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

Southampton General Hospital

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Date of Inspections: 26 April 2013
23 April 2013
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We inspected the following standards as part of a routine inspection. This is what we found:

- Care and welfare of people who use services: Met this standard
- Management of medicines: Met this standard
- Staffing: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
- Records: Met this standard
## Details about this location

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<th>Registered Provider</th>
<th>University Hospital Southampton NHS Foundation Trust</th>
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<td>Southampton General Hospital provides a range of general and specialist medical and surgical services. During this inspection we assessed compliance with the regulated activities diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.</td>
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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 April 2013 and 26 April 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

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

The inspection was completed on 23 April 2013 and we returned on 26 April 2013 to clarify some information with Trust managers. We visited 11 wards including older person medical, general medical, children’s cardiac, neurology, discharge lounge, trauma and orthopedic and general surgical ward. We spoke with 27 patients and two visitors. Patients were positive about their experiences. They said they were happy with the way they were cared for. One person stated "this is a brilliant hospital; I would recommend it to any of my friends and family as a good place to be cared for". Two patients who had previously received care at the hospital said they felt the care they were receiving during this admission was better than on their previous stay. People told us staff were available when they needed them. One said "there seem to be enough staff, day and night".

We spoke with 44 staff including nursing, pharmacy, occupational therapy and medical staff. Staff were aware of how people should be cared for. Staff stated they felt they had sufficient time to meet people’s needs. We observed staff working in a professional and friendly way showing regard for people’s privacy and dignity. We identified concerns with the way people were supported with meals on one ward. The provider had already identified this and had an action plan in place.

We found medication and records were correctly managed. There were effective systems to assess and monitor the quality of service provided.

You can see our judgements on the front page of this report.
More information about the provider

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

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

<table>
<thead>
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<th>Standard</th>
<th>Met this standard</th>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓ Met this standard</td>
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<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
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Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights. They were cared for by staff who were informed about their needs and were able to meet people’s individual needs.

Reasons for our judgement

Our previous inspection in October 2012 identified care had not always been planned and people were at risk of not receiving safe care that met their needs. An action plan was received. This told us a care planning system was being introduced and monitored to ensure all risk assessments were completed and people received appropriate treatment and care.

Patients were positive about their care saying they were happy with the treatment and care received. One said "they explained what they were doing and why, so I had an understanding of what was happening". Another said "they asked all the right questions to find out what was wrong and I felt they really wanted to do the best for me". Patients said they felt involved in their care and treatment. For example one person told us they had negotiated with their doctor that further treatment would be put on hold for a period of time. Patients told us they felt they were provided with information about their illness and the treatment and staff were available to discuss their care and treatment. One patient described their care as "amazing" from their treatment in intensive care through to their care on the ward. Another said their care had been "wonderful".

We looked at 30 sets of patient records covering most of the 11 ward areas visited. We also looked at some specific parts of other records. We found there was a new treatment and care planning system in use on the majority of wards we visited. Assessments had been completed in a timely way and care plans formulated from these. These detailed what support people required with, for example, maintaining personal hygiene, mobilising, pressure area care, food and fluids and how any wounds should be managed. Care plans also contained information about people’s cognitive needs and support they may require if, for example they had dementia. A new system had also been introduced for recording of how people’s needs had been met with entries expected for morning, afternoon and night shifts. All patient assessments viewed were complete and up to date. There was evidence from care plans and daily care records to show people had received care as required.
We also viewed records of 'intentional rounding', which is where healthcare professionals carry out regular patient checks at set intervals. These showed people were checked and received any necessary care on a regular basis. One person said staff regularly checked they were comfortable and they hadn't needed to call for assistance. We observed most people could reach their call bells easily should they need to use them. We saw people were encouraged to change their position on a regular basis and there was checking of pressure area risk points such as heels. Wound management plans were also seen showing a clear plan and record of how wounds should be managed. Risk assessments had been completed in a timely way including risks of falls, risk of blood clots (VTE) malnutrition and moving and handling. We saw that where a risk was identified appropriate action had been taken to reduce people's risks where possible.

We observed staff providing care which corresponded to the patient's care plan. For example, we saw a nurse supporting a patient walking back from the toilet using a walking frame and encouraging them to have a rest on their bed lying on their side. The nurse was able to describe the care the patient required. On another ward a nurse was able to describe the care a patient required including the use of thickened fluids, dietary needs, moving and handling, falls prevention and changes of positions. We saw patients were supported with eating and drinking in an appropriate way. For example, on most occasions we saw staff providing assistance in a sensitive way and did not appear to be rushed. Staff engaged in conversation and listened to what patients had to say. The provider may find it useful to note on one ward we observed one member of staff stood when offering assistance with feeding. None of the patients we spoke with had required support with their meals or drinks however they were aware that staff made time for those who did require help. The provider may wish to note on all wards visited we did not see any patients being offered the opportunity to wash their hands before and after meals.

We saw equipment listed in people's care plans such as bed rails and pressure relieving air mattresses and seat cushions were available and in use. We saw these were being used correctly. Staff stated they had access to all equipment they required and were aware of how it should be used. Staff also said they felt they had sufficient time to meet people's needs and had received training relevant to their role.

The provider told us they were monitoring incidents such as falls, pressure injuries and VTE. They provided information about this which showed when incidents occurred these were examined to determine if they could have been avoided. Although there had been an increase in people developing pressure injuries the trust's analysis of incidents showed there were no discernable trends. We also saw when other adverse incidents occurred there were effective procedures to investigate these. Where possible learning from incidents took place with a view to preventing the likelihood of a reoccurrence.
Management of medicines

Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. Medication was stored securely and medication people required was generally available for them.

Reasons for our judgement

Our previous inspection in October 2012 identified that people were not protected against the risks associated with medicines. People had not been receiving medication in a timely way and medication had not always been secure. An action plan was received and the provider told us of actions they had taken to become compliant.

During this inspection all medication was seen to be stored and administered appropriately. One patient told us staff made sure they took their medication. They felt this was good and staff should supervise medication rather than leaving it for the patient to take later. Another patient felt they would be glad to get back to their home and normal bedtime as the night time medication routine was too late and they did not like to stay awake so long. They acknowledged staff were thorough and this added to the time taken in administering evening medication. This showed that staff were conscientious with medication administration and ensured people took medication as prescribed. Staff on one ward told us medication rounds could be quite lengthy. Staff said they prioritised some medications such as insulin injections to ensure these were given at the correct time to coincide with meals.

Patients who took regular medication prior to their admission said their medication was available following admission. They said there was a minimum of delay in ensuring their usual medication was available. In cases of newly issued medication patients could recall why it had been prescribed and this had been explained to them. Another patient reported seeing staff take time to explain to an elderly patient that despite the packaging being different to their domestic supply the medication was the same as their regular prescription.

Patients told us they received their medications at the right time and received regular pain relief when needed. Patients who required ad hoc pain relief reported this was also readily available. We were told that pain assessment tools were available. One patient was impressed that they had received a visit from the pain team very promptly at the request of medical staff. Whilst in the discharge lounge we found all patients had access to medication and medication was prepared for them to take home where required. Staff on
one ward reported that there were occasional delays in getting medication for people waiting to be discharged. Overall medication was available to people when required.

We observed staff administering medication. The procedures used were appropriate and patients were observed taking medication before it was signed as having been administered. With one exception all wards were on electronic (e) prescribing. Staff were positive about this system and felt if provided less potential for errors. Staff told us there was 24 hour technical assistance to support the electronic prescribing tool.

We spoke with pharmacy staff on the wards we visited. Pharmacy staff told us how they were allocated to wards and this meant they were able to provide a quick service to ward staff and patients. We observed ward pharmacy staff checking records to ensure people were prescribed medication they had been taking before admission. We were told by hospital managers that additional funding had been approved to provide some dedicated pharmacist hours for the discharge lounge. This should ensure when the discharge lounge was busy people would not have to wait for medication to take home.
Staffing

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs. Although there were a number of staff vacancies especially for qualified nurses the provider had procedures in place to minimise the impact of this on patients. The provider was actively working to recruit staff to ensure there were sufficient staff available.

Reasons for our judgement

Our previous inspection in October 2012 identified there were not enough qualified, skilled and experienced staff to meet people's needs. An action plan was received which told us how the provider would ensure more staff were provided to ensure patient's needs would be met.

Patients said staff were approachable, friendly and cheerful. One patient said "there seem enough staff, day and night" and another said "I can reach the bell and they always come". A third patient said "sometimes I have to wait, but not for long, they never forget". Patients did say staff were very busy and sometimes "rushed off their feet". A parent said "her child was always happy to come into the hospital and felt safe". The parent attributed this to the skills and dedication of the staff. On an adult ward a patient told us "they are so lovely the staff here" and another said "they are so kind to me, they will do anything for you and they are always so busy".

For the majority of wards patients acknowledged staff seemed busy however we were told call bells were answered within a reasonable time and if additional or specialised help was required this was "swiftly summoned". Other patients also commented that when specialist staff were needed they seemed to arrive promptly. On most wards patients felt standards had not been compromised due to lack of staff.

Most wards visited during the inspection appeared calm. We spoke with nurses who had a coordinating role for wards. On all wards there were named nurses responsible for patients on each shift. Staff were able to tell us who they were caring for on the day of our inspection. Staff were welcoming, polite and courteous, they had an excellent rapport with patients and colleagues. We observed nursing and healthcare assistants provided care in a gentle and supportive manner.

Nursing staff on wards said there were enough staff to meet patients' needs and the mix of nursing and healthcare assistants seemed appropriate. Staff spoken with told us agency staff were requested when needed. Staff on one ward said they used agency staff
regularly. They felt this worked well for them in terms of the quality of the care as they used the same agency staff frequently. On one ward we found volunteer assistants supported patients with their meals. We were told these volunteers had received training from dieticians and made a commitment to volunteer on a regular basis.

Staff said they were happy working at the hospital, they said staffing levels had been improved over the past few months. The provider said recent recruitment from European countries had been successful. We saw evidence of new staff on different wards within the trust and we found they had integrated well into ward teams. We met new overseas nurses during our inspection. They were confident and told us about the comprehensive support programme they had undertaken as part of their induction.

Hospital managers said the planned recruitment drive was projected to reduce the number of vacancies for nursing staff by the end of the year to around 50 positions before taking account of any increased staffing requirements arising from bed and service expansions. In addition to recruiting overseas staff the provider had a ‘return to practise’ programme. This was for nurses who had not been working for several years or who had been working in non acute settings. On one ward we met a nurse who was working as an additional member of the team, as part of this programme. The provider was therefore working to address the vacancy rates for qualified nurses.

We spoke with senior nursing staff. We were told there was a system in place for escalating a request for additional staff and there was an effective approach to coordinating staffing requests. Staff told us they could request additional staff, including agency, if people required a high level of supervision if, for example, they had a high risk of falls. We saw an example of this on one ward, where an additional member of staff was providing individual support for one patient. Staff told us this was sometimes difficult to provide as they were not always able to obtain extra staff. On another ward we were told a staff member was always present in one bay due to the high level of risks identified for patients. We saw there was always a nurse in this bay whilst we were on this ward.

We also spoke with other staff including doctors, dieticians, occupational therapists (OT) and pharmacists. They felt they generally had sufficient time to meet patient’s needs. One patient said "the surgical staff have been great and X ray staff were very efficient". Where new staff were being appointed we were told that the priority was to get the right staff and recruitment standards were high. This was clear from a senior OT who was recruiting to fill a junior OT position.

Following the inspection the provider sent us some additional information we requested. The information showed that in the weeks preceding the inspection agency staff were available to fill approximately 60% of the requests that were made for agency staff. The provider explained that although not all requested agency shifts were filled they had ensured enough staff were available. This had been achieved by reviewing staffing levels across the hospital and where appropriate moving staff between wards. The provider informed us further staff had been recruited from overseas and were due to commence employment in the two months following our inspection which would help reduce the use of agency staff. The hospital remained dependant on a high number of agency staff especially to fill qualified nursing posts. These were not always available however during this inspection we found that there was minimal impact on patients on the wards we visited and the provider had further plans to actively manage staff vacancies.
Assessing and monitoring the quality of service provision

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw completed questionnaires in boxes at the entrance to wards. We saw large posters and smaller notices on display asking for people's views. One patient recalled that they had been asked for their opinions on their care when they had been discharged from a previous admission.

We were provided with the results from patient's feedback which had been presented to the trust board. Patients had been asked for their opinions on issues such as privacy and dignity, medication, treatment and care and environmental issues. We saw patients were generally happy with all aspects of their hospital stay. Where satisfaction was not at the level the provider felt was acceptable they had plans in place to improve this. We saw the results from a patient satisfaction survey which had been carried out in one of the specialities. However the provider may find it useful to note that there was no action plan to help direct staff to make further improvements.

Managers told us, and this was confirmed by patients receiving care, that senior clinical staff carried out reviews of care at ward level. We were shown copies of the matron's audits which reviewed areas including the environment, availability of information and privacy and dignity. We were told on some audits matrons were directed to review specific areas therefore all parts of the form would not be assessed on all occasions. We were shown the schedule for the peer review quality visits to wards throughout the hospital. This showed there were clear plans in place to ensure all areas were regularly assessed. We identified some concerns with one ward we visited during the inspection. The provider was already aware of issues on this ward and provided a copy of the action plan that had been put in place.

We were told by the managers there were a range of staff forums to enable staff to discuss their views and receive information. One member of staff said they would like to attend but had not been able to do so as they could not be released from the ward. The provider was aware this could be an issue and were considering ways the forums could be made
accessible to more staff. Staff told us they had a lot of information from the provider. For example staff were aware of the way nursing vacancies were being addressed via overseas recruitment.

Staff told us they knew how to report any concerns. Staff spoke about an open culture for reporting and gave examples of a recent meeting to review several infection control concerns. Root cause analysis had been completed for any themes and to identify actions to improve practice. As an example of learning from incidents, the managers outlined the work to address a recent increase in the number of hospital acquired pressure ulcers. We saw there had been an investigation of the increase in pressure ulcers and an analysis of the data. Staff had been alerted to the increased incident rate and were aware this was a priority area for the Trust. This showed evidence of learning from incidents and investigations took place.

We identified some concerns with on one ward and the support people received with their meals. We discussed this with the hospital managers who told us they had already identified concerns and provided a copy of their action plan to address these. This reflected all the issues we were concerned about and provided a comprehensive plan as to how these would be resolved. This showed that the provider’s quality monitoring systems were used effectively and action was taken when issues were identified.

Prior to our inspection we completed an analysis of reported incidents which had been communicated to us. We found, compared to similar Trusts, there was a marked increase in the time taken to report incidents. We asked managers about this and found incidents were only logged onto the reporting system after a level of review by managers. We were told there were plans to introduce an electronic reporting system which would enable staff to report the incident on the system at the time the incident occurred. Staff working in clinical areas demonstrated an understanding of how to report incidents using the current system.

We were told although there was a delay in the commission receiving notifications of incidents this did not prevent the provider investigating and taking action to prevent reoccurrence. We asked for information about a specific incident and the provider was able to demonstrate this had been thoroughly investigated and action taken. We were told there were no difficulties in appointing investigating officers to carry out investigations.

We saw incidents were discussed at the Quality Governance Steering Group which met monthly. They were also discussed at the Executive Board meetings. The analysis of serious incidents by the trust indicated the numbers of such incidents were within the target numbers set and for a three month period averaged at between zero and one a month. There was also a serious incident scrutiny group which was made up of senior clinicians who reviewed all incidents and the quality of the investigation reports to ensure rigour and transparency.

The provider took account of complaints and comments to improve the service. Complaints were monitored and investigated and complainants usually received responses in a timely way. We saw there had been a reduction in the number of complaints processed through to the formal stage and the managers suggested the reduction could be due, in part, to the increased visibility of senior clinical staff on the wards. The provider may find it useful to note one patient said, although they had nothing to complain about, they did not know who to speak to or how to raise a complaint.
Records

Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because all necessary records were held. Records were stored securely.

Reasons for our judgement

Our previous inspection in October 2012 identified that records were not well maintained or secure at all times. An action plan was received which told us an audit of records had been completed and action taken where necessary.

Patient's personal records were fit for purpose. We looked at 10 patients records and related records of care provided. We also looked at parts of other records. During this inspection we found these were well maintained and provided information about patient's individual needs. These records showed how patients' needs should be, and had been, met. Records were easy to follow and documented the treatment and care people had received.

Records could be located promptly when needed. Patients who had experienced multiple stays at Southampton General Hospital felt there was no problem with record keeping and their records were accurate and available promptly on readmission. All records we requested were available and people's records were correctly filed. Records of nutrition and care patients had received were maintained at the time that care or nutrition was provided. The new care planning and recording system provided a more organised and consistent approach to identifying needs and recording care provided. Most staff were positive about these and stated they found them useful and were able to establish what care people required with ease. However the provider may wish to note some nursing staff felt medical staff did not routinely read the nursing documentation.

Records were usually kept securely. None of the patients we spoke with had any concerns about security of record keeping. We saw paper records were kept in open ward 'stations', however staff were present in these areas and there was no sign that confidentiality or security of information was compromised. The provider may find it useful to note on occasions computers with patient information were not logged off completely when not in use.

We spoke with ward clerks who were present on most wards visited. They described their role in helping ward staff sort out admissions, discharges and pharmacy issues. On one ward they identified that records did not always arrive on the ward when the patient was
transferred from another unit. On another ward we were shown how records could be tracked and were told that all staff now had access to this system. They said this had helped ensure records could be located promptly when required. We were told about the procedures for long term storing of records which were not in current use.
We are the regulator of health and social care in England.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Essential standard**

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

- 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.
(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.