Inspection Report

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

Grantham and District Hospital

Grantham and District Hospital, 101 Manthorpe Road, Grantham, NG31 8DG

Tel: 01522573982

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24 February 2014

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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
Cooperating with other providers	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	United Lincolnshire Hospitals NHS Trust
Overview of the service	United Lincolnshire Hospitals has several hospitals. Grantham and District Hospital provides specialities such as surgery, medicine and orthopaedics. it also has a critical care unit and an accident and emergency department.
Type of services	Acute services with overnight beds Community healthcare service
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies 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 24 February 2014 and 25 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

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.

What people told us and what we found

Patients told us they were cared for and their treatment was given to them when required. They told us staff spoke with them in a language they understood. One patient said, "I feel very much so cared for. The room is clean and tidy. I get my medicine regularly."

Patients and relatives were included in decisions about end of life care. The majority of DNACPR forms had been completed correctly, but the staff recognised there was some work to be completed in some areas. Further training was underway for staff to refresh themselves about the Mental Capacity Act (2005).

The care records of patients gave details of when they had been approached about their care needs and who had discussed this with them. Where specific treatment had taken place the relevant staff member had recorded clear details about the event and what was required to help the patient further.

Patients told us their care and treatment had not been compromised because of the staffing levels. They told us they could approach staff and had confidence in the staff to do their job. One patient said, "We all think we should have more attention, but the staff are very busy."

Since our last visit staff had received appraisals to ensure they were capable of doing their jobs and looking after patients.

Patients on the day ward and outpatients were more aware of the complaints process than those on the wards.

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

The patients we spoke with during our visit had been in the hospital between one and twenty-four days. Most patients spoken with in the outpatients department and day ward told us they had been given choices about their care and had been able to make decisions about their care themselves We observed staff, in both areas, explaining processes to patients and ensuring each person had the correct information before moving on to a new topic.

Patients on the ward areas told us they sometimes received confusing information about their treatment and care as so many people appeared to be involved in the delivery of care to them. But on the whole patients were pleased with the attitude of all staff and the way they had been treated.

One patient told us, "It has been very reassuring because I was very frightened." Another patient said, "I was told what would happen the day before my tests commenced and then staff went over it again on the day."

During our visit we looked at 25 sets of patient notes. Each set of notes had recorded preferences of patients, such as the name they would like to be known as, their next of kin and their home address.

The trust has an outstanding action at two other hospital sites regarding the policy on Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), which impacts on this hospital site. However the revised policy was approved by the trust board in August 2013 and due for renewal in August 2015. This sets out processes for staff to follow and how to complete the necessary documentation.

Each of the wards and departments visited were able to show us the folder which contained the up to date policy and the signatures of staff stating they had read the policy. The provider may wish to note the majority of signatures were of nursing staff. We asked two consultants how they had informed their medical staff of the new policy and they told

us this was either on a one to one basis or within team meetings. We saw one consultant asking their team to ensure they had signed the information folder, after we had informed them. Another consultant told us this would be reiterating again with their team that day. A member of the nursing team had been allocated on each ward and department to ensure learning was put in place about the new policy.

The policy clearly sets out what staff should do if people cannot make decisions for themselves and whether they already had an advanced decision recorded about their wishes to be resuscitated or not. The forms seen were not always clear about what type of Mental Capacity Assessment had been completed prior to a decision being reached. We were informed update training in the Mental Capacity Act 2005 would be taking place in the next week, for those staff who required an update on that topic.

The majority of sets of patient notes we looked at contained all the information which had been gathered prior to a DNACPR form being completed. Nursing and medical staff had written in patients history sheets when the topic had been discussed with the patient and included details of when relatives had been present. When a person could not, due to their medical condition, make a decision for themselves, this was generally recorded. When relatives or other named next of kin had been spoken with, this was also recorded.

The provider may wish to note that where the form indicated a reason to be recorded of the decision made the relevant box was ticked but sometimes there was no record made of the decision process. For example on one form the box was ticked for CPR is unlikely to be successful. The form then asked the question - because - this part was not always completed. In another section, if the decision had been discussed with relatives/carers/those with power of attorney or others, the box was ticked for yes but no names or relationships of relatives etc had been added. Therefore we had no means of knowing whether the process had been discussed with anyone.

On one ward we were informed, and saw the list, of a check which had been completed the day before our visit by a member of the nursing staff of all DNACPR forms of patients at that time. A record had been made where forms were incomplete. We were told the relevant doctors had been informed but there was no evidence to support how this had been completed. The nurse told us they would be checking all information was up to date in a couple of days.

However on checking one set of notes we saw a DNACPR form but the nurse in charge was not aware of this person or whether the form had been completed. We asked for clarification on the patient's medical status. When we returned a couple of hours later the patient had been spoken with and all documentation had been reviewed and updated. We were informed this incident had been escalated up to the Medical Director and Director of Nursing for investigation.

On another ward we looked at the notes of three patients who had DNACPR forms. Two had been completed correctly but one had not recorded the mental health status of the patient after the box had been ticked that the patient had not been spoken with. We pointed this out to the nurse in charge who was going to challenge the doctor about the entry. It was therefore not clear whether the patient could make their own decisions.

Staff had various methods of identifying to each other when a person was not for resuscitation. On some wards a code was included on the patient information board and on other wards it was identified on a patient information handover sheet between nursing staff. On two wards the information was not complete on the patient information board.

This was highlighted to the nurse in charge and immediately rectified.

Nursing staff took the results seriously from the monthly checks on documentation which were being completed by the risk management team. Some of the results were low but staff could explain the reasons to the inspector. On one ward the lead nurse for the DNACPR policy had highlighted the last results and put together action points for individual staff to complete. They were completing their own checks to ensure the figures were better the next time.

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.

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

Reasons for our judgement

Patients gave both positive and negative feedback about their experiences at the hospital whilst being in-patients. All patients were either happy or very happy with the care they had received but some told us about some experiences they were not totally satisfied about. Two patients told us they felt they would have liked more help in managing their pain and another patient said they felt staff had not helped them with their physiotherapy exercises over a weekend period. In both cases they had not passed on this information to nursing or medical staff and would not allow their names to be shared.

Patients on the day ward and outpatient department were generally more satisfied with their experiences in those departments. One patient said, "Staff are very nice and attentive." Another patient told us, "Staff are fantastic."

We observed staff interacting with patients throughout our visit. They did this quietly and where possible pulled curtains around the bed area or asked people to move to a quieter area of the ward or department. Staff introduced themselves and ensured each patient understood their care and treatment. Patients told us staff spoke with them using a language they understood and ensured they understood their treatment and care.

We spoke with relatives who were managing the affairs of four patients, due to the patients' poor memory. Relatives we spoke with told us they had to seek out staff members to ask for an update on their family member's condition. They told us staff were pleasant when they telephoned into the hospital to ask for an update. The provider may wish to note this was causing some anxiety with some relatives as the patients could not tell them what had happened each day and staff did not automatically approach them. One relative said, "I don't like to worry staff as they seem so busy, but neither do I want to spend the whole of my visit trying to chase staff for updates." We asked the relative's permission to approach staff about their needs. They allowed us to do so and later we saw staff sat with the relative and patient, going over the recent details about their care needs and treatment options.

We looked at nine sets of patients' notes who were receiving on going treatment for pressure damage to their skin and specific invasive treatments. In each case, staff had recorded each patient's needs, the outcome of assessments and a plan for future care.

Notes were kept in secure trolleys and put away when not in use. Where other health professionals such as occupational therapists and physiotherapists had been involved in a patients' care this was well documented. Staff told us they usually had time to ensure the patients' notes were up to date.

In one ward the number of patient days spent on the ward had increased. Senior nursing staff told us they had instigated more training with staff on documentation to ensure all sections were completed before they were moved to a different area. A staff member said, "We aren't used to completing updates on risk assessments as usually patients have moved on before they require review. It's been a learning curve."

The risk management results of checks on documentation around pressure damage varied on different wards. Nursing staff were able to explain the results in their areas and show us what measures they were putting in place to ensure the results improved in the following month. Staff told us results were on display and better ways of working had been discussed with them to improve the outcomes for patients.

Staff told us information was available on the trust intranet system. We saw a set of information on one computer entitled "Care Bundles". These gave details to staff about certain aspects of care. For example about the track and trigger system if someone was likely to be at certain risks because of complex needs and required close monitoring. This was an effective use of the system to identify risk to a patient who required a tissue viability assessment due to poor skin surfaces. We saw six sets of notes where this had been implemented and other health professionals were involved in the patients care.

In all wards and departments there were areas set aside for information for staff about different aspects of looking after different sets of patients. For example on the wards where the majority of stroke patients were there was information about the Stroke Association and how to access other health professionals. On another ward, where patients were recuperating after operations there were leaflets and posters about pressure ulcer damage and how to prevent pressure damage to skin. In the out patient department information leaflets were on display for staff and patients to access information on topics relevant to their specific problem. This was displayed near to where the relevant outpatient clinic occurred.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

The hospital has a visual hospital scheme and the bed manager and wards had boards which showed when a patient was fit for discharge or had past their discharge time. A meetings occurred every morning between Monday and Friday which was attended by the discharge liaison nurse, bed manager, assertive in reach team, social workers and other health professionals. The reason for the meeting was to discuss all those patients who were medically fit to be discharged and what processes needed to be put in place to ensure the discharge happened. They also reviewed the patients who were in-patients for more than five days,this was to commence a possible discharge plan for each patient.

Times of discharges were monitored. Discharges after 8pm were allowed from the emergency admissions unit and accident and emergency only.

Staff told us discharges into community care establishments were sometimes a problem as there was little availability locally. Staff told us dealing with social care services outside the county was often a problem and could delay a discharge. One patient's discharge had been delayed because they had an infectious disease and could not be readmitted back to their care home. Late discharges sometimes meant patients could not be treated on the correct ward. During our visit the Day Ward was oversubscribed as it could only take 12 patients and 19 had been booked in or moved from another ward. Another ward was helping them take patients so their treatment was not delayed.

One staff member told us the complexities of discharging outside the United Kingdom (UK). They had recently had to discharge a person back to Lithuania. They had been in touch with the Lithuanian Embassy and accessed translation services. Other staff told us how they repatriate patients to other hospitals within the UK if their care can be completed nearer their home. One staff member said, "There is a pathway to follow and we have goal setting meetings, then when appropriate have a meeting re discharge." The stroke unit was particularly well set up in planning meetings from point of arrival. One staff member said, "We plan from day one."

It is the responsibility of the ward staff to arrange the discharges but the discharge liaison nurse helped them to make referrals to other agencies, arrange complex case conferences

and complete health assessments both prior and during the patients stay.

Patients told us they had been involved in their discharge arrangements. One patient said, "My cousin is coming to pick me up, he arranged a suitable time with the staff." However another patient told us, "I keep asking them when I am going home. They have said this weekend, if it doesn't happen I am thinking of discharging myself, especially when I see people worse than me going home. The social workers have not been to see me in here."

We looked at three sets of patients' notes specifically around their discharge arrangements. In each case the discharge checklist had been commenced. in one case the patient told us the physiotherapist had involved them in discussions about the equipment they would need at home. The notes confirmed this. An electronic discharge letter is sent to the patient's GP when the patient leaves the hospital and a copy faxed to the community nurses if needed.

In two sets of patients notes we saw each person had been referred to the social services department two days after admission, so planning could commence.
Where required staff told us they liaised with outside agencies as part of the discharge planning process. In two sets of notes this had involved care staff for home care and the use of different equipment. Staff told us they gave patients leaflets on how to look after themselves. One nurse told us she was in the process of giving a person a leaflet about falls prevention.

Staff told us about one patient who was being discharged back to a care home and required an air mattress. The ward staff had asked the care home to confirm with them when this was in place so the discharge could take place. We spoke to a selection of care homes who had recently had patients discharged back into their care. Home care staff told us they were informed of a patient's discharge and the approximate time but this was often delayed due to transport difficulties.

Care home staff told us they generally received a discharge letter but this was often very medically orientated and did not contain enough information regarding nursing activities. Care home staff made a condition they would not receive patients if more complex nursing equipment was required until it turned up. This usually arrived on time.

Staff told us there is sometimes a delay in the social work involvement team becoming involved in discharge arrangements. One staff member said, "Sometimes there is a delay in social work involvement because referrals are not completed properly and they use medical abbreviations that we don't understand." Another staff member told us, "The healthcare checklist is a burden, it's an NHS document and the NHS staff do not understand the process of the checklist." We were told by staff this sometimes delayed the process when a person required a 30-day bed somewhere in the community. The provider may wish to note that all people involved in discharge should be aware of the healthcare checklist to expedite an appropriately timed discharge.

Patients told us one of the longest waits when they knew they were going to be discharged was for their medicines. One person said, "Try to co-ordinate medication with discharge to avoid a long wait i.e. over five hours." Another patient told us, "I was told I would be discharged three days ago and I'm still here." We noted this was due to the patients' unstable blood results when due for discharge. A more positive comment came from one patient who said, "From coming in to being discharged I had the very best of care. I was informed about my care from start to finish and was treated with kindness consideration."

We looked at the information which we had been sent prior to the inspection about complaints. The PALS department had dealt with five cases which had affected a patient's discharge. Some conclusions were still required for some cases.

We spoke with staff from the occupational therapy department. They told us they felt supported by the ward staff and were involved from day one in the planning for patients. They told us there was a quick ordering system for equipment which often aided discharge. A new team had recently been introduced into the discharge planning arrangements which could assist with quick, non-urgent discharges. The team were able to arrange transport home, take the patient, get in essential shopping and ensure the patient was safe.

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

Since our last visit the trust had changed the way certain wards worked. Areas had been combined and some specialities had moved areas. Staff told us, in some areas, the timings of the moves had been so quick they felt they had not been given time to prepare or settle into each area. One nursing staff member told us they felt, "Done to." We were informed the trust had communicated to staff by team briefings, specific communications via emails and briefings from the Chief Executive. Another method of communication in use was seen on one ward which used a staff meeting or monthly newsletter.The provider may wish to note the communication methods were in place, however not all staff were aware of all methods so felt disconnected with the way this had been dealt with.

Daily ward staffing checks were in place and we were given a copy of the weekly check list which had been collated by the matrons. The Safer Nursing Care Tool had been used on three wards and was planned for a further two wards. All wards reported recruitment to vacancies was in progress.

The review of staffing had also taken into consideration skill mix of staff. Staff told us this had worked well in most areas. The exceptions were; the day ward when after 4pm there could still be 12 patients but only two staff. Also Ward 2 night staffing levels had been raised but this was sometimes reduced if staff were brought in to cover for absence in the afternoon.Staff who worked day and night shifts on the rota told us the staffing levels for nights had been increased since the Sir Bruce Keogh review.

Staff told us the use of bank and agency staff had now reduced but they were monitoring the quality of staff being used. Some bank staff could not fulfil tasks such as monitoring blood sugar levels which put an extra burden on permanent staff. One staff member said, "We need more staff, better quality." Another staff member told us, We're a good team, we support each other."

As part of the commitment to ensure patients were happy with their experience the day ward patients were given a survey questionnaire to complete after their treatment. This was analysed and fed back to staff by the ward manager.

Patients we spoke with gave positive views about the staff. One patient said, "I was looked at straightaway, the level of attention was amazing. I had different tests done and staff

kept me informed about what was happening." Another patient told us, "Very pleasant stay, all been very nice, everything's fine." One other patient said, "It's been a refreshing experience, staff kept me informed, nothing was too much trouble." No patients reported their treatment and care had been delayed due to staffing issues.

Staff told us they felt supported by their ward managers and felt they were approachable.Staff told us they were kept informed and trusted ward managers to pass on information.They told us there was a lot of reliance of electronic communication methods which staff had difficulty in finding time to access. However Matrons told us this was being reviewed. Staff said the human resources (HR) policies were lengthy and there was no flexibility to handle local situations, even when they knew individual staff circumstances.

We saw an area of the hospital which had been shut off where building work was in progress for a possible new type of palliative care unit. The trust has been in discussion with CQC about the registration of this unit.

Supporting workers ✓ Met this standard

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

Since our last visit all the staff we spoke with had received an appraisal or had one booked to attend. Records were seen to confirm these had taken place. Monitoring reports were sent to the board on a monthly basis.

All staff said they had access to mandatory training and any additional training depending on the service being able to release them. Each ward area had a clinical educator role. We spoke with three of them. They also confirmed releasing staff for specific pieces of training could be an issue.

Supervision was something which was not done on a planned programme. However staff told us they could speak to their line managers at any time. The supervision policy was due to be reviewed in November 2012, so was now out of date and the appraisal policy is to be reviewed in July 2014. Matrons told us they did have one to one sessions with their line managers and showed us the form used for each session.

Two new staff told us they had received an induction and shadowed staff when first working on the wards. Two other staff told us they had received preceptorship training, after they had initially qualified. This is a form of mentoring for newly qualified nursing staff.

Staff on some wards had been trained in specific tasks to aid the health and welfare of patients. This included training in lung biopsy, taking blood and draining fluid from a patient's abdomen. Staff were also encouraged to visit other units for ideas. This had worked well in the day unit when staff had visited other similar units and were now looking at the information gathered.

One ward was experiencing a gap in the knowledge and experience of some surgical nursing staff due to recent changes in the types of conditions which patients admitted to the ward were diagnosed with. The ward manager was monitoring the situation and was looking at skill mix in each. The training matrix was being merged, which we saw on the computer. Staff told us this would then give a better overview of staff skills.

Patients told us they had confidence in the staff. One patient said, "Excellent care,

everything was explained to me and I was made comfortable."

Doctors we spoke with told us they were supported by their line managers. They had received appraisals and had daily meetings with the consultant to discuss patients. They said they could raise any topic and felt their opinion was valued.

Health care support workers told us they had taken part in all mandatory training. They told us they had been encouraged to take part in the National Vocational Qualifications programme (NVQ). Some also told us they were looking at completing extended roles in areas such as cannulation and phlebotomy.

Ward managers had recently completed a ward leadership programme. They told us it had been really good. One staff member stated it had been, "Inspirational."

One of the senior managers said money had been set aside to develop clinical nurse specialist posts in areas such has diabetes, respiratory and cardiology nursing. They hoped this would aid training of staff.

Staff were aware that members of the board visited. This had been received with mixed views of staff we spoke with. Some said it was their time to get a view across. One staff member said, "I'll always speak with them, otherwise you can't complain your voice isn't being heard." Another staff member felt the visits had, "Tailed off."

The provider may wish to note that staff were generally not aware of the Ward Health check. We were told by a senior manager this was still under development and would be going to the Quality Governance Committee in March 2014. We have asked the trust to keep us informed of when this will be fully operational.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

During our visit we saw posters on display informing patients and visitors about the Patient Advice and Liaising Service (PALS). The provider may wish to note, in communal areas of the hospital, where patients and visitors were observed sitting, there was no information about the complaints process.

Patients gave us mixed views about the way complaints had been handled. One patient who had been unhappy with their treatment said, "We are not the complaining sort even though this has all gone wrong." They had however completed a Family and Friends survey form. Another patient told us, "Staff told me what to do if I had any concerns, which I haven't." We informed the Director of Nursing of one case where a patient and their relative had been particularly distressed. They had given permission for their details to be passed on. The Director of Nursing said they would ensure the person was contacted after the visit.

Patients on the wards could not give details of who had informed them of the complaints process but told us they had received some information. We saw some written responses from patients about the service they had received. One person said, "I would like to say a huge thank you for all the first class care we received from your team." A day patient told us they had been impressed details about PALS and making a complaint had been sent with their preadmission information. Patients in the day ward and out patients appeared to be more aware of the complaints process than ward based patients.

Staff from the PALS office told us this was a new service to the hospital and they aimed for a quick turn around of enquires and complaints. We looked at the computer records. We saw a sample of current cases which the department was dealing with. One area which they were currently working on was the response time for information from wards and departments. The provider may wish to note this was sometimes hampering the work of this department due to the slow response to information requests.

The cases we saw covered a wide range of concerns. Cases included assessments on admission, appointment times, car parking, changing of bed linen and discharges. The records gave clear pathways of what had been achieved so far and what further information was required to close a case. Where cases had been closed, information was included about how lessons had been learnt from each case.

Staff told us that outside the office hours a recorded message stated what information was required to enable the staff to contact the patient or visitor on their return. A similar undertaking was given to those wishing to use the email address.

Patients were seen by PALS staff in a quiet office, which was away from clinical areas. Staff would also visit patients on the wards. This service was only just developing and was not yet fully operational. Staff told us they were covering two other hospital sites due to staff shortages so could not develop this side of their work currently.

We were informed by staff the complaints process was a, "Work in progress." The new complaints process had been approved but was not fully operational. We had been sent the list of complaints which had been dealt with prior to the site visit. This gave us a view of where the pockets of concerns had been raised and how they had been dealt with. One staff member said. "There was a significant backlog of complaints, now cleared." A clearer system was now in progress of senior trust board members seeing formal complaints the day they came in. The process was now more in depth and took longer. Staff told us this ensured a thorough investigation was completed for each one.

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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