Inspection Report

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

Liverpool Women's Hospital

Crown Street, Liverpool, L8 7SS

Tel: 01517024038

Date of Inspections: 08 July 2013
07 July 2013

Date of Publication: September 2013

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

Care and welfare of people who use services	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✖ Action needed

Details about this location

Registered Provider	Liverpool Women's NHS Foundation Trust
Overview of the service	Liverpool Women's Hospital is one of two in the country that specialises in providing healthcare for women and their babies. The hospital provides a range of services including gynaecology services, maternity services, neonatal care and a reproductive medicine service. Each year, the trust provides care and treatment to around 30,000 patients from Liverpool and the surrounding areas.
Type of services	Acute services with overnight beds Doctors consultation service Diagnostic and/or screening service Doctors treatment service
Regulated activities	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

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 unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 July 2013 and 8 July 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by local groups of people in the community or voluntary sector. We took advice from our specialist advisors, 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 carried out a responsive inspection of Liverpool Women's Hospital as a result of us receiving a number of concerns about the service including a concern about staffing levels on the maternity unit and the impact of this on women's and their babies experiences of the service.

We arrived at the service unannounced at 6pm on Sunday 7 July 2013 and we returned the following day to continue the inspection.

During the visit we spoke with women across the maternity service and with their partners and relatives. This included the postnatal ward, labour ward, the midwifery led unit and the triage and assessment unit. The feedback we received from the majority of women and relatives was very positive and people in the main described good experiences and good outcomes from their stay or visit.

People described the care and treatment they had received as 'excellent', 'brilliant' and they described staff as 'amazing' and 'approachable'. People felt safe and confident in the ability and experience of the staff supporting them.

However, people did also tell us that they felt the staff were 'too busy' and 'very busy' and they felt that this prevented them from asking for too much support.

We found concerns about staffing levels throughout the maternity unit. This was evident through our discussions with women who were using the service, from discussions with staff at all levels and from other information which suggested the staffing levels had been a cause of concern for some time. We found the staffing levels had a direct impact on some aspects of women's care and welfare and on how staff were being supported.

Senior managers were aware of the concerns about staffing levels and had been actively trying to address the problems we found prior to our visit. They shared information with us

about the actions they had taken to date to reduce the risks associated with reduced staffing levels and to prevent future recurrence of staff shortages.

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 13 September 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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People didn't always experience timely care, treatment and support to meet their needs .

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care and treatment was not planned and delivered in a way that fully protected people's safety and welfare.

We looked at this outcome because we received information of concern about the trust linked to the care and welfare of patients on the maternity unit. The concern was that staffing shortages were having a negative impact on patient experience.

We spoke with a number of women on the antenatal / postnatal maternity ward (Mat Base 1) about the care and treatment they had received. They told us they felt well informed about their health and fully involved in making decisions about their care and treatment. Women spoke highly of staff at all levels and told us they felt that staff had met all their needs and those of their babies. People's comments included: "It has been really good, we're really impressed", "They have answered all my questions and explained things in full and it has been very reassuring", "Staff have been brilliant", "I'd come back here I think it's excellent" and "They have been absolutely brilliant. I chose to come here because they looked after me throughout my pregnancy." The feedback we received reflected the results of the 2012 inpatient survey carried out by the Picker Institute on behalf of the trust. Overall 85% of patients who responded rated the care they had received at the hospital as seven or above out of ten and the trust had achieved better than average results in many of the question areas.

Many of the women and relatives we spoke with told us that staff were very busy and they didn't like to bother them if they needed advice or support. However they felt that this didn't compromise their health or wellbeing or put them at risk. One woman told us about a health complication she had experienced and told us that "The staff are very busy but when I needed them they came immediately". One woman told us she was breast feeding her baby and doing "OK" but that she didn't like to seek assistance from staff with this because they were busy. Another woman told us she had received good support and

guidance with breastfeeding from volunteers who attended the ward.

We heard a number of similar comments about staffing at our last inspection visit but we saw no direct impact on patient care at that time and we saw evidence that the trust had carried out a review of staffing levels and was in the process of recruiting additional midwives. However, on this inspection we saw examples whereby women were not receiving appropriate care and support in a timely manner. For example, we spoke with the relative of a woman who was in pain and distress who had been waiting for two and a half hours in the reception area of the triage and Maternity Assessment Unit (MAU). Her relative told us that they felt that the system for triage was very ineffective. Another woman who was complimentary about the service as a whole told us that her experience of the MAU was not good and that she had waited for a number of hours before she received the pain relief she needed because there were no doctors available. Another woman who had been in the MAU for over seven hours told us "Everybody has been really good but there are not enough doctors. The doctor looking after me keeps getting taken away because there's an emergency or someone else needs her more."

We were told by staff that the new system for triage and assessment had been put in place in February of this year. The provider should note that immediate assessment of this system should take place to ensure that women and their babies are supported in a timely manner and not placed at risk.

During discussions with staff throughout the maternity unit they told us they felt staffing levels impacted upon the quality care they could provide. They told us the quality of care given to women was sometimes compromised and they were not able to provide women with the emotional care and support they required. Staff reported that when staffing levels were low midwives had on occasions been allocated a high number of women to care for and this resulted in call bells not being answered in a timely manner. They also told us that staff had not had the time to support women with their babies to the extent they would have liked to and the care they provided had sometimes been rushed which could have lead to mistakes being made.

During discussions with women they said they felt staff were treating them with dignity and respect. We saw that staff spoke about women and engaged with them in a dignified manner and it was clear from the staff that we spoke with that they had women's and babies' best interests at heart. People's comments included: "The staff are lovely, really nice and very respectful" and "I couldn't fault the staff they have been amazing." We saw that staff used curtains to ensure women's privacy and dignity, and in one location there was a designated room referred to as a 'counselling room' which was available for private conversations.

We observed a staff handover on the labour ward. This was managed well and we noted some excellent practice. The handover took place in a private room to respect the women's confidentiality. Women were spoken about in a dignified manner and the person handing over spoke quietly and calmly and ensured all members of the team were engaged. Whilst we found that in general staff were supporting women in a dignified and respectful manner we noted one area of practice which compromised women's privacy and dignity. In the MAU we noted that staff exchanged information about women during a handover which took place in a semi-open area. In the same area a whiteboard which had confidential information about women was clearly visible.

We know from our on-going monitoring of the trust that equality and diversity is effectively promoted across all aspects of the service. During discussions with staff they clearly

demonstrated their awareness of the need to respect and involve all women equally and they were able to give us examples of how they supported people whose first language was not English.

Staffing ✖ Action needed

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 numbers of qualified, skilled and experienced staff on duty to meet the needs of people using the service.

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 discussed staffing levels across the maternity unit with a range of staff with different roles and responsibilities. Staff told us they felt there had always been an appropriate skill mix of staff on duty but that there had not always been sufficient numbers of staff on duty and that staffing levels were a concern. A senior member of staff told us they felt the staffing establishment was unknown to most staff and that currently and for some time there had not been enough midwives and healthcare assistants on the maternity ward. Staff told us that rotas were organised on a two weekly basis but they required constant monitoring to ensure all areas were adequately staffed. Staff described a casual rotation of staff around the maternity service to cover shortages. This resulted in staff being moved frequently and sometimes in the middle of a shift. Staff felt that even if they started their shift with a full complement of staff that this would not be the case for the duration of their shift. They were concerned that this did not allow continuity or promote consistency of care for women and babies and it had caused staff to feel stressed. A senior member of staff confirmed that they were aware that moving staff between the different areas was having a negative effect on staff moral and they told us that maintaining adequate staffing levels was a 'daily challenge' for the team.

Staff told us they found the staffing levels, length of shifts and lack of breaks very stressful. Many staff told us they were frequently too busy to take a break during the course of a 12 hour shift. Staff told us they did without their breaks to make sure the service was safe for the women and babies. They felt concerned about the impact of low staffing levels on the women and their babies. These concerns related to delays in women's discharge home, not being able to manage medicines and pain relief in a timely way and not having the time to support women to breast feed their babies. Staff reported a couple of shifts recently when one corridor of single rooms accommodating up to 17 women and babies had been staffed by only one health care assistant. Staff described a very busy 48 hour period prior to our inspection visit. We knew there had been a number of occasions over the past twelve months when the hospital had closed to admissions as a result of insufficient staffing levels.

A senior midwife said that shortage of staff to provide one-to-one care for women in labour could be a problem between the midwife led unit (MLU) and the labour ward "There's often a problem transferring women who request an epidural because the MLU midwife can't normally transfer to stay with the women and so it depends on labour ward having a midwife who can take on one-to-one care. Then women have to stay in MLU until a midwife is available in delivery suite and this is bad for the woman and can cause friction between midwives in delivery suite and MLU".

We saw a 'trigger list' notice in one ward area for incident reporting. We noted that a shortage of staff was one of the triggers to be reported. A member of staff suggested that although shortage of staff was a reportable incident many staff did not have the time to complete this when staffing levels were low. The member of staff said the analysis of incidents relating to this would not reflect the number of occasions that staffing levels were low.

Staff spoke at length about problems linked to staffing when a new 'Triage and Maternity Assessment Unit' (MAU) was set up earlier this year. Senior managers had recognised the problems with staffing of this service and they shared a 'Maternity Assessment Unit update' with us. This detailed that staffing issues within maternity had led to delay in establishment of a team on the MAU. It had been planned that when the new MAU opened it would have a full complement of staff. However due to on-going problems with staffing levels there was not a full complement of staff available when the MAU opened. The trust's target was that women should be seen within 30 minutes of arriving at the MAU. However the trust's analysis of waiting times between May and June 2013 indicated that only approximately 70% of women were seen within 30 minutes of arrival.

The supervision of midwives is a statutory function delivered by NHS England as the Local Supervisory Authority (LSA) which ensures that every midwife practicing in England is in receipt of appropriate support and guidance from a named supervisor of midwives (SoM). During our inspection we contacted the Local Supervising Authority (LSA) Midwifery Officer (LSAMO) responsible for Liverpool Women's Hospital for information about the supervision of midwives at the trust. She informed us that the annual meeting, which had been arranged for her to meet with all twenty one SoMs employed at Liverpool Women's Hospital, to prepare for the required annual audit of the function had been cancelled and rescheduled to October. The reason was because only eight of the twenty one supervisors were available to take part because of staff absence.

Senior staff told us they did not consider that staffing levels were unsafe but there had been times when levels had been 'on the cusp' and there was the potential for women and babies safety to be compromised as a result. Consultants we spoke with told us they felt that there was sufficient doctor and consultant cover and consultants could be called in quickly out of hours if there were any problems.

We found that staff were confident in speaking with us about their concerns. They told us they had no concerns about speaking up about staffing but felt that they had no confidence that managers were listening to their concerns. However, staff did tell us they knew that the trust was in the process of recruiting midwives. We also saw the notes of a meeting with staff where staff had raised concerns about the number of staff on the MAU, the lack of flexibility for 12 hour shifts and staff concerns that they were not providing a quality service. Manager's responses in the meeting had been recorded and the notes indicated that senior managers had listened to staff and engaged with them positively.

We were provided with copies of a monthly 'Maternity Staff Briefing which informed staff of

key issues within the unit including the recruitment of midwives and their starting dates. The briefings also detailed that there had been a high level of staff absence due to long term sickness and statutory leave and that arrangements for reducing staff sickness were in place. Dedicated staff were to be assigned to the unit. Staff had been offered increased hours to fill vacancies. The escalation policy had been reviewed to ensure it provided a clear process to follow during times of increased activity / reduced staffing levels. A rostering project manager had been appointed to implement a new rostering system to make planning rotas quicker, easier and more efficient across the trust. Systems for listening to staff views through surveys and listening events had also been implemented.

Senior managers were open and transparent in their response to us and they acknowledged that staffing levels were problematic. Throughout the inspection senior managers openly discussed the deficit of staff across the maternity unit explaining some of the work the trust had carried out to increase the midwifery workforce. A trust board briefing paper was provided to us showing that whilst a proposal to increase the workforce had been made the funding available did not allow for the full numbers required. We were informed that the trust had secured some increase in funding towards the end of 2012 and this had resulted the recruitment of 19.38 full time equivalent midwives since the beginning of the year with the latest starting in post mid-August 2013. We were informed that the 'Maternity Management Team' has been addressing the staffing issues and they shared an action plan with us which demonstrated this. We were informed that the trust had experienced high levels of staff sickness in 2012/13 and this together with a number of staff vacancies had led to staff shortages. We were told that the trust was making improvements to ensure that posts regularly go out to advertisement to ensure that any gaps resulting from leavers, maternity leave or long term sickness absence were to be filled more quickly in the future.

Supporting workers ✖ Action needed

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 fully supported to deliver care and treatment to an appropriate standard.

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

Staff were not always supported in their roles and responsibilities and professional development. During discussions with women and their partners and relatives we asked them a range of questions about staff on the maternity ward including whether they felt confident in the skills and abilities of the staff. All of the people we spoke with gave us very positive feedback and staff were described as skilled, professional, approachable and friendly. People's comments included: "The staff are amazing" and "They have been really nice, I couldn't fault them."

Staff reported good team work between the different disciplines and staff we spoke with were clear about their roles and responsibilities and those of their colleagues. Staff told us that they thought the skill mix was good in that there were always staff with appropriate skills and experience on duty. We found during the course of the inspection that staff at different levels were approachable and engaging. Staff presented as knowledgeable, confident and competent in their roles and presented as passionate about their work and dedicated to providing good quality and safe care, support and treatment to women and their babies.

We found that the staff induction training programme for new staff was comprehensive. Staff told us they had undergone a period of induction to the trust when they commenced work. The induction involved orientation to the area of work they would be working in and two weeks of training in topics such as safeguarding, equality and diversity, infection prevention and control and clinical practice such as basic life support. One member of staff described a six week training and shadowing programme when they started work and this included working alongside staff with a range of roles and responsibilities. Staff told us that they received additional training on aspects of clinical care following their induction and in line with their roles and responsibilities.

Staff told us that an appraisal of their work / professional development review (PDR) was carried out with them on an annual basis. A number of staff told us their last PDR appraisal was over two years ago and one person told us that they had to cancel a recent appraisal

meeting because they hadn't had the time to attend it. At our last inspection the trust reported that 80% of staff had undergone a review of their performance in the previous twelve months. The trust was asked to provide information on the current level of PDR achieved for staff on the maternity unit. This indicated that in May 2013 64% of staff were up to date with PDR. Therefore 36%, or over one in three members of staff did not have a current PDR. The figure for the trust overall was that 71% of staff had undergone a PDR within the past 12 months.

Staff did do not have any formal supervision sessions in between PDRs other than team meetings. Staff told us that the last three team meetings had been cancelled as a result of staff shortages. Staff did however report good communication on the ward. Each day a 'briefing' meeting for all staff took place at handover. The ward manager told us that they attended quality meetings every week and the outcomes from these meetings were discussed at the daily handover in the form of a daily brief to staff.

The supervision of midwives is a statutory function delivered by NHS England as the Local Supervisory Authority (LSA) which ensures that every midwife practicing in England is in receipt of appropriate support and guidance from a named supervisor of midwives (SoM). Midwives confirmed that they had regular and annual supervision with their supervisor. One person told us the last time they had an official meeting with their supervisor of midwives was over twelve months ago but generally the midwives told us that they had been able to achieve the requirement to meet their supervisor once per year. We heard from midwives that they felt that staffing shortages were making it difficult for supervisors to fulfil the SoM role because they were generally delivering management and this detracted them from their supervisory function. We were informed that six midwives were in training to become supervisors of midwives to improve availability of statutory supervision.

A senior member of staff on the antenatal and postnatal ward told us they felt there were good opportunities for the professional development of all staff and midwives. Staff told us they had received a range of training in the past twelve months including training in topics such as: health and safety, dealing with emergencies (for example postpartum haemorrhage) and information governance. We saw that a training plan was in place on the maternity ward and information about training was clearly available. This showed a mix of mandatory and specialist training was provided as relevant to the different staff roles. We were told that the training plan was 'work in progress' and dates had been set to achieve any identified gaps in training. It was reported that all staff were provided with mandatory training. This amounted to three days per year for midwives and two for days for health care assistants. A number of the staff told us some of their training had been cancelled as a result of staff shortages. This included midwives who told us they had been "pulled off" training to work on the ward. Discussions with the Head of Midwifery confirmed that this had happened, it had been due to staff shortages and would only be done as last resort, they felt this was not acceptable and should change when more staff were recruited. The trust provided us with statistics on the number of staff who were up to date with mandatory training on the maternity unit. This indicated that in May 2013 69% of staff were up to date with mandatory training. Therefore 31% or almost one in three members of staff were not up to date. The rate for staff being up to date for the trust overall was 82%.

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
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People who use the service were not fully protected against the risk of receiving inappropriate care or treatment by means of the timely carrying out of an assessment of needs of the person and the planning and delivery of care in such a way as to meet people's individual needs. (Regulation 9 (1) (a) (b))
Regulated activities	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: Sufficient numbers of suitably qualified, skilled and experienced staff were not on duty at all times in order to safeguard the safety and welfare of people who used the service. (Regulation 22).
Regulated activity	Regulation
Maternity and midwifery services	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**

This section is primarily information for the provider

	How the regulation was not being met: Suitable arrangements were not in place to ensure staff were fully supported in relation to their roles and responsibilities. (Regulation 23 (1)(a)).

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 13 September 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.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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