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

The Queen Elizabeth Hospital

Gayton Road, Kings Lynn, PE30 4ET

Tel: 01553613613

Date of Inspections: 16 August 2013
14 August 2013
13 August 2013
12 August 2013

Date of Publication: October 2013

We inspected the following standards in response to concerns that standards weren’t being met. This is what we found:

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 August 2013, 13 August 2013, 14 August 2013 and 16 August 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 received feedback from people using comment cards. We reviewed information given to us by the provider, talked with other regulators or the Department of Health, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

What people told us and what we found

We visited the hospital at the same time as NHS England (East and Midlands) who were carrying out a rapid responsive review (RRR) of the hospital. This was because we had an agreement between the two organisations, which meant we could share information and evidence that we gathered.

Our last visit to the trust in May 2013 resulted in us asking them to take actions in order to be compliant with nine regulations. The report of our previous visit has been published and an action plan has been received detailing how the trust intends to become compliant with the regulations. Our recent visit took place in response to some new information of concern that we had received about the hospital.

During the inspection we visited in-patient wards, the maternity unit, the children's ward, the accident and emergency department and the children's out-patient clinic. We received a total of 32 comment cards about the service completed by patients or carers. 13 of these contained negative feedback and 19 contained positive feedback.

Patients told us they were satisfied with the choices of food they received and drinks were readily available. Dietary needs were catered for, for example low fat and high calorie diets. We also found sandwiches, fruit and yogurts were available at night on request from the main kitchen. The trust was able to provide food for patients with religious and cultural needs such as kosher and halal meals. We found nutritional assessments and fluid balance charts had not always been completed and the trend over the past six months had not improved.

Most patients we spoke with told us they felt safe, although two patients were concerned about the lack of staff to support patients with dementia, which made them feel vulnerable and unsafe.
Staff were knowledgeable about the issues and referral systems for safeguarding adults and children and knew the members of staff to contact if they required guidance. Norfolk County Council safeguarding team told us they felt confident in the trust’s systems.

However, lack of comprehensive training for staff in dementia and low staffing levels on many general wards meant patients were at risk of receiving inappropriate or unsafe care.

We saw a shortage of nursing staff especially during our unannounced visit during the evening. Although the trust had put actions in place to increase the recruitment of qualified nurses this was insufficient to ensure that enough staff were available to meet patients’ needs and care for them safely. We told the trust about our concerns immediately and they told us they would take action.

Staff felt supported by their line managers but the opportunity to attend training for nursing staff was limited because of the shortage of staff. This meant staff did not have the correct skills to deliver responsive and effective care to patients especially to those with a dementia.

The systems and processes for managing the risks to protect patients and staff were not robust. We identified that not all serious incidents were managed in the correct way and that some incidents which had been classified as serious had subsequently been downgraded. This meant that opportunities to learn lessons and improve services had been missed.

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 22 October 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 The Queen Elizabeth 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

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<tr>
<td>Food and drink should meet people's individual dietary needs</td>
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Our judgement

The provider was not meeting this standard.

Although patients were complimentary about the quality of food they received, the systems and processes in place were not always used to ensure patients at risk of poor nutrition and hydration received appropriate assessment, support and monitoring to ensure their needs were met.

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

We visited six wards to talk to staff, visitors and patients about the food and nutrition available to patients. We also found out about the support systems that were in place to ensure that patients were being protected against the risks of inadequate nutrition and hydration.

All of the patients that we spoke with were very complimentary about the quality of food provided to them. One person who had been a patient at the hospital several times in the last three years described that the food had, "Much improved," during that time. People also told us they were happy with the choice of food they were offered at mealtimes although a few said they would enjoy having toast but this was not provided. Some senior staff told us that toast was not provided by the trust because the quality could not be maintained during its' transfer from the kitchen to the ward and the fire officer felt that toasters used in ward kitchens were a fire risk. However when we spoke with staff we found that some wards did have toasters and some staff felt its’ availability was very beneficial to patients. The trust should review this policy so that patients have an improved choice of foods they enjoy.

When we looked at the menu offered to patients there were suitable options for people who required particular diets such as vegetarian or diabetic meals. The menus contained some codes to indicate choices that were suitable for people with specific dietary needs such as high calorie or low fat options. We noted that there was information on the menu about how to request smaller portion sizes but no instruction on how to request a large portion. When we spoke with staff they knew how to ensure large sized meals were received by writing a note on the menu request form. This required staff to advise patients on how to request larger sized meals.
Some staff that we spoke with said that 'finger foods' were available for people living with dementia although we did not see this in practice. One senior nurse said she had not seen these foods being used. When we asked the chef, he confirmed that cold finger buffet style food was available but no hot food options were supplied. This indicated that some staff may not be aware of the specific dietary needs for this group of patients and could therefore not respond to them.

When we looked at the nutrition assessment records for a number of patients we found that staff did not make note of any dietary preferences. This meant that when patients' were unable to express their preferences staff may not be able to supply them with food or drinks that they enjoyed.

We spoke with the Head Chef about the food portion sizes. He explained that some work had been done to look at this issue and they had found most patients did not require larger meals and smaller portions were requested much more frequently.

We observed staff helping patients at mealtimes on several wards. We found that when a patient changed their minds about the meal they had ordered, staff did their best to respond to their requests in a timely way. This was done either by swapping with a spare meal tray or making additional requests to the main kitchen.

We observed a lunchtime service on three separate wards during our visit. Staff were available to provide sufficient assistance to patients who required support to eat and drink. Meals were served to patients in a timely manner. However staff in some areas told us this was not always the case when there was a high number of patients on the ward who could not manage to eat and drink without help.

The trust had a 'meal mates' system in place where staff from all areas of the trust had received training to enable them to support patients at mealtimes. Staff on one ward told us they had not received this help for several weeks which meant some patients experienced delays in receiving hot food.

We asked about the availability of food for patients during the evening and at night. Hot food could be accessed until 9.00 pm at night when kitchen staff went home. We were informed that 'snack boxes' were available to order in advance from the main kitchen or, after 9.00pm, a porter could access the kitchen to collect a snack box if required. The snack boxes contained sandwiches, fruit and yoghurt but no hot food option was available. When we spoke to ward night staff about the availability of food at night, we found there were differing levels of understanding about what was available. This meant that patients may not always have access to food that was available.

We observed that a range of hot drinks were provided on a regular basis to people throughout the day. This included early morning before the arrival of the breakfast trolley and in the evening after visiting time had ended. One patient told us that a member of staff, "Went out of their way to fetch me a cuppa," when they had been admitted from the accident and emergency department late at night.

When we spoke with staff we found that serving drinks from the trolley was a role shared by different staff members on different wards. One housekeeper we spoke with was employed on weekdays during hours to cover breakfast and lunchtime but was not available during the afternoon, evening or at weekends. This meant that when there was no additional housekeeping staff the ward healthcare assistants were responsible for providing hot drinks. Both the ward manager and the housekeeper admitted this was an additional pressure on staff when low staffing levels were more likely to be a problem.
During our visits to the ward areas we did not meet any patients with specific dietary requirements due to their religious or cultural backgrounds. The ward staff told us that very few of their patients came from different religious or ethnic groups but on occasions, when patients did have specific needs the kitchen staff were very helpful.

We spoke with the Head Chef to ask how they met dietary needs for people with specific religious or cultural needs. He explained the hospital was able to source halal meat for patients and kosher meals were bought in. The chef was available to meet with patients who had specific needs so that he could listen to their requirements and plan menus for them.

When we visited the wards we found they used a coding system to identify patients who required support to eat or drink. The ward whiteboards contained patient information including specific dietary needs so that staff could easily identify patients who required a level of support. Further information was placed above each patient’s bed. On one ward this included detailed information such as identifying patients that needed specific food consistency, for example a soft or puree diet, or patients who needed to have their fluid intake recorded.

We spoke with a patient who was having their food intake recorded. The patient told us the chart had been commenced the previous day due to the amount of weight they had lost since hospital admission one week previously. We asked to check the care records to see evidence of the treatment plan but found no reference to it in the records. This meant there was no reason given for the care which had been put in place so that staff could measure whether it was being effective.

We checked several other care records to look at the assessment and plans of care to support patients’ nutritional needs and found the amount of information varied. One patient, who was living with dementia, had no problems recorded in relation to their ability to eat and drink. Their records of daily prescribed nursing care gave little information about their dietary needs or the level of care that had been given to them. However after a few days the person was given a thickener for liquids and the care prescribed stated ‘give assistance’. The records did not give sufficient detail in how to use the thickening solution although while we were present a speech and language therapist came to assess the person’s needs and gave a full assessment and instructions for staff to help them to eat and drink.

We spoke with the Speech and Language Therapist (SALT) who was not directly employed by the trust. We were informed that the trust employed a specialist SALT team to support the stroke service but there was only one part time SALT across the rest of the hospital services which they said was not enough to meet needs of the patients. When we asked, they confirmed that they were able to respond to most referrals within 24 hours. They also told us that some nurses were trained to undertake basic swallow assessments so they could assess the patient’s ability to safely manage different food consistencies.

We looked at the nutrition screening tool used to assess whether a patient was at risk of malnutrition. On one ward, we looked at two patient records and we found errors had been made in the calculation of both nutritional risks. We raised this with the ward manager who confirmed our findings and assured us she would ensure staff received additional training.

We also looked at records for a patient with specific dietary needs on two other wards. For one patient, we found there were gaps in the information which meant the risks could not be calculated accurately. For the other patient we found staff had not followed the
guidance to correctly calculate the risk of malnutrition. However, we saw that both patients were receiving parenteral nutrition therefore their nutritional support needs had not been overlooked. (Parenteral nutrition is where patients are fed a specially prepared liquid through a tube into a vein.) All four of the records we reviewed raised training issues for nursing staff in the correct use of the nutrition screening tool. This meant patients could have been at risk from not receiving the correct support in order to meet their nutritional needs.

We noted that the dietary supplements (for people who required additional calorie intake) were supplied to the wards each day by a dietetic assistant. We were informed that these were prescribed for patients and administered by nurses who signed to say patients had received them.

We spoke with a patient who had been receiving nutritional feeding through a tube inserted through their nose and into their stomach, for several weeks. The patient was just beginning to eat normally again. They said that staff had done a good job in supporting their needs. This included flushing through the tube with water on a regular basis to ensure they received enough fluid and did not experience a dry mouth.

We visited the neonatal intensive care unit and spoke with a nurse about the parenteral nutrition being administered to a baby. A review of the records demonstrated that local guidelines were closely followed and checked to ensure the baby's nutritional needs were being met. This included hourly completion of fluid balance chart, checking weight gain and working closely with parents and members of the multidisciplinary team.

We also reviewed the care records for a patient on an adult ward who was receiving parenteral nutrition. This had been prescribed on a medication chart by a doctor and with advice of a dietician. We found that the fluid balance charts used to check the person's fluid input and output had not been fully completed on a number of days, therefore it was difficult to measure the accuracy of the patient's fluid management. However, the records indicated that specialists such as the dietician and diabetic nurse were involved with the care and support of the patient to ensure their needs were being monitored.

We looked at checks that had been completed on fluid balance charts across all the wards. We saw over the last four month period almost half of the wards had poor results for the percentage of charts that were completed correctly. This identified that further improvements are needed to ensure that fluid monitoring charts are used correctly to be responsive to patients' needs and support the delivery of safe and effective care.
Safeguarding people who use services from abuse

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

Our judgement

The provider was not meeting this standard.

Patients were not always protected from the risk of abuse and as a result did not always feel safe. Training in safeguarding was delivered although some staff did not always feel it was adequate and security staff had not received training in relation to those patients with a dementia. The trust did not have the systems and processes in place and had not taken reasonable steps to prevent safeguarding incidents from occurring.

We have judged that this has a major 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

It is important that patients are protected from abuse and any allegations of abuse are dealt with effectively and appropriately. To ensure this happens staff must be well trained in such matters and the trust should ensure robust and effective systems are in place to identify the possibility of abuse and prevent it before it occurs.

Most of the patients we spoke with told us they felt safe in the hospital. However, two patients told us they did not feel safe. This was because of incidents that had occurred on the wards, for example a patient with a dementia hitting a member of staff during the night and shouting. The patient told us there were not enough staff on duty to deal with incidents like that.

During the patient focus group held in the hospital on the evening of Monday 12 August, we heard about a further three incidents of a similar nature. One patient had discharged themselves because they had been frightened to stay on the ward. The NHS England RRR team informed us they had spoken with a younger patient who stated they had stopped their children visiting because of other patients with a dementia.

All the staff we spoke with about safeguarding adults and children in the hospital could explain to us how they would identify patients who they thought may be at risk of abuse, for example physical or emotional. They knew the different forms of abuse that may occur and told us the names of the hospital's two nurses who took the safeguarding lead for children and adults.

The nurses, doctors and therapy staff we spoke with were able to tell us when they had last received training on safeguarding; all the dates were within the previous six months.
They also said the two lead nurses for safeguarding were always supportive and available for advice.

We spoke with both of the safeguarding lead nurses. The adult nurse lead had been in the role in a full-time basis since April 2013 and had recently updated the trust’s adult safeguarding policy which we were able to see. The document was also available on the hospital’s intranet. They were able to inform us about what their role consisted of; this included delivering all the training to new staff during their induction. It also included annual mandatory training updates on the topic. We saw the percentage of staff who had undertaken safeguarding training in the previous twelve months and this was 96%.

The safeguarding lead nurses informed us the length of time they had to deliver safeguarding training had been reduced from one hour to twenty minutes for all new staff. Nursing staff received a further 30 minutes training. They told us they felt it would be better if the training sessions lasted longer as they would have the time to discuss issues with staff. The trust may wish to note consideration should be given on extending the time given for the delivery of safeguarding training.

Two members of staff who had commenced working in the trust within the previous nine months told us the induction was rushed with too many topics to cover in one day. They remembered receiving safeguarding training but would have liked more time to spend on it. One told us, “There is so much to take in it all blurs into one.”

The adult safeguarding lead attended both internal and external meetings relating to their role. These included Norfolk County Council safeguarding team and the trust’s safeguarding adults committee. They informed us they found these meetings very useful and wanted to include discussions with Lincolnshire and Cambridgeshire safeguarding adult teams in the near future. In addition, they also met quarterly with representatives from the local police, care home managers and social services to discuss training and any other issues pertinent to their roles.

The trust’s named nurse for safeguarding children had been in post for eight months. They also delivered training to new staff and annual mandatory training with additional training for those who specifically work with children. We looked at the trust’s children’s safeguarding policy and found it should have been reviewed and updated in August 2012. The children’s nurse lead told us this would be completed by September 2013.

The trust also had in place two specialist midwives caring for pregnant vulnerable women and a named doctor for safeguarding children who was a consultant paediatrician. The maternity ward in the hospital had a bay near the nurses desk so close observation could be made on mothers and babies that may be at risk. The ward manager told us the system worked really well.

Individual and group supervision support was in place for those in the children’s safeguarding team and there were plans to extend this to the paediatric (childrens’) nurses working in the accident and emergency department (A&E).

We also spoke with the executive lead for safeguarding in the trust. They informed us they thought the systems and processes in place were thorough. They also told us their deputy met with the nurse safeguarding leads on a weekly basis and issues were fed up through the line management system. They received a report on safeguarding issues and passed them up to the trust board.
Following our inspection the trust informed us the safeguarding team were invited to give an overview of their work programme and achievement to the board of directors on an annual basis.

When we asked the trust the reason why the safeguarding lead nurses did not report directly to the board they told us the executive lead for safeguarding gave them the information they needed.

Following our inspection we spoke with a member of Norfolk County Council safeguarding team. They informed us they were confident in the referral system for reporting safeguarding incidents from the hospital and felt any investigations that were undertaken by the hospital were comprehensive.

During our inspection we visited the hospital during one evening. We went with a member of the security staff to a ward where they informed us a patient was being disruptive. We saw they dealt with the patient by aiding the staff to take observations by holding their arm on the bed. The patient was confused and disorientated because of a dementia.

Following the incident we spoke with the member of security staff who told us they had received training in "dementia and restraint" when the security company had won the contract in February 2012. They told us they were ‘frequently’ called to wards to manage patients with dementia because, "The girls can't deal with violence and we have zero tolerance to it". When we asked about their training in dementia they told us, "It wasn't really formal training as such, more what we picked up as we go along." This meant patients could be at risk of unlawful or excessive forms of control or restraint

Most nursing staff we spoke with told us they had not received additional training to ensure they had the correct skills and expertise to care for their patients across all the specialities on the wards. For example one ward cared for ear nose and throat, gynaecology, medical, urology and trauma orthopaedic patients. Some informed us they did not have time to meet patients' needs because of the shortage of staff. A ward manager told us they had drawn up a training plan for staff but this had not yet been put in place.

Lack of training in dementia and specific specialties coupled with insufficient nursing staff levels meant patients were at risk of neglect because their needs could not be met.
### Staffing

There should be enough members of staff to keep people safe and meet their health and welfare needs

#### Our judgement

The provider was not meeting this standard.

There were insufficient qualified, experienced and skilled staff employed by the trust to be responsive to patients’ needs. Although it is acknowledged the trust have been working to resolve this issue, patients remain at risk.

We have judged that this has a major 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

When we visited the hospital in May 2013 we raised concerns about staffing levels and told the trust they had to take action. They sent us an action plan in response to the report in which they stated they would resolve the situation by the end of September 2013.

During this visit we were concerned again about staffing levels because of information we had received from the local clinical commissioning group (CCG) who funds care for patients receiving treatment at the hospital.

We spoke with patients, relatives and staff about this. All the patients told us they thought the staff were wonderful but some felt there were not enough of them to give the care they needed.

A patient on one ward told us, "The nurses are lovely but there aren't enough of them. I can't always use the bottle (to pass urine) when I want to and I've had some accidents". They told us they felt, "Awful and embarrassed."

A relative we spoke with told us, "There are not enough staff at night. Junior nurses need more support. They are working their socks off but need more staff to support them."

During the patient listening event held in the hospital on the evening of Monday 12 August, we heard about incidents relating to a shortage of staff on wards. These included call-bells not being answered quickly enough and insufficient staff to care appropriately for patients who had a dementia and became anxious.

Evidence from NHS England RRR team found between December 2012 and March 2013, the highest reported incidents in the hospital were shortages of staff. This had increased from 80 to 453 in the year but they could not see evidence where the trust board or quality...
committee had taken any special action to resolve the issues or provide feedback to the staff who reported these concerns. In addition, they also saw the incidence of reported pressure ulcers increased from 71 to 217 in the same year. This could denote there were insufficient staff to provide care to patients in order to minimise pressure ulcers from occurring.

We were aware the trust had introduced a different shift pattern for a number of the wards. This meant nursing staff working more 'short' days and less 'long' days each week to undertake their contracted hours. The trust told us they had introduced this following a consultation period with staff in order to improve the continuity of patient care and make patient care safer. Some staff said they didn't mind the change but many staff told us they didn't like it because they spent more days at work each week. We were informed some staff had left because of the changes to the shift pattern. One of the reasons given was child care had become more difficult.

Because of the shift change, some staff told us they weren't available to undertake additional shifts on the 'bank'. Bank staff are people who are employed by the trust and who choose to do additional shifts when the hospital is short staffed. The trust used its bank staff as a first option when it needed additional staff.

We saw agency staff had been employed across the general wards and in the A&E department. Agency staff are staff who are not employed by the trust but undertake work for them on a 'when necessary' basis. We were informed by staff and senior management in the trust that agency nurses were employed on a regular basis in the hospital. However the use of agency staff had still not brought staffing levels up to the number required on each shift in many of the wards. For example on 13 August 2013, only two of the areas in the hospital had been fully staffed in the morning, one in the afternoon and three at night. Senior managers had responded in that they had moved staff to areas which they knew were busy.

We looked at staffing levels in the hospital from 21 June to 13 August and found there was not one day when the hospital was fully staffed with the numbers of nursing staff the trust had said it should have on each ward or department; we saw the required numbers of staff on the daily staffing templates. The numbers reflected the skill mix review undertaken by the trust earlier in the year. Because the hospital was not fully staffed, patients were at risk and may not have been safe.

Although the specialist areas were generally well staffed, for example the critical care unit, when we visited the general wards they were not staffed according to the level of dependency of the patients although the trust had closed a number of beds on some wards in response to low staff numbers. On our unannounced visit on the evening/night of 16 August 2013, 17 beds had been closed across the hospital.

On one ward we were informed three qualified nurses had left since March. They told us two of the reasons staff had left were the change of shift pattern and stress. The nurse we spoke with told us, "I do feel stressed and frustrated because I can't do the proper things for the patients. I haven't got time."

The 'Hospital at Night' team was a team of 12 qualified and unqualified nurses, led by a matron. They worked across the hospital going to wards and departments who needed additional help. We spoke with a member of the team who informed us there were three of the team on duty each night.
The board assurance framework for 2013/14 showed in June 2013 there was an 11.8% nurse vacancy rate, and it is acknowledged nurses from the trust's international recruitment drive were due to commence their employment at the hospital in the near future. In addition, during our feedback to the trust about our inspection we were told managers from the trust were again in Portugal to recruit more qualified nurses.

When we visited the A&E department we were told 18 members of nursing staff had either left the department since March or were leaving for a variety of reasons; these included working for other organisations. The trust informed us there were a number of new staff about to commence employment in the department in the near future.

We spoke with a member of senior management and they were able to supply us with the number of qualified nurse vacancies for week beginning 5 August 2013. This showed there were 37.45 whole time vacancies across the hospital. Two new staff had commenced employment and 6.79 nurses had left the organisation. The vacancy rate for qualified nurses for the week was 9.04%. This meant that although the vacancy rate had dropped since June 2013 the recruitment drive had not proved sufficient to lower the vacancy rate significantly and thereby reduce the risks to patients.

The trust’s risk register dated 23 July 2013 showed staffing on adult in-patient wards had been given a risk rating of 16. Actions by the trust included reducing the number of beds on five wards, increasing the use of agency staff and the recruitment of qualified staff from Portugal. The next review date for this was 1 September 2013.

NHS England RRR team also had concerns about low nursing staff levels and told the trust on Wednesday 14 August about them. We spoke with a representative of the trust on the evening of 16 August 2013 towards the end of our unannounced visit and informed them the hospital was not safe because of the low numbers of staff on some of the general wards and asked them to take immediate action.

The trust responded by informing us of action it was going to take to improve the situation. This included further bed closures where this was practicable and requesting additional bank and agency staff to work in the hospital. In addition, they told us they would increase the number of staff on their 'Hospital at Night' team.

Although the trust responded to our concerns, we could not be confident effective measures were being taken to stabilise the staffing situation and improve patient care.
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.

People were cared for by staff who were not always supported to deliver care and treatment safely and to an appropriate standard. This meant that patients did not always receive safe care.

We have judged that this has a major 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

It is important that the hospital is well led. This means there needs to be suitable arrangements in place to ensure that staff are supported to enable them to safely deliver care and treatment to patients and to an appropriate standard.

Appropriate professional development was available for staff, however due to staffing constraints staff were not always able to attend training as needed.

We noted that there was a dementia awareness training programme for 2013 which included different types of dementia and managing behaviours. We also saw dementia training was included in the nursing and midwifery induction and mental capacity training was included in the doctors' mandatory training. The majority of staff we spoke with confirmed that they had not attended training for dementia awareness, however wanted to attend the training to develop their knowledge to provide appropriate care. One ward manager told us the dementia awareness training lasted for about an hour and was ok, but could be better. However, they went on to tell us that if the training was longer, it would be more difficult than at present to release staff from the ward.

A member of the NHS England RRR team spoke with the lead dementia nurse for the trust who explained that attendance at dementia awareness training was not adequate as staff were not released from the wards. This meant they were not able to attend appropriate training to enable to them to safely deliver appropriate care and treatment to patients living with dementia.

Some patients were admitted to wards that were a mixed specialty, for example surgery and orthopaedics, and some wards had changed specialties following a ward reconfiguration. Most nursing staff we spoke with told us that additional training had not
been provided to ensure staff had the correct skills and expertise to care for their patients. However, they told us doctors were very good and explained what they needed to be aware of for specific medical conditions.

A ward manager explained that a training package in caring for patients with very different needs had been developed for their staff, however due to staffing shortages they were unable to complete this. This meant that the staff did not always have the appropriate training to ensure the patient’s welfare and safety was maintained.

Another staff member told us that staff were sometimes moved to work on a different ward to meet required staffing levels; however most of the staff had not had training to deal with specific medical conditions, including chest drains and tracheostomies. A tracheostomy is a tube placed in a patient’s neck to help them breathe. For instance, an incident was reported on 05 April 2013 as, ‘IV antibiotics through central line not given as the shift nurses were not trained for it’. Action taken was to inform the Night Nurse Practitioner and further action taken documented ‘Matrons and higher management aware of the situation continue to book and phone staff to fill this short fall’.

Trust incident reports that we reviewed demonstrated delays in patient care and treatment due to staff not having the appropriate training. One incident on 23 February 2013 documents that the medication round took two and a half hours to complete as the second trained nurse had not yet had their medication competencies assessed. There were three further incidents on the same ward as the junior staff nurse had not been trained in intravenous therapies. One incident states, ‘Ward is acute medicine with patients with ongoing chest pain etc and iv (intravenous) medications. Unsafe to give patients required care and compassion. Patients complaining about waiting and lack of visual presence of staff.’ Another stated ‘Only 1 member of staff trained to do IV (intravenous) medication, therefore all IV medication due at 12.00 or 14.00 were only finished at 16.30.’

The trust recently completed a recruitment drive in Portugal. We were informed that a pre-screening process was completed by a recruitment agency which included English skills before potential employees were interviewed by senior nursing staff from the trust, who focused on their competencies. Staff we spoke with were aware new staff members had undertaken a trust induction which included hand washing, tissue viability and equality and diversity. However, some still needed a competency assessment to allow them to administer medication and intravenous therapies.

It is acknowledged the trust had been commended for a series of competency assessments for newly recruited nurses and this policy had been identified as good practice.

Staff we spoke with explained that although new staff were competent, the level of their English skills was a barrier at times, in particular an impact had been seen during handover. Some staff told us that they had raised their concerns with the trust’s practice development team and English lessons were now held on a weekly basis. Since our inspection visit, the trust has informed us that attendances at the classes are on a voluntary basis and a skills assessment was not held at the end of the course.

Mandatory training (training that staff must have) was available for all staff and overall the completion rates met the trust’s attendance target. However, when we looked at the mandatory training for clinical staff we noted that the attendance rates were below the trust’s target for training in infection control, resuscitation, manual handling and conflict resolution. Ward staff we spoke with confirmed that they were unable to attend mandatory training due to staffing shortages on the wards. This meant staff were not always able to
update their essential skills and knowledge which was necessary to provide safe quality care and treatment.

Annual appraisal rates showed that 60.43% of trust employees had received an appraisal. An appraisal is a process where an employee's performance is analysed over a twelve month period and training needs are identified for future development and career progression. Some staff we spoke with confirmed that they had received their appraisal and that they found it a positive process. Other staff were aware that their appraisal was due and could tell us when it was planned. However, a few told us that regular appraisals did not always happen and were unsure when their next appraisal would be. We were told that staff had fed back that time was not always available under current trust pressures to complete the documentation.

The paperwork used for appraisals had been implemented to ensure that the completion of paperwork was manageable and did not prevent an appraisal from going ahead. The limited number of appraisals completed meant that there was not always the ability to identify skills development to ensure high quality patient care was provided.

Staff were able, from time to time, to obtain further relevant qualifications. A ward manager told us that one of their staff members was due to start a Diploma in Dementia Awareness in September 2013. This would provide valuable knowledge and expertise as the ward had a high proportion of patients living with dementia. The trust informed us that five senior health care assistants had enrolled to start the Diploma which was a two year course. We also noted that the trust offered National Vocational Qualifications (NVQ), apprenticeships and preceptorships. Preceptorship is a period of time given to guide and support all newly qualified nurses, midwives and allied healthcare professionals to make the transition from student to qualified practitioner and to develop their practice further. However, a review of the trust's incident reporting demonstrated that on one ward there were two occasions between 19 March 2013 and 02 April 2013 where staff reported the inability to effectively support newly qualified staff nurses and provide appropriate care to patients.

Staff we spoke with were aware of courses available. A nursing auxiliary told us how they wanted to learn venepuncture (taking a blood sample) and was able to complete the course two years ago with the support of their manager. Another explained that they wanted to complete a nursing course although they were still waiting to hear if they would be able to go on the course.
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 not meeting this standard.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

We have judged that this has a major 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

There was evidence that learning from incidents / investigations was not effective, did not always take place and as a result appropriate changes were not always implemented.

We received information of concern prior to this inspection, which did not assure us that the trust fully considered incidents and complaints they had received. During our inspection in May 2013 we commented on how the trust managed complaints and concerns made to them and therefore we have not looked at these again.

This time we examined how the trust managed incidents and found that an electronic reporting system (Datix) was in place. This was completed by staff when they reported incidents, for example low staffing numbers and patient falls, and we found the system automatically alerted the appropriate senior staff and the on-call director of the trust be informed if a serious incident had been reported.

The trust had two policies in relation to the management of incidents, which provided clear guidance about how to manage all incidents, including serious ones. However, we identified that not all serious incidents were managed in the correct way and that some incidents which had been classified as serious had subsequently been downgraded. We found that the trust had developed an additional category into their incident recording system, known as a 'serious learning event' (SLE).

These were incidents that the trust believed did not meet the criteria for reporting externally as serious incidents, but were considered significant enough that the trust felt they should be investigated, followed up and tracked until closure. On examination of the SLE's we identified that not all had been investigated or subsequent action identified, although the trust's policies indicated that a comprehensive investigation should have been undertaken. We were concerned that as a result of the SLE category the trust was not always reporting serious incidents (SI's) and dealing with them appropriately.
We looked at one incident report. The Datix report showed that the categorisation was not in keeping with the concerns detailed in the incident report. On closer examination of the Datix report, and after speaking with staff in the patient safety and risk management department, we identified that the indicia categorisation had been suggestive of a possible serious incident. There was no information in the Datix report and staff were not able to confirm when the incident had been discussed with two trust directors, as required by the trust's policies. The incident had been investigated and actions, with timescales for completion had been identified to reduce the risk of it happening again. This had been a smaller scale investigation instead of the larger investigation required in the trust's policies.

We also found that not all the actions required had been completed, and one action regarding a special training drill for all staff had not been started. We spoke with staff in the department where the incident had occurred and found they did not all know how to respond appropriately to a similar incident. Other actions, such as discussion at different hospital committees also had not occurred. Where the incident had been discussed, minutes from the committee meeting only provided details of the incident not the discussion or any decisions or actions made as a result of it. This resulted in a lack of agreement by committees regarding the appropriateness of the action plan, as not all the causes of the incident had associated actions against them. Staff in the patient safety and risk management department confirmed the use of a 'tracking' spread sheet to monitor the progress of the investigation of SI's and SLE's. That particular incident did not appear on the spread sheet. The trust informed us the use of the tracking sheet was to monitor the progress of the investigations of SI or SLE. In addition, the trust informed us after the visit they were following their current policy at the time of the incident.

Following the incident a recommendation had been made by the Interim Medical Director that there was a high likelihood of such an incident happening again and it should be put on the risk register. Following this recommendation the incident categorisation was downgraded from major to negligible. We examined both the operational and corporate risk registers kept by the trust and found that there was no record of this incident. Events could only be included in either risk register if the risk attained a particular score or higher. For the corporate risk register, the score was 15, although only items scoring 20 or above were discussed by the trust's board until July 2013 when this was reduced to risk ratings of 15 and above. We examined the ten items on the risk register dated 23 July 2013. These included financial matters, IT systems and the inability to retain laboratory staff. Financial matters rated the highest scores of 20. There were no patient safety incidents reported.

During our review of the trust's various committee meeting minutes we noted that there had been a backlog in filing 10,000 pathology results in patients notes. Recommendation by the committee regarding how to manage this backlog was to destroy paper copies of the results that were within normal limits and over a year old. We identified that approximately half of the records had already been destroyed.

We asked the Trust what actions had been put in place following the release of the staff survey 2012 results which had been available in February 2013. They told us that no actions had been put into place as the results would be analysed with the 'friends and family' test and an organisational culture survey. However, the organisational culture survey was only completed in late June 2013 and the results were not available at the time of our inspection. In the trust's 2012 staff survey there had been a decrease in some of the key areas identified for staff satisfaction. For example, 'I would recommend my organisation as a place to work' and 'Percentage of staff experiencing discrimination at work in last 12 months'. Other results for the trust indicated there was little variation from the average for an acute trust. The trust had delayed the opportunity to implement actions
following the staff survey 2012 and have therefore failed to evaluate and improve the quality of services provided and ensure staff were appropriately supported.

The trusts' audit department completed monthly checks on fluid balance charts and nutrition screening tools. Trust audits showed there was a good level of compliance with completion of the nutrition screening tool. However, we found inaccurate calculations had been made when we selected random examples to review during our inspection. This meant that the audit may not be measuring the quality of the assessments completed. The fluid balance audits showed varying levels of compliance with some wards only achieving 33%. In a six month period we could not see any improvement in the quality of completion of these charts. The results were shared widely with senior nurses and the wards themselves who were being asked to take action to improve the quality of completion.

We looked at the investigations from six adult and six child safeguarding incidents that had been undertaken by the hospital in the previous few months. One of them had a detailed investigation carried out as part of the process. Whilst actions had been highlighted in the investigation report, which had been signed and dated as completed, no actions had been documented as completed. We discussed this with the adult safeguarding lead who adapted the forms to ensure this was recorded when actions had been completed.

After our visit to the hospital we received concerning information from a former patient's relative. The incident had been raised as a complaint to the trust who had responded. We saw the response from the trust sent and this indicated that some of the information should have been dealt with as a safeguarding issue. However, the information had not been passed to the safeguarding team in the trust to take action.

Because of failings within other regulations identified in this report, it has been evidenced these were not isolated failings. The historical pattern and continuation of these failings, the quality assurance processes and systems at the trust have shown they were not effective in assessing and managing the risk to 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 activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td><strong>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Meeting nutritional needs</strong></td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider was not ensuring systems and processes were being used effectively to ensure that patients were being protected from the risk of inadequate nutrition and hydration. Regulation14 (1)</td>
</tr>
</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 22 October 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 activity</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Safeguarding people who use services from abuse</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Patients were not always protected from the risk of abuse and as a result did not always feel safe. Training in safeguarding was delivered although some staff did not always feel it was adequate and security staff had not received training in relation to those patients with a dementia. The trust did not have the systems and processes in place and had not taken reasonable steps to prevent safeguarding incidents from occurring. Regulation 11 (1) (a) (b) (2) (a) (b) (3) (b) (d)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Staffing</td>
</tr>
<tr>
<td></td>
<td>How the regulation was not being met:</td>
</tr>
</tbody>
</table>

There were insufficient qualified, experienced and skilled staff employed by the trust to be responsive to patients' needs. Regulation 22

**We have served a warning notice to be met by 31 December 2013**

This action has been taken in relation to:

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
</tbody>
</table>

**Supporting workers**

**How the regulation was not being met:**

People were cared for by staff who were not always supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a)

**We have served a warning notice to be met by 31 December 2013**

This action has been taken in relation to:

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation or section of the Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
</tbody>
</table>

**Assessing and monitoring the quality of service provision**

**How the regulation was not being met:**

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. Regulation 10 (1) (b)

For more information about the enforcement action we can take, please see our Enforcement policy on our website.
We are the regulator of health and social care in England.

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

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

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

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

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

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

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

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

You can tell us about your experience of this provider on our website.
How we define our judgements

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

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

✅ Met this standard
This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

❌ Action needed
This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

❌ Enforcement action taken
If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

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

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

**Essential standard**

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

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

**Regulated activity**

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
## Glossary of terms we use in this report (continued)

### (Registered) Provider

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

### Regulations

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

### Responsive inspection

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

### Routine inspection

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

### Themed inspection

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