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

The Queen Victoria Hospital NHS Foundation Trust

Holtye Road, East Grinstead, RH19 3DZ

Date of Inspections: 05 February 2013
04 February 2013

Tel: 01342414362

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

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<th>Registered Provider</th>
<th>Queen Victoria Hospital NHS Foundation Trust</th>
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<tr>
<td>Overview of the service</td>
<td>The Queen Victoria Hospital is a specialist centre for reconstructive surgery and rehabilitation, helping people who have been damaged or disfigured through accidents or disease. It also hosts a sleep disorder clinic and provides minor injury services to people who live in the East Grinstead area of West Sussex.</td>
</tr>
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| Type of services | Acute services with overnight beds  
Blood and Transplant service  
Rehabilitation services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Management of supply of blood and blood derived products  
Surgical procedures  
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, carried out a visit on 4 February 2013 and 5 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We were accompanied by a specialist advisor.

What people told us and what we found

This was an unannounced inspection which focused on maxillofacial, orthodontic and paediatric services. We looked at both inpatient and outpatient departments for these areas.

Patient feedback across each of the departments we visited was positive about the quality of care and treatment that people had received. Patients told us that they had experienced care that had exceeded their expectations. People said that they felt safe at the hospital. We found evidence that people had been consulted with and wherever possible had been involved in the planning of their own care. Patients had been given accessible information and support to make decisions about their treatments.

We found staff to be competent and experienced. Staff told us that they felt well supported both by their line managers and the wider Trust. Staff said that the hospital operated an open culture and that they felt able to challenge practices and each other.

The Trust had appropriate systems in place for monitoring the services it provided. We saw evidence that where areas had been identified for improvement the necessary action had been taken to secure this.

We looked at a range of records across the hospital. Many records were found to be detailed and accurate, however we identified areas where significant information had not been fully documented. Where there were gaps it was not possible to evidence that the appropriate action had been taken to protect people.

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 12 March 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

Consent to care and treatment

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We visited Peanut Ward which provided inpatient facilities for up to nine children between the ages of six months and sixteen years. We saw evidence that the children on the unit had been given accessible information about the facilities available and the treatment they could expect. One five year old patient showed us a pictorial book which contained photographs and age appropriate information about staying at the hospital. A fifteen year old patient told us that they had been given full information about their planned operation and had been enabled to make a choice about whether they had a local or general anaesthetic. The parents of a 14 month old baby told us that medical staff had spent a long time explaining the planned treatment for their child prior to them being asked to consent. This meant that regardless of the age of patients, staff had taken steps to involve them and their advocates in their care and treatment.

All of the nurses on Peanut Ward were trained in paediatric care, this meant that they had the necessary skills and experience to work with children in a hospital setting. Where obtaining consent was complex, we were told that the nurses would support children when they talked with the surgeons. All of the nurses we spoke with demonstrated a good understanding about the issues of consent and understood the different levels of consent and when each was required and from whom. This meant that the hospital had appropriate arrangements in place to obtain consent from children.

Each staff member spoken with had a clear understanding of the principles of the Mental Capacity Act 2005 which included what to do if they had concerns about a parent's capacity to consent to treatment for their child. The unit had good links with learning disability specialists and translation services which meant that they had taken steps to ensure people gave informed consent. Staff expressed confidence in knowing what to do if consent was refused or withdrawn and gave examples about situations where treatment had been postponed or cancelled due to patient refusal.
All of the patients and where appropriate, their parents spoken with confirmed that they had been requested to provide written consent prior to treatments being given. Each of the care records we looked at contained copies of consent forms that had been signed by the appropriate people. Where people had undergone multiple treatments or procedures, a separate consent form had been signed each time. This demonstrated that the hospital recognised the importance of people consenting to each stage of their treatment.

We visited the inpatient (Canadian Ward) and outpatient departments for maxillofacial and orthodontic services. Patients in these areas told us that they had received sufficient information about their treatments in order to give their informed consent. We saw evidence in waiting areas of the information leaflets that were available for patients.

Staff spoken with demonstrated a clear understanding of the need to gain consent and also what would happen if there were concerns that a patient lacked the capacity to consent. Staff reported that there were two types of consent forms which were selected on the basis of whether a patient had the capacity to consent or not. Staff spoke of the links with a learning disability nurse who would be involved in cases where a patient with a learning disability had been referred for treatment.

We saw documentary evidence that where staff had concerns about a patient’s ability to give consent that steps had been taken to involve the relevant practitioners in order to make a decision in the best interests of the person. For one person that had included seeking appropriate advocacy services. This meant that where people lacked the capacity to consent people the hospital acted in accordance with legal requirements.

A review of the records in these departments identified that consent forms had been completed for each procedure prior to the commencement of treatment. We saw evidence that forms had been signed by the patient and appropriate person from the hospital. This meant that treatment given respected and involved the wishes of the patient.
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.

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

Reasons for our judgement

We met five children and their parents who had received treatment from the children's departments. All of these people expressed satisfaction with the quality of care they had received. People told us they had "Total confidence in the hospital" and that "The level of expertise and observation is amazing." Two patients commented that they "Cannot imagine private healthcare being be better than this."

We looked at the care records for five paediatric patients and found evidence that people's needs were assessed and care and treatment was delivered in line with their individual care plan. All of the people we spoke with had a good understanding about their diagnosis and the treatment that was provided which meant that the information that was documented had been shared with them.

We saw evidence of three types of care records on Peanut Ward. These were selected dependent upon the length of stay of the patient. This meant that staff had more information about children who stayed on the ward than those who were admitted for day surgery. The hospital employed the services of a play specialist who supported the developmental needs of children on the unit. The ward had a dedicated play room with a range of age appropriate toys and games. This demonstrated that the hospital recognised that patients had needs which were wider than just requiring medical treatment.

We found that where patients had been transferred from another hospital, copies of their notes had been efficiently obtained. This meant the hospital had the necessary information to deliver treatment effectively on the arrival of the patient. All care records we viewed included an initial assessment, pre-operative and post-operative observations including pain tools and theatre care plans. One set of notes for a child who had been an in-patient for several days included an assessment of activities of daily living that detailed communication and speech, eating and drinking, likes and dislikes and mobility and play. There was evidence of good nursing risk evaluation and written evidence that demonstrated prompt nursing referral and assessment by medical staff when risks increased.

We found that patient notes demonstrated the effective use of pain tools by the multidisciplinary team and negotiation of care in relation to physiotherapy. We saw evidence that a child who initially refused to straighten a knee was successfully
encouraged to do by using a clock to count down each stage. This demonstrated that patients were supported to receive appropriate care and treatment.

The records showed that people were provided with detailed information when they left the hospital and a follow-up appointment had been made. This meant that systems were in place to ensure treatment could continue effectively post discharge.

Patients on Canadian Ward and outpatients told us they "Can't fault the care" and "It's the staff care that matters, and that is excellent". People told us that they received their care in a timely way. For example an orthodontic patient reported that their brace had broken the previous week and a same day appointment was offered to fix it.

The care records within maxillofacial and orthodontics were less easy to view than in children's services. We found that information was contained in different places and it was not straightforward to follow the patient journey. Discussion with staff identified that patients received the appropriate care and that assessments were conducted, however the records did not always fully reflect this.

There were opportunities for people to be involved in the planning of their care and treatment and we observed that practical arrangements had been made for one person to attend a multi-disciplinary meeting to discuss their treatment options.

People were enabled to have contact with friends and family and we observed that two people with specific communication needs had family members with them outside of official visiting hours. This meant that the emotional and communication needs of these two people were being supported.

We saw evidence of comprehensive risk assessments that had been completed for patients admitted to Canadian Ward and evidence that emergency care was handled well. People we spoke with said that staff were responsive and call bells were answered quickly. This meant that patients had received appropriate and safe treatment.

The hospital had arrangements in place to deal with foreseeable emergencies. These included the availability of emergency resuscitation equipment in inpatient and outpatient areas. The hospital had qualified staff on duty at all times to provide medical care and deal with any medical emergency. Staff told us that they were all trained in at least basic life support. On Peanut ward staff spoken with said that they completed annual Paediatric Immediate Life Support (PILS) training. Staff reported that they felt confident to deal with an emergency situation should it arise.

The children's unit was supported by paediatric services from another hospital. We saw evidence of a service level agreement between the two hospitals. We met with a consultant paediatrician from the other hospital and both he and the nursing staff on the ward told us that the arrangement in place worked well. Paediatricians worked within the unit three times each week and provided on-call cover for the rest of the time. Staff told us that patients were closely monitored any patients deemed high risk would be transferred to another hospital. We saw evidence in the care records that the nursing staff used a tool called Paediatric Early Warning Score (PEWS) which monitored the dependency and risk of a child. We found that staff had taken the appropriate action according to the PEWS score and as such patients were protected by the systems in place to monitor their wellbeing and manage the risk of medical emergencies.
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

All of the patients and their representatives in paediatrics, maxillofacial and orthodontics told us that they felt safe at the hospital. We were told that patients were treated with respect and that their safety and well being were protected at all times.

Staff spoken with confirmed that they had received training in safeguarding. Staff who worked with children reported that they had completed specific courses in child protection. Records showed that 87% of staff on Peanut Ward had attended and were fully up to date with their child protection training. We interviewed four staff about child protection and each were knowledgeable about the measures in place to keep children safe from harm. Staff demonstrated a sound understanding of the protocols that needed to be followed if they suspected a child had been abused or had any concerns about their care. Staff spoken with were clear about their personal responsibility to take action if they had concerns.

We saw evidence of detailed policies and procedures about safeguarding vulnerable adults and children on the staff intranet which was available to all staff. There were also two designated child protection nurses on Peanut Ward who provided support to staff three days each week and reported to the safeguarding lead for the Trust. This meant that staff had access to the information and specialist advice in order to carry out their safeguarding responsibilities effectively.

In each of the five children's care records we looked at we saw evidence that staff had assessed the child's injury in respect of safeguarding concerns. On the first day of the inspection we observed part of a multi-disciplinary team meeting. This meeting provided evidence that the multidisciplinary team were aware of their roles and responsibilities in relation to identifying children who may have been abused. Any child that had been seen in the department the previous week with burns, scalds or other form of injury was discussed in detail using telemedicine to determine whether the history given by parents/carers matched the injury. Telemedicine is a system of using information and technology to share medical and surgical information and images. We were told these meetings were held every Monday and safeguarding actions were agreed through this forum. This demonstrated that the hospital had systems in place to raise and challenge concerns.
The hospital had good systems in place for documenting safeguarding concerns and recording actions taken. We saw evidence of multi-agency working with the hospital regularly making contact with general practitioners, health visitors and social workers which meant that information about vulnerable children was being appropriately shared. Staff told us that the hospital operated an open culture where they felt enabled to share any concerns. Staff told us that they would report any issues they had to their line manager and gave examples where they had reported things and they had been appropriately addressed.
Requirements relating to workers

Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at the recruitment files for twelve members of staff which included employees of various designations. From these documents it was possible to evidence that appropriate checks which included obtaining references, full employment histories and identity documents had been undertaken before staff began work. We also saw that staff were formally interviewed. This meant that the hospital had effective recruitment and selection processes in place.

We saw evidence that medical and nursing staff held current registrations with the relevant professional regulator which meant that they had been approved as being clinically fit to practice. The hospital had a system in place which ensured that staff professional registrations were kept up to date. We also found that staff had completed appropriate disclosures to show that they were suitable to work with children and vulnerable adults.

Patients and relatives spoke highly of the staff who had supported them. One patient's family told us they had been "Really impressed with the level of seniority and expertise of staff available on the ward." Patients across the departments we inspected said that staff were "Competent" and "Professional".

During the inspection we spoke with consultants, matrons, ward managers, staff nurses and ancillary staff. Staff told us that they had been provided with induction and ongoing training and that they felt well supported to provide care and treatment to patients. Staff stated that appraisals were performed each year and said that there were opportunities to gain post registration specialist training. This demonstrated that the hospital had made arrangements to ensure that patients were cared for by suitably qualified and skilled staff.
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 who use the service and others.

Reasons for our judgement

We found evidence that the hospital had learnt from incidents / investigations which had taken place and that the hospital acted swiftly at times when changes to practice were identified. The hospital had a comprehensive system for managing accidents, errors and untoward incidents. Reports from this type of incident demonstrated that the hospital was keen to learn from any mistakes or near misses that occurred. Results from the latest staff survey reported that 97 percent of staff felt that the organisation took steps to ensure that errors were not repeated. This meant that the Trust was committed to ongoing improvement.

Discussion with staff highlighted that they felt confident to raise issues without fear of blame or reprisal. One Health Care Assistant told us that they felt empowered to challenge staff of any designation. They gave an example that that they would have no hesitation about challenging a doctor who did not wash their hands. This demonstrated the strong professional ethics of staff in terms of patient care and patient safety being the primary focus.

The Trust maintained a risk register. The purpose of the risk register was to identify any incidents, complaints or issues which may pose a risk to patients, staff or the safe delivery of the service. The risk register included the actions to be taken to ensure people’s safety. We saw evidence that the risk register had been used appropriately to escalate concerns to the Trust and effectively managed any potential risks to people who used the service, staff and visitors to the hospital.

We saw evidence of a variety of auditing tools that were used to monitor and improve the level of service provided. It was also evident that where improvements had been identified, an action plan was prepared and monitored by the relevant department. An example of where this type of auditing had worked well was in respect of record keeping on Peanut Ward. In November 2012 the team meeting minutes recorded that gaps in recording had been highlighted in patient notes and as such an action plan was set. We observed significant improvements in record keeping on this unit which meant that this
process had secured improvements.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Patients we spoke with told us that they had been asked to complete feedback forms and we saw evidence of regular and ongoing patient satisfaction questionnaires. We found that results had been collated and statistical outcome data was displayed in waiting areas around the hospital. We saw evidence of monthly feedback from parents and children on Peanut ward. All of the comments viewed were positive about patient experience and typical comments included "Very nice children's ward & staff who have made the stay in hospital not a scary experience" and "Better than any other hospital visit. Always letting me know what is happening and giving me choices."

Staff opinions were also regularly canvassed both through regular staff meetings and also the externally managed NHS staff survey. The results of the most recent staff survey completed in December 2012 are still to be published, but we saw a summary of the findings which showed a positive outcome for the Trust. We saw evidence of increased staff satisfaction from the 2011 survey and 96 percent of staff stated that they were satisfied with the quality of care that they gave to patients.
Records

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

Our judgement

The provider was not meeting this standard.

People were not fully protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

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

Records were kept securely and could be located promptly when needed. Throughout the inspection we identified that records were stored and managed in a way that protected people's confidential information.

We saw evidence across the departments that we visited which showed that care documentation was in a process of change from one system to another. Similarly, staff records were being managed in both paper and electronic formats. The period of change between two systems meant that some information was at risk of not being recorded appropriately.

In children's services we saw that there had been recent improvements in the way information was recorded and the records viewed for five patients were accurate and fit for purpose. The only exception to this was that we identified one safeguarding incident which had been raised in patients notes but had not been entered onto the safeguarding database. There was no evidence of the actions that had been taken to raise the alert and safeguard the individual. Discussion with various staff indicated that this was a recording rather than practice issue.

On Canadian Ward we identified a number of shortfalls in the way information was recorded. These gaps had also been identified and discussed during a team meeting on 10 November 2012 in which nursing staff were asked to ensure that they fully documented the care provided. We found similar shortfalls during our inspection. For one patient there was evidence that their capacity to consent to treatment varied on a day to day basis. Through discussion with the professionals involved in the treatment of this person, it was clear that the appropriate steps had been followed, but these were not fully reflected in the records.

For another patient who lacked capacity there was a medical difference of opinion about the best treatment for the individual. The discussion about these different options however was not documented. The discharge notes for this person had also been inappropriately completed which indicated that the patient had been given information regarding breast
reconstruction and specialist feeding, neither of which were relevant to this male patient who had such no dietary needs.

There was a further query regarding a patient with a learning disability. The hospital's assessment of this individual's ability was different to the individual's representative. How this was managed had not been appropriately recorded.

Through our process of tracking the care pathways for these individuals and discussing our findings with the staff involved in their care we did not have concerns about the treatment they had received at the hospital. The records however did not always reflect the quality of care that patients and staff reported was received.

The Care Quality Commission has responsibilities for ensuring services are compliant with The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations. As part of this inspection we visited the radiology department and reviewed the records the hospital kept to demonstrate their compliance with the legislation. We spoke to the Chief Radiographer and one of the hospitals five Radiation Protection Supervisors. We saw that the hospital had appropriate arrangements in place to safeguard people from the dangers of radiation exposure. We noted that the Local Rules had not been updated or reviewed for over four years although we were told that an updated version would be available in the near future. However the records relating to the qualifications of the Radiation Protection Supervisors and the machine operators were not available. This meant that the hospital could not demonstrate that staff were appropriately trained and qualified to undertake the role of Radiation Protection Supervisor or that all staff operating the equipment were aware of current best practice in order to safeguard people from the risks of radiation exposure.
Compliance actions

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<thead>
<tr>
<th>Regulated activities</th>
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<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td><strong>Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010</strong></td>
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<tr>
<td>Treatment of disease, disorder or</td>
<td><strong>Records</strong></td>
</tr>
<tr>
<td>injury</td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>People were not fully protected against the risks of unsafe or inappropriate care and treatment because some records did not contain accurate and sufficient information about the care and treatment provided.</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 12 March 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.
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.
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:

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<th>Regulation</th>
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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.
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