Care Quality Commission

Inspection Report

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

Royal National Throat Nose & Ear Hospital

330 Grays Inn Road, London, WC1X 8DA

Date of Inspection: 26 June 2013

Date of Publication: August 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	University College London Hospitals NHS Foundation Trust
Overview of the service	The Royal National Throat Nose and Ear Hospital became part of the University College London Hospitals (UCLH) Foundation Trust in April 2012. It mainly provides planned day surgery and out-patient clinics, although some patients may stay for a few nights. Some people have unplanned admissions through UCLH's Accident and Emergency Department.
Type of services	Acute services with overnight beds Diagnostic and/or screening service Urgent care services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

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 26 June 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider, were accompanied by a pharmacist and were accompanied by a specialist advisor.

What people told us and what we found

The Royal National Throat Nose and Ear Hospital provided care and treatment to local patients as well as those travelling from further afield. We saw evidence that the hospital was responsive to individuals' needs and patients' comments were mainly positive. For example, one person had written 'Thanks to all the staff who have made what could be a frightening experience very calm and relaxed' in a comments book.

The hospital was based in an old building and, since it took over the running of the hospital in April 2012, Universities College London Hospitals Trust (UCLH) had started to refurbish the premises. Two patients noted that the hospital was kept clean despite its age.

We observed that some patients were experiencing difficulty with the way the Urgent Referrals Clinic was organised. We also thought that the hospital needed to get rid of some old paper files to eliminate the risk of staff looking at outdated policies and procedures. There was an over-reliance on bank and agency staff in theatres, but senior staff were aware of this issue and it was in the process of being addressed. Out-patient waiting times were sometimes too long.

A small on-site pharmacy was available during office hours and there was an out-of-hours medication cupboard and an on-call service at other times.

We saw that there were robust systems in place to assess and monitor quality and safety and the staff members we spoke to had a good knowledge of them.

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

Consent to care and treatment ✓ Met this standard

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.

Reasons for our judgement

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

Staff told us that they confirmed consent to surgery on the day of admission and we saw forms had been signed appropriately by patients. We spoke to two patients who told us they had been approached to give consent for their operation. They said the surgical procedure and its risks had been explained to them and they had received the same information in out-patients.

Senior staff told us that issues in relation to consent were rare events so they would probably contact the Trust's safeguarding lead for advice if there were any concerns that consent was not informed or freely given. A member of ward staff said the same. This included getting advice about making assessments of capacity if people did not appear to be able to make their own decisions, as required by the Mental Capacity Act 2005.

We noted that there were contact details available for the Independent Mental Capacity Advocate (IMCA) and all staff who were asked were able to talk us through the Mental Capacity checklist which formed part of the Trust's relevant policy. All staff said the Mental Capacity Act was included in their annual mandatory training, some of which was available by e-learning. Two members of ward staff told us that they usually had time to undertake e-learning during night or weekend shifts.

Due to the specialisms of this hospital we checked with six members of ward staff how patients' communication needs were supported. They gave us some examples, including use of foreign language interpreters; involving people who knew the patient well (if the patient consented to this); use of notepads to communicate by writing and speaking slowly. All staff we asked said they had undertaken Deaf Awareness training. One junior member of staff had paid for their own basic training in British Sign Language (BSL), but we were told few patients seemed to rely on this method. Staff said that they would use Language Line to obtain BSL interpreters if required and we saw that contact details for

this service were displayed at the nurses' stations.

Patients on the men's ward told us they could access public wi-fi, but patients on the women's ward could not. Senior managers told us that UCLH was planning to commission wi-fi across all its locations. The provider may wish to note that access to wi-fi would assist patients with electronic communication aids, especially those who preferred not to involve a friend or relative in their care and treatment. We saw that there was a Communication Aids folder containing various useful line drawings on the women's ward. The provider may wish to note that all the pictures featured men.

Our visit coincided with the installation of new magnetic patient information boards above all the beds. These whiteboards had spaces for the name of the patient, what they wished to be called, the name of their Consultant and other information. They were accompanied by a set of magnets, which, with the patient's consent, could be used to indicate if they had additional support needs. For example, a forget-me-not flower magnet showed that the person had needs associated with dementia. We observed that the person installing the boards gave nursing staff copies of the guidelines for obtaining people's consent to use the boards.

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We visited two in-patient wards, one for males and one for females. The paediatric ward was not being used. This was because the hospital had consolidated its paediatric operating hours, so these beds were used for only part of the week.

Staff told us that the male and female beds would sometimes be combined on one ward on weekend nights. When this happened one gender was assigned to the high dependency unit. This meant the hospital could manage the segregation of the sexes effectively. As most patients attended for day surgery there were often only a few patients staying overnight, but the hospital could receive emergency admissions at any time.

We looked at five sets of patient notes and saw evidence that full medical histories had been taken and there had been communication with the GP or referrer. Consent forms were signed and, for those who had attended surgery, the WHO surgical safety checklist had been completed.

We saw that there was always a Consultant, as well as junior doctors, on call. Ward staff told us that there was an effective handover system so they always knew which patients to expect. Senior staff explained to us that they were conducting some pre-assessments by phone as a number of patients came from far away for treatment or found travelling hard. They were starting to explore if people could have MRSA screening near home, before travelling to London for their operation. This showed that the hospital was taking account of people's travel difficulties.

Very few falls occurred at this hospital, but we saw there was a post-falls protocol in place which detailed the appropriate steps for reporting and recording falls.

Staff told us that recently a patient with learning disabilities had been treated on one of the wards and they had provided them with a pre-admission induction so they knew what to expect. They had also arranged for a relative to stay beyond visiting hours to provide additional support and comfort. This showed that the hospital took account of people's

individual needs.

Other people received their ward induction on the day of their operation. One member of staff said 'we give them [the patients] an orientation.' We observed one patient being shown around on arrival, but one patient told us that it did not happen for them. We saw that every bed was equipped with a new clock face. The hands on the clock face were moved to show when the patient could next expect a nurse to check on them. We noticed that this system was starting to be implemented. All patients had access to a call bell by their bed to summon assistance between planned checks.

At the foot of every patient's bed on the women's ward there was a folder which was meant to contain useful information, but, when we looked this was out-of-date and some of it was linked to the previous Trust. The provider may wish to note that patients were not being provided with current information at their bedsides, although there was some more up-to-date information displayed around the ward.

One person told us that they felt communication had been poor, they were confused by their admission letter and they said their local consultant had had difficulty getting feedback from the hospital about tests which had been conducted. They said they 'felt like going home' as they could not understand why they had been booked in at 11am when their procedure was going to be carried out at 4pm.

We saw that discharges from day surgery could take place up until 10pm at night. Staff informed us that they would not discharge anyone who was vulnerable due to age or infirmity late in the day unless they had an escort. They also said they tried to ensure that anyone who had had a general anaesthetic that day had someone to escort them home.

Three out-patient clinics were taking place on the afternoon of our visit and we observed that appointments were fairly prompt for two of them. No one with an appointment was sitting in the reception area for more than 15-20 minutes. However, one in-patient told us that their previous experience of out-patients was a 'standard two hour wait' and two out-patients also mentioned the waiting time, with one describing it as 'the only problem.'

People's names were called clearly for two of the clinics and staff waited for people, greeting them and then escorting them to the consultation rooms. One person told us this did not always happen.

Some people were attending the Urgent Referrals Clinic and a different system applied for this particular clinic. The provider may wish to note that this did not take account of people's needs so well. Some people could not hear the receptionist calling out or were confused about where to sit. We spoke to one couple who had sat in the wrong area and had had an extended wait as they had not been identified as an urgent referral. Another person said 'If I can't see someone I can't hear them' so they had also missed their call for this clinic.

In total, we spoke to five people attending out-patients, one parent escorting a child and two other people accompanying a patient. Two people commented that the out-patients department was hard to find. One person told us that one of their out-patient appointment letters had arrived after the date of their appointment and they had not been allowed to re-book, instead their GP had had to re-refer them. Another person told us that they had tried to re-schedule their appointment, but the automated booking system did not seem to allow this. One person told us they were concerned about the length of time they had to wait for test results - 7 weeks.

We also heard positive comments from out-patients and those accompanying them, including 'I've been treated with respect'; 'we are happy to be here'; 'everyone has been very pleasant' and 'treatment is very good.'

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection.

General observations within the wards and waiting areas confirmed that they were kept clean, with the exception of dust under the units within one nurses' station. One toilet seat within the women's ward needed to be replaced. The occasional hand sanitiser dispenser was empty. Patients did not raise any concerns about cleanliness with us, two people commented that the hospital was kept clean despite its age. We noted that the telephone number for an infection control advice line was displayed on the staffroom wall of the men's ward. Nurses commented favourably on the dedication of the cleaners. One nurse said that if there were any concerns about a cleaner's performance they would raise it with the cleaner's manager.

We focused mainly on infection control in theatres and the recovery area during our inspection. Within these areas it was generally very clean and tidy. All bins were accessible and staff were observed carrying out hand washing at appropriate times. However, there were a few exceptions to good infection control measures, for example, there was a back-pack on the floor of the prep room; a member of staff was wearing a necklace; there were water bottles in evidence, suggesting staff may have been drinking in these areas.

We asked a nurse to take us through a number of procedures. They were able to describe them well and told us they felt able to confront colleagues if poor infection control practice was observed. We also spoke to the lead infection control nurse for the hospital who told us that they carried out a regular walk around theatres and recovery, but did not make notes. The provider may wish to note that keeping a record of these walk arounds would enable them to pass on information to those not present at the time of the infection control nurse's visit and help to monitor new and recurring problems.

We noted that whilst infection control data, for example, the Saving Lives dashboard and hand hygiene compliance, was displayed on the wards, it was not displayed in the theatre areas and we were told this was due to the hospital still being in a process of transition from the previous Trust.

We looked at the hospital's infection control policy, including some specialist procedures, for example, the decontamination process for larangeal masks. We saw that the hospital used the Trust's Sterilisation and Disinfection Unit and this unit had been assessed and certified as meeting the latest international standards.

We looked at the anaesthetic room which was clean and well equipped. A nurse was able to describe the process for preparing the room and how the WHO safe surgery checklist was used by the whole team. The nurse was also able to demonstrate how infection control policies and guidance could be accessed on the intranet and we were able to view the Saving Lives data, care bundles and peripheral line insertion data for May 2013 on-line.

There was no record of Clostridium Difficile (C.Diff) having been present in the hospital for many years and Meticillin-Resistant Staphylococcus Aureus (MRSA) screening showed that it was present on admission for some patients, but there was no record of it being acquired within the hospital.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Appropriate arrangements were in place in relation to obtaining, recording and storing medicines. Medicines were prescribed and given to people appropriately.

We visited two wards of the hospital and the pharmacy department to assess medicines management. We spoke to three nurses, one pharmacist and one patient about this aspect of the service. The patient we spoke to said that they were happy with the way their medicines were managed. They told us that during the night they had been in pain and that when they discussed this with the nurse, pain relief was brought promptly and they then felt more comfortable.

Pharmacy services to the wards consisted of a supply function, screening and dispensing take home medicines and medicines advice. There was a 24 hour on call service for an out of hours' pharmacist supplied by the local trust out of normal working hours. All staff we spoke to knew how to access medicines out of normal working hours, either from the emergency cupboard or the on call service.

The ward staff we spoke to said that they had a good service from pharmacy. Many of the patients had their operations during the working day and pharmacists were involved in preparing their medicines to take home and in dispensing to outpatients. Pharmacy technicians visited the wards and theatres weekly to ensure that there were sufficient supplies so that medicines did not run out. Most admissions were planned so the discharge process commenced early in each patient's stay. The wards kept pre-packed take home medicines which could be issued if a patient was discharged after the pharmacy closed.

We were told that nurses generally explained the medicines to the in-patients but the pharmacy always supplied a contact number for any queries after discharge. Nurses explained the different methods they used to communicate with patients if they were unable to hear or speak. People with swallowing difficulties were identified and the appropriate medicine formulation discussed with pharmacy.

We heard how patients brought in their own drugs but they were stored securely in the clinical room when they had their operations and nurses administered them as prescribed

and returned them when they were discharged.
The pharmacy told us that they carried out a monthly audit on medicine stocks. We looked at storage in two wards and the pharmacy and saw that all medicines were securely locked in fridges and medicines cupboards in the locked clinical rooms. Space was restricted in the pharmacy but we saw that all medicines were secure and the controlled drugs cupboard and the pharmacy had additional electronic security.

The wards and the pharmacy had access to the trust intranet and, therefore, medicine policies and procedures and also on-line medicines information. All staff knew how to report medicines errors and we heard how nurses carried out audits on the prescription charts.

We saw from the prescription charts that people's medicines were prescribed, checked and administered as intended by the prescriber.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

The provider had taken steps to provide care in an environment that was suitably adapted and adequately maintained.

The hospital was in an old building with a newer wing alongside. Senior management informed us of the refurbishment of the premises that UCLH had started. This included fire safety upgrades (completed) and lift replacements (underway). Staff told us that the main building was slow to warm up or cool down. We heard that an operation had had to be cancelled on one recent hot day as the temperature was too high in the operating theatre. We were advised that the refurbishment would include new 'chiller units' for critical areas such as this.

Staff reported that maintenance staff/ contractors were quick to respond to requests. One senior nurse told us that UCLH had introduced a concierge system to take all repairs and maintenance responsibilities away from ward staff. This meant there was more time for patients as ward staff now just had to make one phone call to report an issue.

We saw that storage space within the hospital was adequate, although the age of the building meant that it was rather dispersed. A major UCLH procurement project was described to us. Upon completion this should mean that the risk of over or under-stocking of supplies is reduced. This would make best use of the storage space available.

One member of confirmed that there was adequate storage space within the wards but it was not always in the ideal location. They noted that they had had to work around problems such as there being no space for a clinical waste bin exactly where they wanted it. They were pleased that the Trust had quickly installed an extra hand basin on the women's ward when they assumed responsibility for the building.

A few months prior to our visit the hospital had experienced a serious power cut which resulted in a small number of patients being evacuated to the main UCLH site and the cancellation of surgery and clinics. We saw a report which showed that several factors had combined to cause the power cut and, although there had been prompt investigation when there were some early warning signs, past mislabelling and a hidden drain had got in the way of solving the problem before the main power cut occurred. Remedial works were now

in progress to ensure the problem could not reoccur.

We noted that there were three entrances to the hospital with receptionists on duty at each of them. We were told that outside office hours only the main entrance was open. A security officer was on duty 24 hours a day and they monitored the main entrance after 5pm as well as patrolling the hospital. Senior staff told us that a swipe card access system was being planned.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs.

As many people attended the hospital for day surgery there were times when the wards were not very busy, but they had to be staffed to deal with any emergency admissions. Staff told us they had to be flexible as they had to work wherever the patients were located. This meant that some staff worked in both in-patient wards and out-patient clinics and/ or both the men's and women's wards. Senior management told us that staff were encouraged to take annual leave at short notice if the hospital was over-staffed. However, this was not enforcable.

At other times staff could be fully occupied. We observed two very busy periods on the women's ward - 11am admissions and the late afternoon return from surgery. We were told that the ward was missing one member of staff as they had been sent to escort a patient for tests in another part of UCLH as the patient had some additional support needs.

A member of staff on the men's ward told us 'When someone calls in sick there is always someone ready to replace them.' However, we received different feedback from a member of staff on the women's ward who said 'the bank cannot find us anyone who is prepared to work in ENT [Ears, Nose and Throat]'. We noted the high use of agency and bank staff in theatre, but we were told that plans were underway to recruit to vacancies through internal promotion and UCLH's 'Recruit 500' campaign.

We looked at the staff rota for the men's ward and saw that it was consistent with the number of staff on duty at the time. Staff told us staffing was typical for a weekday on the day of our visit and this was confirmed by the rota. There was a similar staff rota in place for the women's ward, but two staff members told us they often had to extend their working hours to ensure patient safety, due to the non-availability of bank staff. However, they did say they usually managed to get the time back during quieter periods.

We noted that a significant number of staff had worked in the hospital for many years and there were few vacancies on the wards. The women's ward had recently been able to recruit an extra nurse from UCLH's 'Recruit 500' campaign.

Senior staff on the wards were looking forward to the implementation of bespoke e-

rostering in the near future. They told us how this should make it easier to allocate staff. It had been rolled out to another UCLH location and they had heard it worked well.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 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

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

UCLH headquarters and the hospital itself provided us with high quality information in a timely manner when we requested information to support our inspection visit. Some of the paper and on-line documents we reviewed demonstrated how information was used on a number of levels. For example, the Trust knew exactly how many people had received infection control training each month and how many still needed to attend refreshers. Managers could get detailed up-to-date infection control training information relating to their team and individual team members could see when they personally needed to attend refresher training.

We read publicly available Trust documents, such as their Workforce report and recent Trust Board minutes, and saw that information was being escalated appropriately and plans were in place to address areas of underperformance.

There were two systems available for gathering patient feedback on the wards, an iPad survey and a comments book. We looked at the comments books which were generally very positive on both wards. In the last month typical comments read, 'Staff very nice and doctors very good' and 'Thanks to all the staff who have made what could be a frightening experience very calm and relaxed.'

All the staff we asked were positive about the transition from the previous trust to UCLH. We saw the key findings for this hospital from UCLH's staff survey and an action plan showing how senior staff were addressing the issues which had been raised. We saw a notice inviting staff to give feedback on one of the wards. We tracked staff and patient feedback with one of the senior nurses and saw that it was recorded, acted upon and any identified actions were fed back to staff.

We noted that there were a lot of paper information files on the women's ward which referred to the previous Trust. Many of them contained out-of-date policies and procedures. Staff told us they did not refer to them, they looked for information on the

UCLH intranet. However, they also said that student nurses did not have access to the intranet so they might look at the paper files. They provider may wish to note that some staff could be consulting out-of-date policies and other information. One patient showed us a leaflet they had been sent alongside their admission letter. It appeared to contain information about preventing the spread of norovirus, but was unreadable, due to poor photocopying.

A senior nurse on the men's ward told us that each regular member of staff had been allocated an essential standard from the Care Quality Commission's Guidance on Compliance and tasked with the job of keeping up-to-date on this standard and sharing their knowledge with their colleagues. This demonstrated that they were well informed about the standards for care and treatment.

We were informed by senior managers and ward staff that there had been a recent Patient Environment Action Team (PEAT) visit and a report of their findings was due. Staff told us they could get monthly statistical information about their ward from the Meridian database on the intranet at any time, but two people admitted they had forgotten their password for the system. However, this information was distributed to the matron and all senior nurses each month.

We looked at some of the risk assessments which were in place. All were clear and informative and, if followed correctly, the identified risks would be significantly reduced. We saw a particularly good example entitled 'Continued operating in RNTNEH theatres 1, 2, 3 when the main theatre lift is unavailable'. It had been drawn up following a role play exercise and contained a photo to guide staff.

We heard that there was a project underway as part of the Matrons' Development Programme at the King's Fund to design a structured information board showing ward or clinic performance in an accessible way. We were also told of a separate project within UCLH to identify the essential checks that should be incorporated into a Matron's walk around.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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