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

Royal Hampshire County Hospital

Romsey Road, Winchester, SO22 5DG

Date of Inspection: 15 January 2013

Date of Publication: February 2013

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

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<th>Standard</th>
<th>Result</th>
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<tr>
<td>Care and welfare of people who use services</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Staffing</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>✓ Met this standard</td>
</tr>
</tbody>
</table>
## Details about this location

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<thead>
<tr>
<th>Registered Provider</th>
<th>Hampshire Hospitals NHS Foundation Trust</th>
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<tbody>
<tr>
<td>Overview of the service</td>
<td>Royal Hampshire County Hospital is a general hospital providing a range of service including emergency care, surgery, diagnostics, paediatrics and maternity. It is located in Winchester, Hampshire, and is one of two acute hospitals provided by Hampshire Hospitals NHS Foundation trust.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Community healthcare service  
Diagnostic and/or screening service  
Rehabilitation services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Family planning  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
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 the provider, carried out a visit on 15 January 2013 and observed how people were being cared for. We talked with people who use the service, talked with carers and / or family members and talked with staff.

The team included two advisors with specialist knowledge of hospital theatres and infection control.

What people told us and what we found

The inspection team included two advisors with specialist knowledge of hospital theatres and infection control. During the inspection we spoke with 16 staff, in a range of roles, including healthcare support workers, housekeepers, nursing staff, doctors and managers. We also observed care and spoke with 12 patients and visitors. We visited a sample of elderly care and rehabilitation wards, surgical and maternity wards.

Patients told us that they were happy with the care and treatment they received. One patient told us; “Doctors and nurses have explained things well and I know what to expect. Staff are calm and respectful and have answered all my questions.” We saw that patients’ needs were assessed and treatment and care was delivered in line with their needs.

We found that the hospital was kept clean and procedures were in place to prevent and control the spread of infections. Patients were positive about the standards of cleanliness. Most commented that they had observed staff wash their hands frequently, and use gloves and aprons when necessary.

Patients said that staff had the right skills, saying, for example; "I am amazed at the levels of calm and competence of the nursing and care staff,” and "Nothing is too much trouble for the nurses.”

Some patients said that there were not always enough staff available however. We found that some wards often had fewer staff than expected. The trust was aware of this and was recruiting additional staff.

You can see our judgements on the front page of this report.
What we have told the provider to do

We have asked the provider to send us a report by 22 February 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

| Care and welfare of people who use services | Met this standard |
| People should get safe and appropriate care that meets their needs and supports their rights |

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

During our visit we spoke with 12 patients and visitors. People told us that they were treated with respect whilst receiving care at the hospital, and that their care met their specific needs. We spoke with people on different wards. For example, one patient told us; "I understand what is happening (with my care and treatment) and my care is brilliant." Another said; "Doctors and nurses have explained things well and I know what to expect. Staff are calm and respectful and have answered all my questions." On a third ward one person said; "The quality of care could not be better". We were also told; "The appointments system is excellent and the follow up has always been good".

We looked at care provided in the main theatre suite and in the treatment centre theatre. We found that hospital pre-admission and admission forms were completed, to assess people's needs and risks. Patients were required to consent to treatment and risk assessments were undertaken, including those for venous thromboembolism (VTE), or blood clots. We saw that patients were given leaflets appropriate to their care, on topics such as VTE, pain control and rehabilitation exercises. The theatre teams used checklists to ensure patients' surgery was carried out safely, and in line with best practice. This checklist was based on the World Health Organisation (WHO) tool, and adapted for use with specific theatre treatments. This indicated that patients' care and treatment reflected relevant research and guidance.

We visited elderly care wards and spoke with senior staff about how care was provided to meet patients' specific needs. On Freshfields ward, we found that there was an emphasis on preventing falls, following a recent review of falls incidents. It had also been recognised that elderly patients would benefit from additional afternoon snacks, and a 'cakes and milkshakes' initiative had been implemented. Two apprentice healthcare support workers had been appointed, to provide additional help at mealtimes and with personal care, and to support patients with dementia. The lead nurse on the ward, a trained dementia care champion, explained how care arrangements had been influenced by the needs of the patient group. For example, visitors could call at any time, and were encouraged to help at meal times. Patients who were identified as at risk of falling were monitored using a
movement sensor that alerted staff to provide assistance.

We were also shown notes from a 'Dementia Focus' event held in November 2012. This event was used to identify changes that could be implemented to provide better support for patients with dementia. During our visit we saw that some recommendations had been progressed. For example, a dementia specialist had been appointed and the clinical services lead was carrying out an audit of ward for dementia care.

We looked at how patients' health and wellbeing was monitored by sampling patients' notes on different wards. We found that patients were regularly assessed to find out if their health was deteriorating, using a specific monitoring tool. We saw that people were assessed on admission for risks associated with moving and handling, pressure ulcer development and malnutrition. Where one patient had been admitted with a pressure ulcer, we observed that appropriate action had been taken to support their recovery and that care was monitored. This showed that patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

On Shawford ward however, we found that some observations were not recorded. For example, for one patient, their cannula assessment had not been monitored in line with hospital guidance, and the two-hourly checks had not been completed for the previous day. This meant that there was a risk trends would not be identified promptly. We spoke with the nurse in charge who investigated this.

Staff said they would use the hospital's incident reporting procedure for notifying the trust of incidents, accidents or near misses, for further analysis. One staff member commented; "We were given feedback following a review of falls on this ward. We made changes to how we monitored patients as a result." Minutes from the clinical quality and safety committee meetings in July and October 2012 showed the trust investigated individual incidents and also looked for trends that could help to prevent further incidents. This meant that care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare.

During our visit we spoke with staff about how patient information was communicated at shift changes, and we looked at handover reports. We saw that the separate nursing and doctor handover sheets included key information relating to patient medical or nursing plans, as well as background information about the patients' specific risks. On one ward we saw that the two sets of information correlated. One member of staff commented; "The handover meetings are structured, with all those present who need to be involved." From trust documentation we saw that the quality of handover information had been monitored and that further improvements to the methodology were planned.

We saw information that showed that people's discharge dates were planned. One patient commented; "I had thought I was going home today, but I understand why I have to stay longer." Proposed discharge dates were on the handover forms that we reviewed. We spoke with two members of staff who commented that discharge might be delayed due to factors such as waiting for medicines or waiting for appropriate arrangements with social services. One new housekeeping staff said that part of her role was to support patients' discharge, by liaising with pharmacy and helping patients to pack their things.
### Cleanliness and infection control

<table>
<thead>
<tr>
<th>✔️ Met this standard</th>
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#### People should be cared for in a clean environment and protected from the risk of infection

**Our judgement**

The provider was meeting this standard.

Patients were protected from the risk of infection because appropriate guidance had been followed. Patients were cared for in a clean, hygienic environment.

#### Reasons for our judgement

During our inspection we observed the environment and hospital cleaning practices in general. We also reviewed infection control procedures in greater depth within maternity services and in a sample of surgical theatres. The trust's appointed lead for infection prevention and control explained arrangements in place within the hospital. We also spoke with members of the infection prevention and control team.

We were shown a range of audits that had been carried out to monitor the effectiveness of infection control measures. These audits included assessments of the environment as well as observations of staff hand-washing techniques and checks on medical devices, such as catheters. The provider may find it useful to note that information provided by the trust showed that hand washing audits had not been carried out in the Royal Hampshire County Hospital as frequently as in Basingstoke Hospital. For example, audit results showed that the Geoffrey Hammond antenatal and postnatal wards and the Kemp Welch surgical ward had not been audited, as part of the weekly hand hygiene audit programme, in the last three months.

Systems were in place for infection control assistants to carry out the audits and for ward staff to take responsibility for monitoring that actions were taken when required. The audit of commodes in December 2012 identified instances of unclean commodes on most wards. Ward staff had been informed of these results however, and were required to make improvements.

We observed that the sluice room in one ward was maintained in good order. Items of equipment that had been cleaned, such as commodes, were marked with labels to demonstrate they had been cleaned and were ready for use. Our observations showed these had been cleaned effectively.

Patients were routinely screened for infections, in line with national guidance, and results were communicated promptly. This meant that nursing staff could take appropriate action to minimise the risk of cross-infections. The hospital had recently experienced an outbreak of norovirus prior to our visit, and this had been controlled and managed effectively. We found that there were some leaflets available to inform patients and visitors about norovirus. Information about the norovirus outbreak and restricted visiting times had also been communicated using the trust website and through local media. If patients needed to
be nursed away from others, to reduce risks of cross-infection, appropriate signs were placed on closed doors. We observed that staff used protective aprons and gloves when entering these areas, and disposed of them on exit. This showed that there were effective systems in place to reduce the risk and spread of infection.

The trust showed us reports from different ward or department 'walkrounds'. Walkrounds are where a member of the executive management team or a governor visit wards or departments to observe care, talk to staff and talk to patients. We saw that these had been used to review infection control measures on some wards and any actions for improvement were noted and communicated to the ward.

Prompts and guidance relating to infection control were available but these were not always consistent across the hospital. People were reminded to wash their hands or use the hand gels on entry to the hospital and onto wards. We saw cleaning regimes posted in some wards, outlining how often different parts of the ward were cleaned. We were told that some posters and leaflets relating to infection control had been removed however, to be replaced with ones developed by the Hampshire Hospitals NHS Trust, following the hospital merger.

In maternity services we found that plans were in place to upgrade the environment. Two maternity theatres were being upgraded to meet current guidelines. The general environment of maternity services was found to be clean and plans were in place to replace the flooring. However there were excess items of equipment on wards that meant that cleaning was more difficult. The water birth facility was being upgraded. The infection prevention and control team showed it had a role in advising on environmental standards for departmental upgrades elsewhere, and had been involved in the plans for the upgraded endoscopy suite.

We also visited the neonatal services. As in other wards, all admissions were screened routinely and regularly for MRSA infections. The environment appeared clean and records were maintained to show that cleaning was completed. We observed that staff used safe hand hygiene practices and water safety arrangements were in place to keep people safe from water borne infections. The hospital's water safety plan and procedures were applied in all high risk areas, including the chemotherapy units. The trust had also set up monthly water quality meetings to monitor and address any issues relating to water quality and safety.

During the inspection we asked eight patients for their views on hospital cleanliness, and they were all positive about the standards maintained. Most commented that they had observed staff wash their hands frequently, and use gloves and aprons when necessary. One person said "It's clean and bright" and another described how staff kept the ward clean. We talked to staff about cleaning and infection prevention and control and they were familiar with best practices. We found that patients were cared for in a clean, hygienic environment.
Staffing

<table>
<thead>
<tr>
<th>Action needed</th>
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<tbody>
<tr>
<td>There should be enough members of staff to keep people safe and meet their health and welfare needs</td>
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</table>

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet patients' needs. This appeared to be particularly noticeable in the medical wards. The trust was aware of the situation and was taking action to reduce the risks from staff shortages.

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

Reasons for our judgement

During our visit we spoke with 12 patients and visitors. We were told that staff were; "Quick to come if needed" by a patient on Freshfield ward. A patient on Kemp Welch ward commented; "There are less staff at night so they are slower to respond." A patient on Shawford ward told us he thought the ward was sometimes short-staffed, because "dementia patients take a lot of staff time". Another patient commented that while he "would question staffing levels, they still cope." When we visited Clifton ward, one patient said she sometimes had to wait a long time for staff assistance, for example when in the lavatory. We spoke with a patient in maternity services, who commented that there were "Definitely the right number of staff. I had one to one care throughout my labour."

Everyone we spoke with commented positively about the skills of the staff. One patient said that staff "have the knowledge and skills to do the job" and "I really appreciated their help when I was ill."

When we spoke with staff on the different wards we visited, most said that the staffing levels were adequate to meet patients' general needs. We were told however that staff sickness was sometimes difficult to cover. We were told that if a ward needed additional staff, due to staff illness or other factors the ward coordinator would first seek staff from other wards within their directorate. After that, the trust used bank staff. The trust did not use agency workers and required a level of adaptability from staff. We were told that if a bank shift could not be filled, clinical service managers reviewed the staffing and dependencies across the wards and placed staff in the most appropriate places.

Trust reports on staffing showed that the wards had experienced shortages during the week commencing 14 January 2013, against the expected staff levels. For example, Freshfield elderly care ward was short of trained staff on eight shifts and healthcare assistants on two shifts over the 21 shifts that week. On six shifts however, the ward had a supernumerary new nurse available and an apprentice was on duty for eight shifts. Kemp Welch ward experienced shortages of one healthcare assistant on eight shifts, seven of these at night. On Shawford ward, the report showed that 13 of the 21 shifts that week were short of a healthcare assistant, and two shifts was short of a trained nurse. Similarly,
Clifton ward was short of trained nurses and healthcare assistants on three and seven shifts respectively. On four of these shifts, an apprentice was on duty.

We were told by ward leads that if fewer staff were on duty than expected, and this was considered a risk to patient safety, they would raise this as an incident. This hospital had 110 reported staffing incidents between 1 September 2012 and 31 December 2012. When the data was broken down by ward, we saw that Freshfield ward reported incidents each month, with 11 incidents in October 2012. The overall level of staffing incidents at this hospital was significantly higher than for the trust's other hospitals, and had been a subject for debate by the clinical quality and safety committee in October 2012. It was reported that a review of these incidents showed that 80% resulted in no or low harm. 20% were reported to risk moderate harm due to issues such as delays in administering medication and providing basic nursing care. The trust had already identified issues with staffing and was reviewing staffing levels, skill mix and patient dependency.

The trust had initiated a recruitment campaign and staff skill mix was being reviewed. For example, the trust was using healthcare and therapies assistants to provide personal care and socialisation and was increasing non-clinical roles, such as ward clerks, housekeepers and ward managers’ assistants. This was being implemented to release trained staff from non-clinical tasks.

During our visit we found requests for bank staff on two wards were not always met, due to the lack of staff. We saw from the minutes of Freshfield’s ward meeting in December 2012 that staffing vacancies for ‘specials’ (staff needed to provide specific care to people at risk) were only being filled 20% of the time. We were told that the trust was also actively recruiting to the bank staff pool, and was reviewing the reasons why shifts were not being filled.

We found that initiatives to adapt staffing to patient needs were being implemented. For example, on Freshfield ward, apprentice care staff had been introduced to assist with non-clinical tasks. These included assisting at meal times, supporting patients with dementia and talking with patients. A newly recruited nurse was also in place, working in a supernumerary capacity, and a housekeeping assistant had been recruited to start the following week, to assist with general ward duties. We found that this housekeeping role was considered effective in other wards and was being rolled out across the hospital. On Freshfield ward, we were also told that staff breaks had been changed to improve staff presence on the ward to respond to patients' needs.

A member of the trust management team explained that a detailed review of baseline staffing and skills mix needs of each ward was carried out in March 2012. Further reviews were due in March 2013. Each ward monitored staffing and assessed need locally, with the freedom to flex the staffing based on the actual or anticipated dependency of patients. We were told that a recent review of patient falls had shown there was no correlation between the incidents and staffing levels. It had already been recognised that there were concerns relating to staffing within this hospital, and that staff were being asked to work more flexibly.
Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

During our visit we spoke with 12 patients and relatives about their care. People were positive about the skills of the staff. We heard comments such as; "I am amazed at the levels of calm and competence of the nursing and care staff," and "Nothing is too much trouble for the nurses." Another person said; "I've never felt uncomfortable with any of the staff in the three weeks I've been here. They've done brilliantly with me, I feel really good". One person told us; "They have exactly the right skills."

We spoke with a sample of staff and they said they were well supported and had access to training and further professional development. Three of the non-clinical staff we spoke with said that they had attended an introductory training course before commencing work and had then 'shadowed' experienced staff on the ward. They said that the nurses and other colleagues were supportive, listened and gave advice. Staff told us that access to training was good. One nurse commented that the simulation training for resuscitation was particularly effective, and tailored to the needs of the specialism in which she worked. We were told that staff were prompted to attend refresher courses and that some courses, termed 'skills and drills' were particularly valuable. We spoke with a domestic assistant who was confident that she was kept informed and supported in her role, and that she was up to date with her training. A ward sister told us that she monitored completion of mandatory training. She was aware that her team needed to complete some training, and told us that this had been booked to ensure training would be up to date by April 2013. We were also told that night staff were rostered to work occasional day shifts in order to maintain their skills.

A clinical services lead told us that staff undertook care competency tests which included tests for dementia awareness. A housekeeper we spoke with also said she had to complete a competency test prior to being allowed to assist patients with their meals. The workforce development team explained that the trust used simulation events to train staff and assess competency in a range of situations. This enabled staff to practice skills in realistic conditions, and assess their knowledge of, for example, moving and handling, infection control and emergency skills under pressure. We were also told that the trust was implementing 'e-assessments' to identify which staff needed additional training, based on their level of competency. The trust outlined a range of creative courses in development for different staff groups.
The trust monitored staff statutory and mandatory training each month. The provider may find it useful to note reports showed that a lower percentage of staff were up to date with their training than a year ago. The trends indicated slippage in completing statutory and mandatory training. We spoke with one lead nurse who commented that the electronic monitoring of training was not as up to date as her own ward records. The workforce team explained that the trust's electronic learning system went live for all staff in January 2013. This enabled staff to access training courses and view their own training records. From November 2012, managers received monthly reports showing the training rates for their staff to prompt individual staff members as required. We saw that the education centre was planning a publicity campaign to promote mandatory and statutory training requirements with all staff so staff would know exactly what training they needed to do.

The workforce team outlined arrangements in place to train staff in coaching and supervisory roles. The trust had a bank of supervisors and coaching staff, publicised on their website, to enable staff to access clinical, professional or personal advice. In addition, we saw that team meetings were held at different levels, to communicate and share learning, information and key issues trust wide. This meant that staff had access to professional support and development.

Staff were able, from time to time, to obtain further relevant qualifications. A healthcare assistant described how she had been supported to take a leadership role in infection prevention and control, and had attended additional training for this. Another nurse described how she had received additional training to become a lead for patient dignity. The trust had started to support apprentice schemes, with plans to appoint over 30 apprentices. Schemes were also in place to enable staff to gain foundation degrees in health, in conjunction with another health provider. September 2012's workforce report showed that a preceptorship scheme for new nurses was in place, so they received support and mentoring.

Staff we spoke with were positive about the support they received, however statistics showed that less that 60% of staff had received an appraisal in the past year. Those we spoke with could recall having had an appraisal, or knew when this was to take place. The trust monitored appraisals, and had recognised that appraisal rates had declined since the trust merger. We saw that one division had introduced new arrangements for appraisals to improve this position. It had communicated to staff that all appraisals should be completed in April and May 2013. Staff had been told they needed to ensure they were up to date with training by this time. This meant some staff were required to postpone their appraisal until the next financial year. We saw a chart for booked annual appraisals in one ward office, which showed staff had time to prepare for these discussions. Overall, we found the provider was working to maintain and improve high standards of care by creating an environment to support clinical excellence.
The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Staffing</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The registered person must ensure that, at all times, there are enough suitably qualified, skilled and experienced staff employed to carry out the regulated activities. Regulation 22</td>
</tr>
</tbody>
</table>

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

The provider's report should be sent to us by 22 February 2013.

CQC should be informed when compliance actions are complete.

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

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

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

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

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of 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.

✔ 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. 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.
### Contact us

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