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

Northwick Park Hospital

Watford Road, Harrow, HA1 3UJ

Tel: 02088643232

Date of Inspections: 09 November 2012
08 November 2012

Date of Publication: November 2012

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

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## Details about this location

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<th>Registered Provider</th>
<th>North West London Hospitals NHS Trust</th>
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<tr>
<td>Overview of the service</td>
<td>Northwick Park Hospital (NPH) is part of North West London Hospitals NHS Trust. The North West London Hospitals NHS Trust manages Northwick Park and St Mark’s hospitals in Harrow and Central Middlesex Hospital in Park Royal. NPH also a key site for the teaching of medical students from Imperial College London. The hospital has approximately 470 beds.</td>
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<td>Acute services with overnight beds</td>
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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, reviewed information sent to us by the provider, reviewed information sent to us by other organisations and carried out a visit on 8 November 2012 and 9 November 2012. We observed how people were being cared for, talked with people who use the service, talked with carers and / or family members and talked with staff.

We were accompanied by a professional advisor during the first day of this inspection.

What people told us and what we found

The inspection team was led by a Care Quality Commission (CQC) inspector joined by three other CQC compliance inspectors and a practising professional with operating theatre experience. The inspection took place over two days, during the first day we visited two wards and an operating theatre and on the second we carried out an out of hours inspection of the Accident and Emergency department (A&E).

People told us what it was like to be a patient in Northwick Park Hospital (NPH). We looked at people’s care records that showed us individual records of consent to treatment were signed by the patient and care records that were personalised for the individuals included assessed potential risks and the action required to minimise those risks.

People who attended the hospital through the accident and emergency department (A&E) and were waiting to be seen were supported by staff that regularly assessed those waiting; ensuring people with high level needs were prioritised.

Patients were generally positive about the hospital regarding the information they received about their care and treatment, ward environment, choice of menu, facilities and their surroundings.

Areas inspected were clean and appropriate, hand hygiene procedures minimising the risk of spreading infections were followed.

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

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

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

Respecting and involving people who use services

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Met this standard

Our judgement

The provider was meeting this standard.

Patient's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Patients understood the care and treatment choices available to them. Patients we spoke with were generally positive about the information regarding the ward environment and Accident and Emergency Department (A&E), choice of menu, facilities and their surroundings. Patients had access to public telephones and televisions at an additional cost.

Patients knew why they were in hospital, what their treatment plans were and when they could expect to leave the hospital. Patients’ relatives were satisfied with the way doctors discussed treatment with their relatives. Relatives who had raised concerns with nursing staff had been able to discuss and resolve their concerns.

Patients were able to be independent but told us that they could call on staff to assist them if they needed help. Patients told us that they had been treated with dignity and respect at all times and by all levels of staff. Patients who had been on several wards were equally positive about their experiences on the different wards. One patient commented, "I am well looked after here." Some patients spoke positively about the way other patients were treated.

Patients were cared for in single sex bays or in single rooms on both the wards we visited. There were female and male only bathrooms. We saw that patients could have the curtains closed around the bed when they wished or when they were receiving care and treatment. We saw staff knocking on room doors before entering. There were quiet rooms available for private conversations when needed. There were lockable cupboards for patients to keep their possessions securely.

Patients were given appropriate information and support regarding their care or treatment. Staff greeted patients when they approached their bedsides. We observed that nurses, doctors and other staff were attentive to their patients and were courteous, calm and respectful in their manner. They spoke loudly enough to be heard, but as quietly as possible to avoid being overheard. Staff explained what they were going to do before
starting treatment, for example before taking a blood sample.

We saw staff assisting patients to walk. They encouraged them to walk at their own pace and provided support. Patients were free to move around the wards, walking frames were within reach of patients. Patients were also encouraged to be independent if they could, in caring for themselves and in eating and drinking. On one occasion we noted that a drink was placed in front of a patient, but no assistance was given.

During our visit to A&E we observed one patient requiring assistance for personal support; it took staff however a long time to respond and led to the patient requiring additional support. We were told of a similar concern by a relative when we visited the wards. We discussed this during our feedback session, it was acknowledged during our feedback session to senior staff that staff at A&E was very busy, but changes could be made to reduce the risk of peoples’ personal needs being responded to more satisfactorily.

Two hourly comfort rounds took place on the wards. These rounds involved a named nurse or health care assistant in charge of a group of patients visiting each patient and checking if they needed anything such as pain relief or drinks.

People’s diversity, values and human rights were respected. Staff was aware of dignity and cultural issues and dignity and privacy was part of core nursing training. Patient’s choices and preferences and their care needs were discussed on initial assessment when they arrived on the ward and reviewed by staff at staff shift handover meetings. There were facilities available to meet the needs of patients of different faiths.

People expressed their views and were involved in making decisions about their care and treatment. Nursing staff told us that they assessed patients on admission and during care rounds to ask preferences and to check they were meeting their needs. Other healthcare professionals, such as doctors, physiotherapists, occupational therapists and dieticians, saw and reviewed their patients regularly. Records were updated following discussions so that other staff could use the most up to date records. Multi-disciplinary staff meetings involved patients or their relatives.
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.

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

Reasons for our judgement

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We spoke to 16 patients and 7 relatives, during our inspection, those spoken with said they had been fully involved and could make decisions regarding their treatment. At a pre assessment appointment patients who had planned admissions to the hospital were given a full explanation of the process of their treatment and details of the expected outcome.

Before people received care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Patients who went to theatre for an operation told us that the risks involved with their treatment was made clear to them and they had made the decision as to whether or not they went ahead with the surgery. Patients told us that the explanations were worded suitably so that they could understand the information about the surgery. They told us that they "felt confident about what was being done after the explanation." One person told us that the surgical staff had explained the risks involved in the procedure they were about to have and made sure that they understood them before they signed the consent form.

People who were admitted to the hospital and were identified as lacking the capacity to make some decisions were supported by the hospital staff team who understood the procedures that should be followed to ensure that any decision was made in the persons best interests. Not all nursing staff we spoke with told us they had attended training in and around the Mental Capacity Act 2005 (MCA 2005), however they demonstrated that they understood the MCA 2005 and knew the way people who lacked capacity should be supported, including making best interest decisions. Two people, we noted, did not have the capacity to consent but in both of these instances, we saw evidence that the provider had acted in accordance with legal requirements. However, the provider may find it useful to note that consent should be obtained for all treatment provided not just medical intervention. This was confirmed by one of the Matrons who told us that this 'should probably happen'.

Although we did not speak with anyone who could not speak English the executive team told us that language line could be contacted and an interpreter could be accessed if needed to enable patients to fully understand their treatment.

We looked at the care records for seven of patients. These contained a signed consent
form which showed that consent had been given before the medical procedure was carried out.
Care and welfare of people who use services  

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

Care and treatment were planned and delivered in a way that was intended to ensure people's safety and welfare.

The majority of patients said that staff were nice and that the overall care had been 'exceptional'. One patient said that staff "are very caring, very approachable and listened to his needs." Patients confirmed that they had been nursed in single sex bays throughout their stay.

Most of the patients interviewed, knew the name of the nurse looking after them. A minority of patients felt that nurses could have been quicker to respond to call bells.

We were informed by staff and saw evidence of, risk assessments being undertaken on admission, for example, nutrition, skin, and food and falls assessments. Staff explained how these assessments are applied in practice for example, those at risk of malnutrition will be assessed by a dietician and have their food intake monitored.

Staff told us that they complete electronic incident forms if needed and they receive feedback on incidents. Risk and Patient Safety reports are produced and reported to the board. These include a breakdown of all incidents, and actions arising from them.

We noted that regular checks were made on each patient to ensure they were seen regularly and offered support, if and when required. We observed staff as they carried out their day to day tasks. We noted staff were confident and supportive and assisted at regular intervals for any tasks required. These regular checks were logged in the person's care notes by the side of their beds.
### Meeting nutritional needs

**Food and drink should meet people’s individual dietary needs**

- Met this standard

### Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

### Reasons for our judgement

Patients’ food and drink met their religious or cultural needs. Patients were provided with a choice of suitable and nutritious food and drink. We observed lunchtime on one ward. A choice of meal was provided and this included choice of portion size, salad or a light choice. Patients were offered two menus to choose from a British/European and a cultural menu. Patients were able to choose kosher, Asian, African and West Indian meals from the cultural menu. Patients were satisfied with the hospital food in general and told us they had enough to eat and drink and that food was served at the appropriate temperature. They chose what they were going to eat for the day each day and said there was enough choice to meet their needs. Meals were described as tasty and we saw there were few leftovers. One person told us "the food is very nice and I don't need any help." Another said "the presentation of food is good, and also there was a suitable tasty choice."

Snacks for patients who missed their meals were available on the wards and patients were able to get sandwiches, biscuits and drinks during the night in A&E. Extra nutritional supplements and special meals, such as gluten free or meals for diabetic patients, were available for patients and these were prescribed by dieticians.

Patients needing specialist support with nutrition, for example using intravenous or nasogastric feeds had their diet planned and reviewed by the medical team, dieticians and pharmacists daily during their multi-disciplinary team ward rounds.

Patients were supported to be able to eat and drink sufficient amounts to meet their needs. Hot drinks were served during the day and we saw jugs of water at patient's bedsides. The wards we visited had protected mealtimes and no other patient activity was allowed in that time. Staff understood the importance of adequate nutrition and fluids as part of their patients’ treatment. Meals were served by the catering staff and the mealtime was coordinated by designated members of staff. Meals were served in stages so that assistance could be given to patients and the meals were served hot.

Patients had their nutritional needs assessed within 24 hours of admission and reviewed if needs had changed. For example we saw if patients were not eating as well as had been originally assessed, then a new assessment and care plan would be undertaken. Specialist advice and support was obtained, for example from speech and language therapists if patients had swallowing difficulties, if patients were observed to require this. Patients requiring support or at risk of malnutrition received a red tray. We saw that patients with a red tray received support to eat and drink.
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

There were safeguarding policies and procedures in place. The ward, operating theatre and A&E staff confirmed that safeguarding training was included as mandatory training for all staff. This was available on the hospital 'intranet' and updated for staff annually. Staff were aware of the procedure for reporting concerns. They knew about the different types of abuse and were able to explain the processes for following up any potential safeguarding issues. We asked staff what was expected of them if they had any concerns about suspected abuse of vulnerable adults. Staff knew who they were expected to report to if they had concerns. Staff told us that they would report to senior staff or the safeguarding lead in the trust. Staff was confident that safeguarding concerns were dealt with appropriately by their senior and the hospital's executive team. We asked about any information on the ward, to which staff could refer. In response we were shown leaflets near the entrance of the ward that contained supporting information and contact numbers.
Cleanliness and infection control

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 cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection. Patients we spoke with said they were very satisfied with the cleanliness and hygiene in the hospital. The areas we saw were cleaned regularly, and a cleaning schedule was available, which demonstrated the frequency and type of cleaning undertaken. One staff member who was responsible for cleaning the ward told us about the cleaning checks that were carried out regularly. This told us that infection control procedures were followed and that checks were in place to maintain appropriate standards of cleanliness.

On our walk around the hospital we noted the equipment had a label attached, which stated when they were last cleaned. Commodes taken to patient's bedside s were covered with a strip of paper showing when and who had last cleaned the equipment. One person told us that all the staff constantly cleaned their hands before and after they attended to anyone. Also, they had noticed that when the cleaners hadn't been able to sweep the floor properly near someone's bed for various reasons, they came back later and cleaned the areas they had previously missed.

There were sufficient hand gels, disposable gloves and aprons for use by staff and visitors and infection control signage was clearly displayed throughout each of the wards we inspected. There were effective systems in place to reduce the risk and spread of infection. We noted that one person, who required 24 hour one-to-one support, was in a single room and that isolation procedures were being used.

During our inspection of the operating theatres we noted that the lino wall guards and paintwork in the corridor between theatre 9 and the manager's office showed evidence of wear and tear. This could result in cleaning duties not being carried out appropriately and the risk of infection could be increased. We discussed this concern with the executive team who advised us that NPH received significant financial resources to carry out a multi-million pound theatre refurbishment and would resolve our concerns without delay.
Safety, availability and suitability of equipment  

Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

The provider ensured that patients and people who work in or visit the premises are not at risk of harm from unsafe or unsuitable equipment. They benefit from equipment that is comfortable and meets their needs.

Reasons for our judgement

People were protected from unsafe or unsuitable equipment because staff told us that they had the appropriate equipment available to them, which was well maintained and suitable for its purpose. Staff received training about any new equipment. They told us that they were not allowed to use medical equipment until they had been trained. This ensured that equipment was used correctly and safely. There were processes in place to report and rectify any broken equipment. Multi use equipment was sterilised appropriately and regular documented theatre rounds were carried out by the theatre manager.
### Staffing

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<tr>
<td><strong>There should be enough members of staff to keep people safe and meet their health and welfare needs</strong></td>
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### 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

People who used the service told us that staff was very helpful. The accident and emergency department was very busy; one person who had been admitted to hospital via this department told us how calm and relaxed staff were. While we were in the accident and emergency department we saw that staff took the time to explain to people who were waiting, what was happening and the time left to wait.

All of the wards we visited were fully staffed at the time of our inspection. One patient told us that there was always "plenty of staff around." Another patient said that although they were always busy staff were all "very pleasant."

We were told by one person that "99% of the time" the staff were very quick in responding to their call bell and that, generally, the only times they had "a bit of a wait", was when the ward had been dealing with emergency situations and during the night, when there were less staff on duty.

We observed patients who needed assistance to eat their meals had help from staff during the lunchtime period. We noted that staff were very respectful towards them and treated them with dignity.

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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.

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

Reasons for our judgement

Staff received appropriate professional development and were able, from time to time, to obtain further relevant qualifications.

Staff had induction training that included manual handling, health and safety, basic life support (BLS) for paediatrics and adults, safeguarding and infection control. Induction lasts five days. Mandatory training stipulated by the Trust was refreshed yearly, managers were alerted by computer records, when a member of their staff needed to update training or when a professional registration.

Most staff at a junior and senior level told us that they found their senior staff to be supportive, approachable and that most had an open-door policy so staff could contact them at any time.

All staff we spoke with told us they had regular contact with their line manager and were appraised yearly as part of the hospital's performance development process.

There were regular team meetings where staff were kept up-to-date with developments and clinical governance issues. Any important messages from the meetings were displayed in staff areas.

There was an escalation policy in place in A&E that ensured staff were aware of how and when to access the support they required immediately. We observed this policy in operation during our visit to the children’s A&E department.
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.

Reasons for our judgement

Following previous visits to NPH the trust responded quickly to the concerns highlighted in the inspection report by sending us an action plan. The staff on the wards, theatres and A&E we spoke with were aware of the audits that were carried out and they told us that many improvements had taken place as a result of the findings.

We gathered information from a tool we used called a quality risk profile (QRP) that told us about the quality of this hospital trust compared to other similar trusts. The results were about the same with no significant concerns identified.

During our visit we saw posters that requested feedback and gave information about making complaints were displayed. Nursing staff we spoke with told us that they took all complaints seriously and immediately reported them to the person in charge. We have always received full cooperation from the executive team of the trust in response to complaints that we have been notified of. These complaints have then been followed up by detailed reports of full investigations that were carried out by the hospital.
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.
### (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.