cannula is the needle through which a patient is given fluids). We were told that there had been a problem with infection for a patient within that month. We were concerned that given this, for the subsequent month of November no score was recorded. We were told that cannulae were uncommon on the ward and the reason no score was present was that no patient had had one in place that month.

We discussed another issue that was picked up through the audit, with the charts used to record the amount of fluids that patients received and lost. We were told that when the problem was noted an action plan was developed and practice educators were involved to give staff training. In subsequent months scores showed that the practice was once again acceptable. We also saw that the wards assessed the incidence of falls and were given performance improvement targets to meet such as "10% reduction" and "no repeat falls". The latter target is useful as it addresses the reassessment and changes to care plans needed in response to someone falling.

We spoke to staff on both wards about the use of the indicators and everyone we spoke to was able to discuss them confidently and talk about recent issues and what was being done to address them. They also told us that they discussed the scores and any action plans during team meetings and when we looked at the notes of those meetings we saw it was the case.

It was clear from our discussions with staff, notes of ward meetings and action plans that ward managers were making use of the clinical indicator system to drive quality improvement.

Cooperating with other providers ✓ Met this standard

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, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We visited Ward 2 and asked senior staff about arrangements for discharge planning. We were told that this process started on admission where assessments were made of a patient's circumstances, how long they were likely to stay hospital and how well they might be on leaving.

We were told there was a named discharge co-ordinator and we took the opportunity to speak to them. This member of staff described the role of the Integrated Discharge Team which is a group of professionals from the hospital and social services co-located at Leighton Hospital who work together to support the discharge of patients. They told us how the process worked and made reference to The Trust's discharge protocols and procedures.

When we spoke to patients on Ward 2 we asked them whether staff had discussed arrangements for going home with them. One patient told us they didn't know a date to go home as it was some way away but that "the physio and me are working together" and that the arrangements for the support that would be needed at home had been discussed. They said the consultant had involved their relative in the discussion. Another patient told us their discharge was dependent on the work they did with the physiotherapist. They said they had had assessments for tasks of daily living such as washing and dressing (which would have been done by social services staff) and that their spouse was also involved in discussions.

On Ward 21b we spoke to patients about how they were involved in any planning for them to go home. One gentleman said the staff were planning for him to go home but that he needed support for this and they were arranging for a "type of home help".

We looked at the notes for a sample of patients on the ward and saw good examples of discharge planning. In one file there were discharge checklists which demonstrated co-operation with other providers through communication with and input from social workers. There was also evidence of referral to community staff who work for a separate NHS trust such as a community matron and continence advisor.

For a second patient there was again a discharge checklist and there was evidence that discharge planning had started on the day of admission and continued with input from a

multi disciplinary team. There were communication sheets showing that relatives of the patient had been involved in the planning.

In the documentation of another patient who was ready to go home that day we saw the notes demonstrated the arrangement of out-patient appointments, an assessment by social services of their home and plans for support by a community dietician. There was documented involvement by an occupational therapist and transport arrangements for them to get home had been arranged with an ambulance service.

We asked that The Trust send us copies of the discharge polices and procedures that staff had referred to during our inspection visit. We saw that this confirmed what we were told in our conversations with ward staff and that there was a Joint Discharge Policy that had been developed in conjunction with Cheshire East and Cheshire West and Chester councils. There were also policies for groups of patients with a need to be supported by a specific service outside of The Trust, for example Macmillan Nurses.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We visited Ward 2 and spoke to senior staff about the arrangements in place on the Ward for the Protection Of Vulnerable Adults (POVA), also known as "safeguarding". We were told that if staff suspected abuse they would contact senior staff who would gather information prior to faxing a safeguarding alert to social services which was in line with The Trust and local authority safeguarding procedures. When we spoke to other ward staff they were clear about what constituted abuse and that they would report it internally but with one exception they did not talk about the role of social services in safeguarding.

We asked about the arrangements for training staff in safeguarding and we were told that these were addressed though The Trust's Biennial Mandatory Update (BEMU) programme which all staff attended every two years as well as being covered on induction for all new staff. This was confirmed by The Trust's Training Prospectus as well as by staff that we spoke to..

We spoke to staff on Ward 21b about the protection of vulnerable adults. Staff were knowledgeable about safeguarding and were able to tell us what they looked out for and what they would do if they had concerns. Recently appointed staff referred to training they have received as part of their induction and other staff mentioned the BEMU updates. Staff also generally understood that safeguarding was the responsibility of social services and investigations were conducted independently of the hospital.

We visited a third ward and spoke to two members of staff about their knowledge of safeguarding. One member of staff knew about the different kinds of abuse and was clear that they would act should they have any concerns, however they told us they would contact the "Head of Patient Safety" on a particular number rather than follow the hospital's procedures. Another member of staff was less confident in their knowledge of adult safeguarding.

The provider might find it useful to note that as we spoke to staff if became clear that many were more conversant with the procedures for protecting children than they were for those intended to protect adults. If was also of note that staff on Ward 21b were more confident than staff elsewhere in the safeguarding of adults.

One member of staff said to us that the training for children was classroom based and that

for adults self guided through a workbook. Another member of staff could not recall the POVA training being in their workbook although they said they had completed the course. A third member of staff recalled completing competence checks following the training for safeguarding children but not for adults.

We asked to speak to The Trust's lead for adult safeguarding. When we met them we noted that they were new to the post and had been working with senior managers to assess The Trust's safeguarding provision and make improvements. They told us that it was intended that the processes for safeguarding children and adults be brought together and they were working to do this with the local safeguarding authority. They also said that they, like CQC, had noted the training for children to be more effective than that for adults and as a result future training in the safeguarding of adults would be face to face. We were reassured by the plans being developed and that issues that we had identified during the inspection were already recognised and being addressed by The Trust.

Following our visit we asked The Trust for documents known as the Provider Compliance Assessment (PCA) for this outcome. These describe how the organisation considers it meets the requirements of the regulations. These documents that gave a cogent account of how the organisation met its responsibilities and were consistent with the information we gathered during the inspection.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The service did not fully protect people against the risks associated with the unsafe use and management of medicines as the hospitals arrangements for medicines handling and recording were not consistently adhered to.

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

We spoke with six patients on three wards about their medicines. Most people we spoke with were positive about their stay, however, Trust staff had recently identified some concerns about medicines handling on one ward. They told us how this was to be progressed through the hospitals error reporting procedures, so appropriate action could be taken. We found that the prescription charts were generally clearly presented but codes for recording the reason why doses of medication were not given were not consistently used.

We looked at how medicines were handled and saw appropriate arrangements were in place for confirming and reviewing people's medicines on first admission to hospital. When patients were admitted to the hospital doctors recorded and prescribed their medicines following a standard procedure. This was then checked by the pharmacy team within 24 hours to make sure all the information was correct.

People we spoke with had enough information about their medicines. One person told us they received "good care" and told us that doctors had explained about the medicines they were taking, and why. A second person told us "sometimes my medicines looked different, but I asked the nurses and they explained it was just a different brand". Two people confirmed that their pain was well managed, however, when we approached one patient they told us they were in pain. The lunchtime medicines were due but we saw that the actual time the last dose of painkiller had been administered was not recorded, so it was not possible to tell whether another dose could have been given slightly earlier. Records of medicines given to people on discharge were clear. Nurses in the discharge suite went through people's medicines with them to help ensure they knew how to take them, before they went home.

The hospital wards had a regular clinical pharmacy service. We saw evidence of regular medicines audits that helped identify weaknesses so that any necessary improvements could be made. Concerns had been identified about medicines handling on one of the wards we visited and this included one example of missing a dose of a medicine included on the hospitals list of medicines that should never be missed. The Trust had picked up

these concerns through their monitoring. We were told us how this was to be progressed through the hospitals error reporting procedures, so appropriate action could be taken.

We looked at medicines record keeping. Appropriate arrangements were in place in relation to the recording of medicines but were not followed consistently. The prescription charts we looked at were generally clearly presented, however, on three of the seven charts we looked at the reason for missed doses had not been recorded using the chart key. We also saw one example where the actual dose of an injection prescribed with a dose range was not recorded. Clear records showing the treatment people have received are important when carrying out reviews. However, we saw one record that showed a medication had been increased from twice, to three times daily when the patient was currently refusing to take it. The rationale was not recorded and there were no records to show whether any alternatives had been considered.

We found that medicines were safely stored. An audit of the storage and security of medicines carried out by The Trust in October 2012 had identified some concerns but action had been taken to address these. Controlled drugs were properly recorded and checked. However, on one ward there were unwanted controlled drugs that needed to be removed by pharmacy. Emergency medicines were available on the wards but the daily checks had not been completed for the previous day on two of the wards we visited. These checks are important to ensure that everything is at hand, should it be needed.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

Following our visit we asked The Trust for documents known as the Provider Compliance Assessment (PCA) for this outcome. These describe how the organisation considers it meets the requirements of the regulations. These documents gave a cogent account of how the organisation met its responsibilities and were consistent with the information we gathered during the inspection.

NHS trusts are required to submit adverse incident information to the National Reporting and Learning Service (NRLS) which analyses it and passes information to CQC. One of the indicators looked at is the reporting rate for adverse incidents, where a high rate is considered a positive indicator as it can reflect open culture with good reporting systems. Prior to this inspection we looked at the information we held and noted The Trust to have a particularly low rate of notifications which caused us concern.

When we discussed this issue with senior managers on the day of inspection they were surprised because they considered their reporting rates to be high, something we later noted that they had commented on as positive evidence in their PCA for this outcome. Following the inspection we asked The Trust to provide evidence of this and we also independently obtained information from the NRLS. This information showed that The Trust was consistently recorded as a high reporter being in the top 25% for three of the last four quarters.

When we carried out our inspection visit we spoke to staff on wards 2 and 21b about the arrangements for reporting and leaning from adverse incidents or "near misses". We were told that incidents were reported using the "IR1 system" which referred to a form that was completed under these circumstances. We understood that this information was held on a specialised computer system know as "Ulysses".

We asked about the training arrangements for staff to enable them to report incidents and we were told that it was covered in The Trust's Biennial Mandatory Update (BEMU) programme which all staff attended every two years as well as being covered on induction for all new staff. We looked at the relevant training syllabuses to confirm this and

requested training completion figures. The figures showed that training took place as did our conversations with the staff we spoke to..

When we visited Ward 2 we asked the Ward Manager for an example of an adverse incident recently reported by the ward. We were told of an incident involving a medicine overdose in October 2012. We followed this incident through and found that it had been appropriately investigated with the support of the Medicines Management department and that root causes had been identified. We were told that as a result of the investigation staff had received additional training and that feedback had been given to all staff on the ward. We asked staff about this and they recalled the incident and that training they had been given. We also saw that reference was made to the incident in the notes of the ward meeting.

We asked The Trust on the morning of our visit for reports of incidents that had take place on the wards we visited. They were able to provide this at short notice demonstrating their ability to analyse and sort the information held on their Ulysses system.

One of the means that CQC uses to provide information on NHS trusts is to look at mortality outlier figures provided by government and other bodies such as Dr Foster. A mortality outlier is when there is a higher number of deaths for a particular group of patients than might be expected. A higher number is not in itself a cause for concern but should prompt the hospital and others to ask further questions.

These alerts occur throughout the year and CQC often speaks to trusts to ask for a report and explanation of the figures. This might result in the issue being judged as no concern or the trust might notice the opportunity for improvement and produce an action plan. We gain assurance that action plans are implemented through regular dialogue with The Trust. As part of this inspection we looked at the outcome of a recent alert about alcoholic liver disease where we had been told that a new care pathway would be introduced by the end of November 2012. We visited a ward where we expected to find this pathway in place but staff there were not using it. Due to an emergency on the ward at the time of our visit we were not able to speak to senior staff about the issue.

We spoke to managers about this and they told us that the pathway was not yet in place because it had not been received back from the printers, however we were quickly provided with a draft copy. We were appreciative that our visit was less than a week after the deadline for the introduction of the pathway.

We understood through previous conversations that The Trust has an internal Hospital Mortality Reduction Group where they discuss mortality alerts generated externally and also from their own internal monitoring of indicators using a commercial package. We asked for notes of the most recent meetings of this group to assure ourselves that this analysis of indicators takes place and that the specific issue of the care pathway for alcoholic liver disease was being monitored through this group. We saw this to be the case and there was good evidence that The Trust worked with other hospitals through bodies such as the North West Mortality Collaborative to learn from one another's experiences. We also saw evidence that other recent alerts that we knew about continued to be monitored and managed.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The service did not fully protect people against the risks associated with the unsafe use and management of medicines as the hospitals arrangements for medicines handling and recording were not consistently adhered to.

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 14 February 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.

This section is primarily information for the provider

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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