Inspection Report

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

Broadoak Unit

Thomas Drive, Liverpool, L14 3PE

Tel: 01512505003

Date of Inspection: 31 May 2013

Date of Publication: July 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mersey Care NHS Trust
Overview of the service	Broadoak unit is an inpatient unit providing 24 hour assessment and/or treatment for people experiencing mental health difficulties. Broadoak unit has three ward areas, as well as housing the Crisis Resolution Team, and is based on the Broadgreen hospital site in East Liverpool. The service is operated by Mersey Care NHS Trust, who provide specialist mental health and learning disability services for the people of Liverpool, Sefton, and Kirkby.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Transport services, triage and medical advice provided remotely 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 31 May 2013, talked with people who use the service and received feedback from people using comment cards. We reviewed information given to us by the provider and were accompanied by a pharmacist.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

We also spoke with Mental Health Act Commissioner's regarding the service and reviewed recent visit reports for this service.

What people told us and what we found

During our visit we spoke with nine people who used the service, eight members of staff in a range of different roles, two visiting advocates, senior managers and a visiting social worker. At the time of our visit, there were a number of patients who were not able to tell us about their experiences directly. However we spent time observing the support and care they received from staff. Feedback we received from patients included:

"I feel very safe here".
"We can go to the office and interrupt staff without feeling a nuisance".
"They really respect our dignity and privacy, they knock on your door, and they never just barge in".
"If I'm looking a bit down or depressed, they ask if they can help".

We found that people's privacy and dignity were respected and there were enough qualified, skilled and experienced staff to meet people's needs. The provider had an effective system to regularly assess and monitor the quality of service that people received. However, people's physical health care and treatment was not planned and delivered in a way that ensured their safety and welfare and medicines were not always safely managed.

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 07 August 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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

During our visit, staff were observed treating patients with respect and we found that all designations of staff spoke with patients in a calm and sensitive manner. Interactions between patients and staff were frequent and appropriate. Comments we received from people about the care and support they received at Broadoak Unit included:

"My consultant is really good, he discussed my medication and explained things to me".
"We all like the food".
"My consultant is brilliant. My care plan was fully discussed with me, I felt my care and treatment plan was an equal partnership".

People who used the service understood the care and treatment choices available to them. People who used the service were given a leaflet on admission which included important information about the unit, visiting hours, safety, diversity and cultural needs, ward reviews, protected meal times, community meetings, groups and therapeutic activity, access to advocates and how to complain. This information was available in other languages. There was further detailed information given in the ward patient information pack that included extra detail on advance statements, Mental Health Act and Mental Capacity Act.

As a result of their mental health, some patients were unable to be fully involved in care planning and decisions about treatments. Staff we spoke with told us that patient's wishes and preferences were discussed with them or their representatives on admission and recorded in their care plan to ensure that the care plan fully reflected the wishes known or the preferences of the patients. If patients wished to be involved in their care plans, they were asked to sign the document to show their agreement with its contents. If a patient had declined to be involved in the care planning process, this was recorded. Staff told us that people who used the service were involved in decisions about their care and welfare. They also told us that on occasion best interests decisions were made by medical and

nursing staff to support people who used the service.

People's diversity, values and human rights were respected. Staff told us they recognised the importance of maintaining patient's privacy and dignity. We spoke with staff about how they meet people's religious or cultural needs. Members of staff we spoke with were able to tell us how they can access translation services and that this service was readily available. On the day of our visit, staff were arranging translation services for a number of patients on the unit. Staff were able to provide food to meet the religious or cultural needs of patients and one patient we spoke with told us, "I'm not from England so they asked me what food I liked to eat". There were rooms available for patients to use for prayer/quiet time. However the provider may find it useful to note that uptake of equality and diversity training was low on one of the wards we visited. This was highlighted to senior managers on the day of our visit.

Two of the three wards on the unit were single sex. One ward at the unit was a mixed ward, which was divided into male and female areas to maximise privacy. Staff we spoke with were able to tell us the ways in which they ensured privacy for both genders on the ward. This included designated bathrooms and social spaces for men and women, which were clearly signposted. We saw evidence of a privacy and dignity audit for same sex accommodation. Of the seven replies all said they felt safe on the unit and that their privacy and dignity was respected. These were distributed monthly.

The service had a number of ways of gathering the views of people who use the service. Community meetings and patient's forum meetings took place on alternate weeks and notes of meetings were recorded. These were held on file in the ward office and also as an electronic record. We saw evidence that action plans were developed following this meetings to implement requests made by patients, such as feedback on the food and changes and improvements to the environment. Patients we spoke with were aware of these meetings, and many of them spoke highly of them. One person told us, "It's very informal and everyone is encouraged to participate" and another said, "I really enjoy these meetings because they are meaningful and not just tokenistic". Many of the people we spoke with told us they felt these meetings were very productive, comments included:

"We asked for a Wii and got one".
"We said the computer wasn't working and they fixed it that day".

During our visit, a situation occured where taff had to restrain a person for their safety and wellbeing. We observed that screens were used to maintain the dignity of the person. Staff told us they always knock on the door before entering a room and we observed this occurring throughout our visit. We also saw evidence of local 'behaviour agreements' that were signed by people who used the service. These agreements included information about respecting others and how they would be respected. They highlighted a person's rights as an voluntary patient and as a patient detained under the Mental Health Act, responsibilities and acceptable behaviour, information about illicit drug and alcohol use. This was signed by the patient and countersigned by the admitting nurse. We saw evidence of completion of these.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment of people's physical health needs was not planned and delivered in a way that ensured people's safety and welfare.

We have judged that this has a moderate 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

People who used the service were allocated a named nurse on admission. This information was displayed in the ward office and on the corridor. Patients we spoke with were aware of who their named nurse was and told us they found the system beneficial. One patient we spoke with told us that they had once asked to change their named nurse and that staff had been supportive of this. They said, "They made this very easy for me as they didn't probe and question my reasons, which would have been embarrassing and awkward as I my self- esteem is quite low and I don't have the confidence to complain. I was given another nurse and I was able to develop a more positive therapeutic relationship".

Care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. We looked at the care records for eight people who used the service and found that whilst comprehensive information, care plans and risk assessments were in place for their mental health needs, vital information was missing to ensure people's physical health needs were met.

Before people moved into the service, we saw evidence that a detailed pre-admission assessment took place. This ensured that the service could meet the needs of a potential new patient. Mental health care plans and risk assessments were generally established in a timely manner. Each person was given a physical health assessment on admission. There was also a dedicated physical health nurse available if needed.

Many of the patients at Broadoak Unit had health conditions which required management by staff, for example epilepsy, diabetes or fractured bones. We reviewed the care records for some people who needed additional support in these areas and found they lacked important information to ensure people received care and treatment that met their needs.

We reviewed the care records for two patients at Broadoak Unit who had diabetes. One person had a comprehensive care plan in place, which included key information regarding acceptable blood sugar levels and what action should be taken if blood sugar levels fell

outside of agreed parameters. However the second person had no care plan in place to provide staff with information and guidance about their diabetes.

We reviewed the care plan of a patient who had epilepsy. No care plan was in place to provide staff with guidance about the actions they should take in the event of a seizure. Another person had sustained a fractured bone prior to their admission to Broadoak Unit. No care plan was in place in relation to the fracture, nor was their any guidance as regards their moving and handling or risk of falls. Failure to plan and document people's care needs may put them at risk of receiving care or treatment that is inappropriate or unsafe.

Staff told us that during shift handovers they discussed each service user and the risks involved with them. Staff we spoke with on the ward discussed the handover system with us, which included a written record of the discussions held between staff during this time. This record was then scanned and uploaded onto the trust's computer system to generate an audit trail of all handovers. The wards we visited had also started using 'at a glance' boards. These boards, located in the nursing stations, contained key information about each patient and were updated daily by the nurse in charge. Staff we spoke with told us that the boards had helped improve communication and meant that nursing staff could spend more time with patients, without being interrupted by members of the multi disciplinary team.

There were arrangements in place to deal with foreseeable emergencies. All patients completed 'pre leave forms' before going on leave from the service, which detailed their clothing, destination and time of return to ensure that staff could provide other relevant agencies with up to date information should a patient not return from leave. Personal Emergency Evacuation Plans (PEEP) were complete when relevant, for example for any patients who received sedatives overnight to help them sleep. Emergency drug kits, defibrillator and oxygen supplies where kept on the ward and supplies were regularly checked by pharmacists. Staff received regular updates in first aid training, which included basic life support training and Cardiopulmonary resuscitation (CPR). We saw evidence of regular fire alarm tests being completed and recorded on the premises.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them.

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

We found that people's medical needs were provided for by doctors and suitably qualified nurses. Each ward had support from a clinical pharmacist who carried out checks of medicines handling. On one of the wards we visited the clinical pharmacist was involved in the daily acute care meetings, to directly discuss the use of medicines with other clinical staff, helping to ensure the safe use of medicines. We were advised that this would be extended to other wards.

At this visit we spoke with nurses and the principal clinical pharmacist about the systems in place for reporting, assessing and acting upon information provided through the hospitals medicines audits and medicines error reports. The hospital had recently set up a committee to monitor medicines handling and to ensure that appropriate medicines training was provided, helping to ensure that medicines are safely handled in accordance with trust policy.
Appropriate arrangements were in place in relation to obtaining medicines. Nurses explained that most medicines were administered from 'stock' except leave medicines and medicines which were individually labelled. If needed, leave medicines could be supplied in compliance aids to assist with administration. We found that medicines including controlled drugs were safely stored.

Medicines were prescribed and given to people appropriately. Arrangements were in place to confirm people's current medication on admission to the ward. Forms authorising people's treatment were kept with the prescription charts. We spoke with four people on two wards specifically about their medicines and no-one raised any major concerns. However, the provider might find it useful to note that two people we spoke with felt that the evening medicines were administered too late at night.

We found appropriate arrangements were not in place for medicines recording. We looked at the individual written information supporting the safe use of medicines. On one ward nurses explained how two people were supported to self-administer some of their own medication and one of these patients confirmed that they preferred to self-administer their

medication. However, risk assessments and care plans were not completed to ensure appropriate support and monitoring of safe self-administration and any associated risks.

There was a lack of written risk assessments and recorded information about how people's medicines needs would be best met as part of planning for periods of leave from the hospital. We reviewed the records of a patient who had recently been on weekend leave from Broadoak Unit and found that no risk assessment had been carried out for their period of absence from the hospital. Furthermore, no checks had been carried out of any additional medicines brought into the hospital after the period of leave which could place the patient at additional risk of harm.

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

Throughout our visit we observed that there was good rapport and interaction between the people who used the service and staff. We saw that there was a team of doctors, nurses, health care assistants, domestic staff and student nurses available to deliver care, support and rehabilitation to people. We found that, on the day of our visit, there were sufficient staff to enable them to sit and engage with patients. One visiting professional told us, "I am really impressed with the staff, they are very supportive and very tolerant" another said, "It [the ward] seems ok, but staff do seem to be a bit rushed".

There were enough qualified, skilled and experienced staff to meet people's needs. We received varied feedback from staff regarding the numbers of staff on duty on the wards. One staff member we spoke with told us they felt there were sufficient staff on duty at all times but another told us they felt at times there were not enough staff on duty, in particular if they had to cover special observations or support a patient at another hospital. One staff member told us, "I like working here but it's quite stressful. Sometimes you don't get the support from management."

There were procedures in place to record any staffing problems on the trust wide incident recording and risk management system. Staff also told us that managing staffing was discussed during one to one supervisions. In addition, ward manager meetings week. In these meetings, any areas of low staffing were highlighted and discussed. Staff we spoke with told us that they were able to request annual leave with their manager and that, if reasonable notice was given, their line manager was usually able to grant their request.

Senior members of staff told us that staffing levels were assessed depending on people's needs and if necessary additional staff could be obtained. The organisation had undertaken a staffing review of all services using a wide variety of data from various sources. This included the 'Telford' method of professional judgement, a tool that relied on the professional judgement of senior nurses at ward manager level and above. Also included in the review were trust incident data, attendance records for staff and the use of additional staff. A combination of these methods was used to determine the staff numbers and skill mix required to ensure that a safe, secure and therapeutic environment was maintained. One key part of the staffing review was to ensure that at least one Registered Mental Nurse (RMN) was on each ward at all times. The provider may find it useful to note

that during our visit the RMN was involved in ward round throughout the morning and therefore had limited availability to support other members of staff.

We reviewed rotas and saw evidence that occasionally there had been a high usage of bank and agency staff. However, we reviewed the local induction paperwork which provided evidence that bank and agency staff had been assessed as competent to undertake their duties on the unit. The local induction included a tour of the unit, introduction to staff and general health and safety. Bank and agency staff were also informed of the adverse incidents procedure and were up to date with moving and handling, cardiopulmonary resuscitation (CPR) and control and restraint. Throughout our visit we observed agency staff undertaking their duties in a competent manner and patients we spoke with did not raise concerns regarding the use of bank and agency staff.

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 to regularly assess and monitor the quality of service that people receive.

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. Patients we spoke with told us that, should they have a concern, they felt able to speak with staff. Comments included:

"They act quite quickly on any complaints and always feed back to me".
"They always let people know it's alright to complain, as they said to me, they wouldn't know if they were getting things wrong if people didn't complain".

We reviewed the data from patient experience questionnaires for a period of two months. 56 people had completed the questionnaires from three different wards. The majority of people felt they were treated with dignity and respect, and indicated they understood their assessment, diagnosis and treatment.

The provider took account of complaints and comments to improve the service. There were regular community meetings on the wards and we observed one of the meetings taking place. These meetings discussed compliments or concerns raised by the people who used the service. Once a concern or compliment was raised and discussed, an action plan if applicable was agreed and a staff member was identified to lead. Feedback was given at the next community meeting once this was resolved. For example, a patient raised concerns about their medication. It was agreed that it would be reviewed by the consultant in co-operation with the person and documented in their care record. We also saw evidence that records were maintained of these meetings. There was a suggestion box that was checked daily and a notice board detailing what people said and what was done to improve a situation, such as new microphones for the computer console. We also saw that information on how to complain was displayed for the benefit of patients. The trust also had a policy and procedure in place to handle formal complaints.

We reviewed the clinical governance framework during our visit. The Liverpool Clinical Business Unit (CBU) Governance Forum and Sub-Groups, of which the Broadoak Unit is a part, received information from the trust board through committees such as Integrated Governance, Infection Control, Mental Health Act, Adverse Incidents and Health and

Safety. They also received information and guidance from groups such as Physical Health Care, Safeguarding Strategy and Fire Safety Management.

The Liverpool CBU Governance Forum then cascaded information to its sub-groups, including Equality and Human Rights, Adverse Incidents, Medicine Management and Physical Healthcare, Health and Safety and Infection Control and Quality and Effectiveness. Patients were represented on all groups and committees where appropriate. We reviewed the minutes of the Liverpool CBU Governance Forum and saw that all actions had a nominated person against them and a timeframe for completion.

If the Liverpool CBU identified a risk this was placed on the trust risk register, following scrutiny by the Trust Clinical Governance Forum. This ensured that any action taken was appropriate and that the leadership team had full knowledge of identified risks. We reviewed the Liverpool CBU risk register. The register contained information that described the risks, the controls in place, action undertaken, the responsible person and positive assurance of the effectiveness of controls. These included risks to improving quality or value of services, the continual improvement of services and governance. There was also a system in place for reviewing and removing items from the register once the risks had been reduced or removed. We saw evidence of positive reduction of risks such as recruitment of medical staff to reduce the use of locum medical cover. Information about the quality of care was also displayed on each of the wards in the form of 'dashboards'. Staff told us this information was aimed at patients and their visitors; however the provider may find it useful to note that these displays were complicated and may not be easily understood.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. Staff told us they received support after incidents through their line management. One staff member told us they attended a reflective practice forum and were offered confidential counselling after an incident. However another staff member told us they did not feel supported and if they went off sick they were pressurised to come back to work. Staff we spoke with were aware of how to report an incident using the incident reporting system and stated they had received training in using the system. The provider may find it useful to note that whilst staff stated they received written confirmation that an incident had been logged, they did not receive any formal feedback on actions taken following their report.

The Trust had a whistle blowing policy and procedure in place. Staff we spoke with felt confident in raising their concerns. They said they would not hesitate to speak with their line manager or another manager to raise concerns should the need arise.

This section is primarily information for the provider

Action we have told the provider to take

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.

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment of people's physical health needs was not planned and delivered in a way that ensured people's safety and welfare. Regulation 9(1)(b)(ii).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Patients were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them. Regulation 13.

This section is primarily information for the provider

injury	

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 07 August 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

Contact us

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