Inspection Report

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

Chesterfield Royal Hospital

Chesterfield Road, Calow, Chesterfield, S44 5BL

Tel: 01246277271

Date of Inspections: 06 June 2013
05 June 2013

Date of Publication: July 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Meeting nutritional needs	✖ Enforcement action taken
Records	✖ Action needed

Details about this location

Registered Provider	Chesterfield Royal Hospital NHS Foundation Trust
Overview of the service	Chesterfield Royal Hospital NHS Foundation Trust provides a range of acute services at Chesterfield Royal Hospital including a 24 hour accident and emergency service. The hospital serves the local population of Chesterfield and north Derbyshire.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

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 to check whether Chesterfield Royal Hospital had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Meeting nutritional needs
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 June 2013 and 6 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

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

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We visited four wards in the hospital over two days. One was a medical ward designated as caring for older people and one was a specialist unit for the treatment and rehabilitation of people who had suffered a stroke. Two of the wards were for people having assessment of their needs before being transferred to other wards or being discharged home. We spoke with people using the service and their representatives. We spoke with staff including clinical, care, ancillary and therapy staff and senior managers.

We found that the provider had taken action and had addressed some of the concerns from our previous inspection in August 2012. However, we found that the provider had not achieved compliance in any of the three standards we looked at.

People we spoke with told us they were involved in decisions made about their care and treatment and they understood the choices available to them. We found many examples of good practice where people's privacy, dignity, independence and personal views were taken into account. However, we also found examples where people's privacy and dignity were not well promoted. People's views were sought, but it was not always clear what action had been taken or was planned to address issues raised.

Many of the people we spoke with were satisfied with the quality of the food provided. We found that people were not always offered a suitable choice of food. As at our previous inspection, we found that some people did not get the support they needed to eat enough for their needs.

We found that accurate records were not always maintained for people using the service. This meant that people were not fully protected against the risks of unsafe or inappropriate care.

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 27 July 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 Chesterfield Royal Hospital to protect the health, safety and welfare of people using this service.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People using the service were involved in making decisions about their care and treatment and understood the choices available to them. People were encouraged to express their views views in relation to their care and treatment. However, their views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care. People's privacy, dignity and independence were not always respected

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

At our previous inspection in August 2012 we found that people's privacy, dignity and independence were not always respected. We judged that this had a minor impact on people using the service and told the provider that action was needed. The provider told us in November 2012 about the action they had already taken and further action they planned to take to achieve compliance. The provider told us they would be compliant by the end of April 2013.

At this inspection we found many examples of staff treating people with consideration and respect. We saw staff mostly speaking courteously to people and providing sensitive assistance. Many of the people we spoke with told us they felt their privacy was respected and their dignity upheld. Most people said they had been asked for their preferred name and were addressed by this. We saw that toilets and washrooms were mostly clearly signed for male or female use. People were accommodated in single sex bays on the wards, or in single rooms. The exception to this was a designated 'ambulatory' bay on one ward which was mixed sex. People we spoke with in this bay told us they had no concerns about it being mixed sex. One person told us, "It's not like I'm sat here in my night clothes or anything, plus I'm not going to be here long."

People we spoke with said that they were supported to be as independent as possible. One person told us, "All of the staff are good at getting you to do things for yourself. The physios are great as well as the nurses. They make sure you're doing as much as you can for yourself." We saw that some people on one ward wore ordinary clothes during the day, rather than nightwear or hospital gowns. Staff told us this was to encourage rehabilitation

and independence for people who were getting ready for discharge home.

However, we also found instances where people's dignity, privacy and independence were not respected and promoted. We observed that staff sometimes discussed people within the hearing of other people using the service. On one ward we found there was a lack of suitable space if people required privacy for sensitive conversations with staff.

People we spoke with on two wards told us they had not been asked if they preferred male or female staff to assist with personal care. People were not aware that they had a choice. Two people, (both female), said they would prefer female care staff and wished they had been asked. One of these people said, "I think it's because we're an older generation. We get embarrassed with young men around when we're getting dressed." Staff we spoke with told us they did not routinely ask people about this preference. We saw the provider's policy 'Privacy and Dignity in Patient Care' which stated that staff should check that people had given their permission to be washed or examined by a person of the opposite sex, and should respect people's wishes where possible.

We saw a person on one ward was being assisted with a shower. The door to the shower room was open, compromising the person's privacy and dignity. We observed two people wearing incontinence pads which were on view because the people had removed their bed covers. When we started to speak with these people, staff did come to cover them up.

We observed examples of inappropriate and insensitive communication between some staff and people on two of the wards. We saw that some people in the day room on one ward were embarrassed when a member of staff at a mealtime called out, "Who wants a pinny?" Another member of staff asked people individually if they would like an apron, which was a more dignified approach. We observed staff referring to people by the number of the bay and bed they occupied, rather than by their name.

People using the service were mostly involved in making decisions about their care and treatment. The people we spoke with were satisfied with how they were involved in planning their care and treatment. Most people we spoke with said they wanted the health care staff to make the decisions on their care. People told us, "They know what they're doing, so I just let them get on with it.",and, "I know all I need to know."

Several people praised the physiotherapists working with them in terms of involvement. One person told us, "We make a good team. The physios really work with me to see what I can do now and what I need to do more of."

People we spoke with whose needs were being assessed told us they were kept well informed about their care and about moving to other wards. Three people said that there were lots of changes about which wards they were moving to or whether they were moving at all, but they (and their relatives) were kept up to date.

Most of the people we spoke with on the wards we visited told us that staff were supportive and listened to them. People said they were given opportunities by doctors to ask questions. People said they understood why they were in hospital and the treatment or investigations they were having.

We looked at the nursing care records for 16 people using the service. As at our previous inspection, we found that the care plans lacked detail of the person's individual preferences regarding routines and personal care. For example, some people on one ward told us they would like to eat their meals in the day room, but this was not often available

to them because it was used for meetings. There was no note of where people preferred to eat meals, (for people who it would be appropriate to offer alternatives to), in the care plans we saw. Some people had information about their food and drink preferences by their bed, but this was not usually recorded in their care plans.

People using the service were encouraged to express their views as to what was important to them in relation to their care and treatment. The provider sought people's views through processes such as questionnaires for people using the service and assurance ward rounds carried out by senior nursing staff.

We looked at the action taken by the provider to accommodate the views of people using the service. We found that the views collected were reported to the provider's council of governors and the board of directors. The views of people using the service were also fed back to ward staff. A senior manager told us that the results of questionnaires of people using the service were shared with the ward matrons and senior matrons each month. They were then expected to act on the results. The senior manager told us that action plans were not produced to address issues identified.

The senior manager told us there were sometimes ad hoc surveys of people using the service and we saw an example of this for one ward. There was an action plan to address the key points raised from the results of this survey. However, the action plan was not dated and lacked detail of the measures to be taken. We also saw an action plan for one ward that was produced in response to concerns raised, including from feedback from people using the service. Again, the action plan was not dated, although a senior manager told us that it was put in place on 13 May 2013. There was no specified date for review of the action plan.

People's diversity, values and human rights were usually respected. One relative told us they were very pleased that they and other relatives were supported by staff to provide round the clock support and company for the person in hospital. The person had complex mental and physical health needs. Their relatives were able to ensure the person's needs and preferences were known and met. Staff told us that they could use an interpreter service if needed for people whose first language was not English. This had recently been used to assist a person on one of the wards we visited. On the two assessment wards we found that interpreter services were available but were difficult to access and sometimes only by telephone. There was no mobile or cordless phone available for people admitted to these wards. This meant that if people were not well enough to get to the nurses' station to use the telephone, it was not possible for them to speak with the interpreter.

To conclude, we found many examples of good practice where people's privacy, dignity, independence and personal views were taken into account. We found that the provider had taken action and had addressed some issues raised at the previous inspection. There was improved signage of male and female toilet and washing facilities, and people's preferred names were recorded and used. We found that people using the service were usually encouraged to express their views in relation to their care and treatment.

However, we also found that people's privacy and dignity were not always promoted. People's views were sought, but it was not always clear what action had been taken or was planned to address issues raised. The provider was still not compliant with this outcome.

Meeting nutritional needs ✖ Enforcement action taken

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition because they were not always provided with a choice of suitable food or supported to eat sufficient amounts for their needs. There were arrangements in place to ensure that people had food and drink to meet requirements arising from their cultural or religious background.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

At our previous inspection in August 2012 we found that people were not always protected from the risks of inadequate nutrition and dehydration. We judged that this had a moderate impact on people using the service and told the provider that action was needed. The provider's action plan received in November 2012 told us about the action they had already taken and further action they planned to take to achieve compliance. The provider told us they would be compliant by the end of April 2013.

At this inspection we found that people were not always provided with a choice of suitable and nutritious food and drink. Some of the people we spoke with were satisfied with the choice, quality and quantity of the food provided. They told us, "I can't complain about the food. It's usually tasty enough", and, "There's always something I can eat. You get a choice and the nurses help people who can't fill in their forms, so they get what they like."

Seven people told us they were unhappy with the food. Two of these people said they did not like the taste of the food. Both of these people were observed eating very little of their main meal, but they ate and enjoyed their puddings. They both said this was often the case. They were not offered alternative main meals. One of these people said "It's always the same. It's rubbish what you get." Four people on one ward told us they found the food tasteless and cold. They had complained about the food on the day before our visit. They said that a representative from the catering provider had visited the ward to speak with them and was investigating their comments.

Staff told us that people needing pureed food had a limited variety to choose from. This meant that people found the food monotonous and did not always want to eat it. This was a particular issue for people who were in hospital for many weeks following a stroke.

We saw that people on one ward had been asked about their food likes and dislikes. These were displayed on handwritten notices above their beds, though were not included

in their nursing care plans. One person told us they were often served meals that they did not like and they were frustrated by this. Relatives had complained on the person's behalf as the person had some difficulties in communicating, but the problem persisted. The person was able to indicate to us that all other aspects of their hospital stay (care, dignity, privacy and so on) were fine and they would give eight out of ten as marks of satisfaction. For the provision of appropriate food they would only give three marks out of ten.

We found that if people required food in between meal times, staff could order a snack box for them. The snack boxes consisted of sandwiches and cold food. However, the snack boxes were not suitable for people who required a soft or pureed diet. We found that one person was admitted the previous night and had not eaten since their lunch at home the previous day. Staff told us that the person required pureed food and this would be ordered for teatime, (approximately two hours after we spoke with staff). There was no attempt to provide food for the person before teatime, although they were offered drinks.

We observed three mealtimes on each ward: teatime on the first day of our visit, then breakfast and lunch on the second day. On two of the wards the teatime meal we observed was very disorganised.The meal on one of these wards took so long to serve that the food dropped below a safe serving temperature. At this point three people had not had meals. Snack boxes were ordered for these people and they were offered desserts while they were waiting for the snack boxes. A hot meal alternative was not offered. We saw that breakfast and lunch the following day were better organised on both wards and most people appeared to receive what they had ordered from the menu.

We did not identify any people using the service with nutritional needs related to their cultural or religious background. Staff we spoke with told us that meals could be ordered to meet specific cultural or religious requirements if required. We saw that this was supported by the provider's food and nutrition policy.

People were not always supported to be able to eat and drink sufficient amounts to meet their needs. We saw that some people were offered appropriate and sensitive assistance from staff. For example, we observed a member of staff offering assistance in a kind and friendly manner to a person who was struggling to open a package of cheese and biscuits. We saw staff sitting with people who needed help to eat and drink. However, we did see a few instances of staff standing when assisting people to eat which is not considered good practice.

Throughout our inspection we observed that some people were not offered appropriate support and assistance. Some people did not have the correct adaptive utensils or equipment; others were not helped to an appropriate position for eating and were not always offered the help they needed to open packaging.

The provider had policies and procedures in place to identify people at risk of inadequate nutrition and dehydration and to manage their care and treatment. However, we found that these systems were not always effective and procedures were not consistently followed in practice. We found that two people had lost significant amounts of weight during their hospital stay. Despite identifying the risk and monitoring their nutritional status, appropriate action was not taken to reduce the risk of further weight loss. Another person was identified as at risk of inadequate nutrition and was promptly referred to the dietitian who provided advice. However, the dietitian's recommendations were not followed in practice, increasing the risk to the person of inadequate nutrition.

To conclude, we found that many people using the service were satisfied with the quality

of the food provided. We saw that there were arrangements to ensure that people were provided with food and drink to meet their religious or cultural needs. We found that the provider had taken action and had addressed some issues raised at our previous inspection. For example, we saw better use made of signs at each person's bed to identify their individual dietary needs, such as thickened fluids or assistance with eating and drinking.

However, we found that some people using the service were not always provided with suitable food to meet their needs. We found that people did not always get the support they needed to eat sufficient amounts for their needs. We were concerned that, as at our previous inspection, people were not protected from the risk of inadequate nutrition and that the provider had not achieved compliance with this standard.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. People's records could be located promptly when required but were not always kept securely.

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

At our previous inspection in August 2012 we found that people's nursing records were not accurately or fully completed and were not kept up to date. We judged that this had a minor impact on people using the service and told the provider that action was needed. The provider's action plan received in November 2012 told us about the action they had already taken and further action they planned to take to achieve compliance. The provider told us they would be compliant by the end of April 2013.

At this inspection we found that people's personal records were not always accurate or fully completed. We looked at the nursing records for 16 people using the service. We also looked at the handover records for two wards we visited. The handover record was used to provide staff with brief details of the diagnosis and needs of all people on the ward on that day. This record was produced from the details held on the electronic board on each ward.

We saw that one person was having a trial of oral food, (after a period of being fed enterally due to swallowing problems, that is, through a tube directly into the stomach). We saw brief instructions for staff about the type of food to be offered and when, but no detailed care plan about how the person should be supported and how the risks should be managed. The lack of accurate information in the records meant that this person was at risk of receiving unsafe or inappropriate care.

We saw that one person's care plan was updated on 5 June 2013 and stated: "Able to feed self independently". However, the handover record produced on the same day stated that this person required assistance with nutrition. There were no details of the specific assistance required by the person. This meant that staff lacked accurate information to ensure the person received safe and appropriate care. We observed that this person had difficulty in eating their meal and only ate a small amount. The person was not offered any assistance by staff.

The same person's nutritional status had been assessed and monitored using the

malnutrition universal screening tool (MUST). This tool provides a score based on the person's weight, body mass index, unintentional weight loss in the last three to six months, and appetite. The person's MUST score was incorrectly calculated and recorded on 28 May 2013 and 5 June 2013. The MUST record showed that the person had weight loss of more than 10kg in seven weeks. The correct MUST score for this person should have taken this weight loss into account and should have triggered a referral to the hospital dietitian. The inaccuracies in these records meant that the person did not receive the specialist support and advice of a dietitian when they needed it.

We saw that another person's MUST record also had incorrect scores. We also saw a MUST record that should have been completed each week but there were no entries for two weeks. We spoke with a senior manager who told us that nursing notes were audited at least weekly. This included checking that where the MUST score showed a level of risk, appropriate action was taken according to the care plan. They told us that the audit did not currently check if the MUST score was accurate. We found that MUST records were sometimes completed by health care assistants on the wards we visited. Although these staff had received training about meeting people's nutritional needs, this did not include how to complete MUST records.

When people are found to be at risk of inadequate nutrition, their doctor or dietitian often requests nursing and care staff to record the amount of food and drinks they consume.One person was identified as being at risk of inadequate nutrition and so their food intake was to be monitored and recorded. We saw that their food record charts were not always completed. There were no entries recorded on 3 June 2013, only breakfast recorded on 4 June, and the teatime meal was not recorded on 5 June. We saw other examples of food record charts not fully completed. We also saw fluid balance charts that had not been fully completed. We had found the same issues at our previous inspection.

At our last inspection, we found that a 'Do not attempt cardiopulmonary resuscitation' (DNAR) form had not been fully completed. A DNAR form records the wishes of a person, or the decision taken in their best interests, not to attempt to resuscitate them in a life threatening emergency. All relevant aspects of these decisions need to be recorded accurately and communicated to others effectively. Following the last inspection, the provider planned action to review and improve the completion of DNAR forms. At this inspection we saw one DNAR form that was not fully completed. We saw the provider's report of a recent audit of DNAR forms. This identified significant shortfalls and little consistency in completion of these forms across the hospital. The provider told us that the findings were to be discussed at the next meeting of their Quality Delivery Group later in June 2013.

People's records in the wards we visited were mostly kept securely and could be located promptly when needed. We saw that people's medical records were stored in the drawers of trolleys by each bay on most wards we visited. The exception was one ward where the medical records were kept in one open trolley near the entrance to the ward. Although this made the records easily accessible for staff, we observed that the trolley was not always within view of staff. This meant there was a risk that an unauthorised person may have access to the records without staff knowledge. On another ward we saw that some medical records were left in an unlocked office that was not constantly attended by staff. Again, this created a risk of unauthorised access to records.

Nursing care records, including charts for staff to complete, were kept at the end of each bed. This meant these records were easily accessible for staff to use. Electronic boards with details of people using the service were out of sight of people and visitors to ensure

confidentiality of personal information.

To conclude, we found that people's records could be located promptly when needed. We found that the provider had taken action and had addressed some issues raised at our previous inspection. This included the action taken to address the issue of DNAR forms not fully completed. However, we found that accurate records were not always maintained for people using the service. This meant that people were not fully protected against the risks of unsafe or inappropriate care. We saw that there was a risk of some records not being kept securely. The provider had not achieved compliance with this standard.

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 Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Suitable arrangements had not been made to ensure the dignity, privacy and independence of service users. Service users were not always treated with consideration and respect. The views expressed by service users in relation to their care and treatment were not always accommodated. Regulation 17(1)(a)(2)(a)(d)
Regulated activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: An accurate record was not maintained in relation to the care and treatment provided to each service user. Service user records were not always kept securely. Regulation 20(1)(a) and (2)(b)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

The provider's report should be sent to us by 27 July 2013.

CQC should be informed when compliance actions are complete.

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

This section is primarily information for the provider

✖ 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.

We have served a warning notice to be met by 26 July 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: The registered person had not provided service users with a choice of suitable food or support, where necessary, for the purposes of enabling service users to eat sufficient amounts for their needs. Regulation 14(1)(a) and (c)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

✓ **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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.