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

Sunderland Royal Hospital

Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP
Tel: 01915656256

Date of Inspection: 13 November 2012
Date of Publication: January 2013

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

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<th>Standard</th>
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<tr>
<td>Respecting and involving people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>✓</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>✓</td>
</tr>
<tr>
<td>Records</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>City Hospitals Sunderland NHS Foundation Trust</th>
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</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Sunderland Royal Hospital provides acute hospital services to the Sunderland area and specialist services to the wider geographical area. This includes acute services for elective and emergency care including in-patient, outpatient, and day care.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Acute services with overnight beds</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and/or screening service</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and screening procedures</td>
</tr>
<tr>
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<td>Family planning</td>
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<td>Maternity and midwifery services</td>
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<td></td>
<td>Surgical procedures</td>
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<td></td>
<td>Termination of pregnancies</td>
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<tr>
<td></td>
<td>Treatment of disease, disorder or injury</td>
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</tbody>
</table>
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'.

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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, reviewed information sent to us by other organisations, carried out a visit on 13 November 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who represent the interests of people who use services, talked with people who use the service and talked with carers and / or family members. We talked with staff and talked with stakeholders.

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 visit to Sunderland Royal Hospital began at 7am on the accident and emergency department. We visited the medical admissions unit, surgical admissions unit and wards E53, B26,C32,C31. We focused on the pathway people took from accident and emergency to the initial admission areas and to the ward appropriate for their condition.

Patients told us their privacy was maintained for example "they try their best but it's a shared ward", and "they make sure that I am not embarrassed even when I need to use the toilet". Others told us "the nurses are great, we have no problems and they have a nice manner." Patients told us they "felt safe", one said "Staff are nice" and another person who had frequent admissions told us "I feel safe and nurses are kind. I have no complaints."

Staff were positive about the support they received, their training and the resources available to carry out their role effectively. They gave us examples about how they talk to the patients about their treatment options and give support in line with the nursing and medical care plans.

The information we had for the outcomes we looked at, from external surveys and reports from other agencies was similar or better than other comparable services. People shared their views about the service by using the NHS Patient Choices website and the CQC "Tell us your experience" facility on our website which were positive and negative in nature. We looked at the issues raised as part of this visit.

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

Respecting and involving people who use services  ✔  Met this standard

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 meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care

Reasons for our judgement

We looked at the information we held about the trust for this outcome, from external surveys and reports from other agencies. The information we had regarding incidents, concerns and untoward events that had occurred in the service were at the same level as other similar services. We had some information from a survey we undertook of patients, and this showed that when asked about their privacy and dignity people responded in line with other services of this size and complexity. We received a number of individual comments for this service related to this outcome. There were seventeen positive and fourteen negative comments. We reviewed these comments and looked at the issues raised in this information as part of this visit.

The wards visited provided single sex accommodation and toilet facilities. Call bells were within easy reach of those who needed them and we saw them being answered within acceptable timescales. Staff talked at a discreet volume and used curtain screening around beds to attempt to maintain patient's privacy and dignity. One person told us, when we asked them about their privacy said "they try their best but it's a shared ward", another said "they make sure that I am not embarrassed even when I need to go to the toilet".

We saw some instances when staff involved patients and their relatives and reassured them about their anxieties, for example one person who was worried about going for a scan which was explained to them by a nurse. One person was not happy with the way one doctor had spoken to them, another said of the same individual "He's lovely and tells me everything I need to know, but he does talk twenty to the dozen".

We spoke to seven people on the wards who were all happy with their care. Two said it was hard to say if they were involved in their care as they had only just been admitted to hospital but they both said that if they need anything the staff would get it for them. One person told us that they were hoping to visit the on site hairdressers that day as their hair needed doing. Later we observed staff trying to arrange this.

One person told us that they had waited for six hours in accident and emergency
department before they were given a bed. They said they had had a sudden bleed and the staff immediately cleaned them up, offered them clean clothes and changed the bed which they described as "great". We were told by a number of people attending a clinic that they had waited "a long time" and although staff had told them that it was running late and to go for a drink they had been disappointed that the information was not more detailed about the time of the wait or why it had occurred. We discussed this with senior staff who agreed to look into this.

There was some evidence within assessments that patients and relatives had been consulted and given explanations about medical conditions and treatments including one person who had been given information about their medication.

Staff described how they ensured patient privacy when they assisted older people with toileting needs. They said they helped them to the toilet and left after explaining how to use the buzzer to alert staff when they were finished. They also said they made sure the person was clean and had washed their hands before they were assisted back to their bed.

We saw a porter on a ward inform a patient that he was there to take her to theatre. He also explained that he would bring her back and she appeared very reassured by this. We asked patients how well staff passed on information to them and to each other about the care they received. One person told us, "I've been kept up to date but sometimes they don't know because I'm waiting for a scan".

A medical consultant explained the system for ensuring there was always a consultant on the ward during the day including weekends which he told us greatly assisted the continuity of care. There was a handover every week when a new consultant takes over. The registrar told us that there was a chaperone nurse in the clinic at all times. The staff generally told us that communication with regards to patients and their needs was "good" and they had regular handovers.

There was evidence in one record that an assessment of the level of confusion which might suggest dementia, was carried out to establish the patient's ability to give consent and make particular decisions about their care and treatment.

The trust has provided training in the Deprivations of Liberty Act for the staff so that they would be aware of their legal responsibilities in ensuring that patient freedom is respected at all times.

The hospital had a Patient Advice and Liaison Service (PALS) that provided support, advice and information to assist patients make decisions about their treatment options and understand their personal circumstances. Information about the service was available on the wards and out patients departments.

A range of leaflets was provided for patients and visitors giving information, and these included information on how to give compliments and suggestions and raise concerns or complaints, health care associated infections; and preparing to leave hospital.
Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We looked at the information we held about the trust for this outcome, from external surveys and reports from other agencies. The information we had regarding incidents, concerns and untoward events that had occurred in the service were at the same level as other similar services. We received a number of individual comments for this service related to this outcome. There were thirty nine positive and twenty six negative comments. We reviewed these comments and looked at the issues raised in this information as part of this visit.

We arrived at the accident and emergency unit at 07:00 and spent time observing the way the service was organised and speaking to patients and staff. We asked patients how they felt they were being looked after. One person said, "I couldn't fault the care" and when asked about how they were treated, one person said that staff were "really nice and helpful" and another person said "very good."

We looked at the way the service monitored the time people waited in the accident and emergency. On the night prior to our visit some people had waited in excess of the four hour maximum waiting time, these are known as breaches. We attended the meeting, which was held every morning, when each individual person who was not moved from the area in four hours was discussed. This was used to review if things could have been done better. The discussion suggested that the breaches were a result of issues which could not have been predicted or prevented. The target for this is 95% and the hospital had consistently achieved this.

We looked at five people's care plans in the accident and emergency area and 10 in the other clinical areas. All had care plans and risk assessments and a social history in place except one person whose records were being updated by a nurse. The risk assessments included falls, Malnutrition Universal Screening Tool (MUST), skin integrity, depression score, intravenous device care, nutrition and mobility.

Patients' records showed that a range of assessments were regularly updated including risk of falls, handling, nutrition, skin integrity and infection control. There was a recorded early warning system which triggered the need for further assessment. Computerised care plans were used in a format that enabled standardised interventions to be pre populated using "activities of daily living" model.
We spoke to people in the ward areas and in the outpatient department attached to casualty (the green area). Comments from patients included, "The nurses are great, we have no problems and they have a nice manner.'

We saw people being assisted with their day to day care and supported as part of the medical assessments and treatments. Staff asked patients their choices of tea, coffee or milk before meals and if they required any support or specialist equipment this was provided.

We received some negative comments including one person who told us that they felt that they had been misled about the need to have an X-ray and that they had received little information from staff. These comments were passed on to the hospital and action was taken to address peoples' individual concerns.

All of the staff we spoke with were aware of how they should care for patients and involve them in their care and treatment. One member of staff described in detail how they had provided care for patients from other cultures in relation to their dietary needs and how they liaised with the catering staff.

The staff confirmed they were kept up to date about patients' welfare through handovers at each shift change, and developed and reflected on their practice at meetings and clinical supervision. We observed the first handover which told staff where they would be working and their responsibilities and the second meeting focusing on individual people’s care involving the nurses who were passing responsibility to the nurses coming on duty.

We were given information about the dignity and dementia champions who had been identified in most wards and departments, and in all of the medical wards. There was a matron who led on Privacy and Dignity and also one who lead on Dementia. There were meetings for champions and links to ensure effective communication to wards.
Safeguarding people who use services from abuse  
Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

When we interviewed patients on the wards we asked them if they felt safe in the hands of people providing their care at this hospital. Those patients who were able to answer this question said they did feel safe, and some added comments such as "They are nice", one person who had experienced frequent admissions told us "I feel safe and nurses are kind. I have no complaints."

The staff we spoke with had a clear understanding of protecting vulnerable people and children and of how to raise concerns about their safety and welfare. One told us about a safeguarding incident that they had been involved with and how this has been linked with the local authority procedures.

Ward staff said they had prompt access to mental health professionals who provided support including assessment of patients' capacity to give consent to treatment, best interest decisions and deprivation of liberty safeguards. They also told us "We make referrals to the child protection nurses, nurse advisors or the safeguarding team if there is a concern", "I would feel fine about reporting something I was concerned about" and "I have completed CIN2b forms to refer any concerns I may have so a health visitor will pick this up and visit the family."

There had been a recent change to the recording of people's information which included an assessment tool for identifying if people had dementia and therefore may need additional support or treatment. This assessment tool was being implemented in the nursing records we observed.

During our visit we noted that there was information displayed in different areas of the hospital including the corridors for patients and visitors about safeguarding adults and children.

The newly qualified staff we spoke with said they had received safeguarding training for both children and adults. Some of the longer serving staff members could not remember receiving this training but they all knew what abuse was and who to report any issues to both inside the hospital trust and outside of the organisation.

Information provided following the visit showed that there was an ongoing programme for
safeguarding adults and children in place and that it was up to date.
<table>
<thead>
<tr>
<th>Supporting workers</th>
<th>Met this standard</th>
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<tbody>
<tr>
<td><strong>Staff should be properly trained and supervised, and have the chance to develop and improve their skills</strong></td>
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**Our judgement**

The provider was meeting this standard.

People were cared for by staff were supported to deliver care and treatment safely and to an appropriate standard.

**Reasons for our judgement**

We looked at the information we have about the way staff were provided with the support and training they needed to deliver care and support effectively and safely. We found that staff received appropriate professional development and were able to obtain further relevant qualifications. We asked the Executive Director of Nursing and Quality to provide us with additional information about the way that this was achieved. This was provided in a timely way and in sufficient detail.

The trust told us that a training database is used to monitor the training of all staff. It showed the training already undertaken by an individual, any that was outstanding, and training that was due for a refresher course. We were told that managers had access to the tool to enable them to monitor training compliance within their team. Information from the database was used in performance management of staff.

There were induction arrangements for new members of staff and new starters underwent both corporate and local induction. Corporate induction sessions covered a range of subjects applicable to all staff. Local induction covered subjects that were applicable to particular groups of staff. Line managers were responsible for ensuring that training needs were identified and that appropriate training was requested. A newly employed worker confirmed that this was the experience they had when they started working for the trust. During this time she had undertaken mandatory annual training such as moving and handling, learning disability awareness and infection control.

Attendance at training was monitored and any non attendance would be followed up. We asked how the overall training needs for the hospital were established, and were told that individual training and development needs would be picked up via the appraisal process.

When we spoke to staff on the wards we asked them to tell us about the training provided to them by the Trust. In addition to induction and mandatory training (infection control, health and safety and fire safety etc), staff told us they had also completed some specialist training courses, funded by the Trust, such as end of life care, and a university course they needed to become a nurse practitioner. One member of staff commented" We are always getting training I had in house training on Tuesday" and another commented, "I always receive mandatory training and I have recently had training in chest drains and I've been on a course about strokes". "I received 15 days of clinical skills training" and "They do support me to retain my registration with the NMC".
A registrar told us they felt the hospital provided good support; they felt their induction was extensive and very useful. A medical consultant we spoke with explained to us that he felt supported by management and recently a business case was put forward for more consultants which was heard and resulted in more vacancies being created. One more junior doctor told us there were some problems with the numbers of senior house officers available for the rota but this was covered using more senior doctors. He also told us "It is the most supportive department I've ever worked in" and that the senior staff are always supportive and encourage junior staff to discuss both clinical issues and training issues with them.

The hospital had a preceptor programme for newly qualified nurses. Initially, nurses are supernumerary to staffing requirements to enable them to receive appropriate training and support. The nursing staff we spoke with were complimentary of this preceptorship programme. One nurse said "brilliant support". Another nurse we spoke with had recently undergone an induction at the trust. She said she had undertaken mandatory annual training such as moving and handling, learning disability awareness and infection control.

All staff confirmed there were regular staff meetings and they had received appraisals. One person said that if they were well supported by both their colleagues and managers on a day to day basis.

Incident forms were completed and monitored and follow up support was provided to staff involved in untoward incidents. Staff said they received a range of training, including courses that could be completed through e-learning.

We spoke with a healthcare assistant on the ward who had worked in the area for some time. We asked her about any training she had undertaken recently and she told us that she was up to date with all of her training. She told us how she was informed when her mandatory training was due to be renewed through an e-mail and a letter.

Staff on a ward told us they enjoyed their work and felt part of a team. They said they felt supported at work and were able to explain what they would do if they felt threatened or vulnerable.

The trust provided us with information about training being planned and provided including, electronic learning packages adapted to reflect nutritional support for patients, Acute and Critical Care Awareness Training, the Critical Care Skills programme, Three programmes delivered by Northumbria University, Medical Patient's Acute Care and Treatment (IMPACT), Care of the Critically Ill Surgical Patient (CCGSP) and Acute and Life Threatening Events Recognition and Treatment (ALERT). Additional training was provided for Health Care Assistants through the Health Care Assistant Development programme.
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.

Staff records and other records relevant to the management of the services were accurate and fit for purpose. Records were kept for the appropriate period of time and then destroyed securely.

Reasons for our judgement

We were supplied with a copy of the hospital "Clinical Records management policy". It said that NHS records are public records under the Public Records Acts and must be kept in accordance with statutory and NHS guidelines for example the Freedom of Information Act 2000, Human rights Act 1998 and the NHS Confidentiality Code of Practice. We looked at how records at the trust were managed. The records were found to be accurate and kept securely.

For example, the records kept for individual patients we pathway tracked contained detailed information about how the staff were to meet each person's needs. All of the care records were kept as electronic records and could only be accessed through two levels of security passwords. Other paper records were kept in lockable cupboards at the nurse's station on the ward or clinical area. Some records were kept with the patient near their bed or in their room if they were in accident and emergency.

We discussed with the Executive Director of Nursing and Quality the way the medical records were not always locked away on the wards, we agreed that they also needed to be immediately accessible to the staff and that she was confident that staff were aware of the risks to confidentiality.

We were provided with evidence that demonstrated the hospital had procedures for staff recruitment. The human resources manager told us all staff were taken through the recruitment process and they cannot start to work at the hospital until this is completed. They went on to tell us applicants are interviewed and are only successful when they have been subject to an enhanced CRB (Criminal Records Bureau) check and submit satisfactory references.

We looked at a sample of ten staff files, which confirmed what we were told about recruitment practices. They contained evidence staff had been subject to a CRB and references had been sought. Any gaps in applicants work history had been explored during the recruitment process. We were supplied with evidence that the hospital had checked that staff when appropriate, had valid proof of registration with the relevant professional bodies. Staff we spoke with confirmed they had been vetted prior to them being offered a post in the hospital and they had not worked directly with patients until their
The hospitals clinical records management policy contained a definition of clinical records such as patient records, photographs and X rays. The policy also stated that clinical records were defined as "All material which holds clinical information". When we looked around the hospital, we saw that large white boards were displayed on the wards and in the clinical area of accident and emergency department.

We saw that the accident and emergency area and wards had white boards displayed in public areas on which the staff recorded information. This included the person's name, their location, information about their consultant and some coded information about their treatment. Staff we spoke confirmed that this information was used to keep staff up to date with a patient's status and plan of care. However, some staff told us that they sometimes found it difficult to keep this information private and secure as the public had access to these areas. This was particularly the case in the A and E department where two staff informed us that peoples relatives tended to congregate in the corridor where the white board was placed and during our inspection we observed this. We discussed our findings with the staff and the representative of the provider and they agreed that they would review this practice to make sure that people's confidentiality was maintained.

The trust had policies and procedures in place to make sure that records were securely destroyed when it was appropriate to do so. These were in line with the national guidance.
About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th><strong>Met this standard</strong></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>
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<tbody>
<tr>
<td><strong>Action needed</strong></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>
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<tr>
<td><strong>Enforcement action taken</strong></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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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

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

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

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

**Essential standard**

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

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

**Regulated activity**

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

**Registered Provider**

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

**Regulations**

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

**Responsive inspection**

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

**Routine inspection**

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

**Themed inspection**

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