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

Date of Inspections: 13 February 2013
12 February 2013

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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	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✗ Action needed
Supporting workers	✗ Action needed
Records	✓ Met this standard

Details about this location

Registered Provider	United Lincolnshire Hospitals NHS Trust
Overview of the service	United Lincolnshire Hospitals NHS Trust has several hospitals. Grantham and District Hospital provides specialties such as surgery, medicine and orthopaedics. It also has a criticial 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 12 February 2013 and 13 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with staff, reviewed information we asked the provider to send to us, were accompanied by a pharmacist and reviewed information sent to us by commissioners of services. We reviewed information sent to us by other authorities, talked with other authorities and were accompanied by a specialist advisor.

What people told us and what we found

As well as inspectors from the Care Quality Commission we also took a pharmacy inspector and a theatre specialist.

During the visits we went to five wards, the theatre suites, the accident and emergency department, the pharmacy department, the critical care unit and the day care unit. We spoke with patients, staff and senior managers as well as relatives. We also looked at some hospital records.

Patients' privacy and dignity was respected and they felt involved in their care. One patient told us, "The curtains are always drawn if a doctor wants to examine me."

Patients were complimentary of the care they received and about how medicines were managed. However, one patient told us the administration of their intra-venous antibiotic was delayed by two hours.

Doctors and nurses raised concerns about staffing levels in wards and departments.

All the patients we spoke with told us of their confidence in the staff. We had concerns that not all staff had received appraisals and at times junior doctors did not feel they had the appropriate support.

Records were kept securely when not in use. Some documentation was not always completed.

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 24 April 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.

Patients' privacy, dignity and independence was respected. Generally, patients expressed their views and were involved in making decisions about their care and treatment.

Reasons for our judgement

During our visits we spoke to patients in all the areas of the hospital. We saw posters and leaflets on wards telling patients about how the hospital promotes privacy and dignity for patients. We also found members of staff had been appointed 'dignity champions' on the wards. Those members of staff were responsible for making sure their patients were always respected.

Patients' experiences were very positive. All of them told us they were called by their preferred name. They were involved in their care and had things explained to them by doctors and nurses in a way they could easily understand. One patient told us, "I know what is the matter with me because they've told me and they always ask my permission before they do anything." Another patient told us, "Staff have kept me informed of my treatment all the way along the line."

The trust had a policy with guidelines for the use of "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) forms with additional information for relatives. It was not clear from looking at patients' records whether staff had always adhered to the policy on such issues.

We saw patients were being cared for in single-sex bays on each ward. In all the areas we visited we saw curtains being pulled round patients and a 'no entry' sign was attached to them to make staff aware of the need to ask if they could go in. Patients told us they were always given privacy when it was required. One told us, "The curtains are always drawn if a doctor wants to examine me and they pull them if I need to have anything done to me."

When we spoke with nursing staff about how they provided privacy and dignity they were able to tell us in detail what that involved and how they respected their patients. For example, explaining procedures, pulling curtains around patients and calling them by their preferred name. They also knew they needed to ensure patients could be as independent as they were able to be. For example, washing and dressing themselves. One nurse we spoke with told us, "It's really important we communicate with patients. That's the way you

can find out what is important to them and treat them as individuals."

During our time of observing the care that was delivered in all areas we visited, we saw staff treat patients courteously and with respect. A patient in the accident and emergency department told us, "Staff are very courteous and they have listened to what I have told them." However, on one ward during a lunchtime observation we saw that one patient did not get the support they should have. In ten minutes, the member of staff hardly spoke to the patient at all and wiped their mouth with the side of a metal spoon when food had been spilt. We informed the ward manager about this. The trust may wish to note patients should be fully supported in a timely and respectful manner to maintain adequate nutrition.

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.

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

Reasons for our judgement

We spoke with patients about the care they received whilst they were in the hospital. In all the wards and areas we went to the patients told us they had received good care. One patient told us, "I have been treated excellently. The nurses are really good." Another one said, "I can't fault the care I've had at all. This hospital should be put on a pedestal. It's wonderful!"

Patients with allergies had been identified by the wearing of red wrist bands to alert staff. We saw a patient who was allergic to penicillin wearing such a band. Their care records clearly identified the allergy.

There was a robust system in place for discharge arrangements including, where appropriate, home visits for patients accompanied by occupational therapists to assess risk.

In the accident and emergency unit we found patients were complimentary of the care they had received. There was access 24 hours a day for patients requiring x-rays. At the time we visited a refurbishment programme was in place for the x-ray department which had led to increased waiting times for some patients.

We spoke with a senior doctor in the department who told us they did not have access to a paediatrician (children's doctor) all the time. We were told the East Midlands Ambulance Service always took children to Lincoln or Pilgrim Hospital but if a parent took a sick child into Grantham who needed specialist care, staff had to deal with the situation and wait for an ambulance to transfer the child. This caused them concern.

A senior nurse in the department informed us they always tried to ensure ambulance 'turnaround' times were no longer than 15 minutes. A 'turnaround' time is the time between an ambulance arriving at the hospital to deliver a patient and leaving again to undertake another job. If the department was busy this was not always achievable.

We saw doctors in attendance on all the wards and departments we visited except the day unit. Nursing staff told us doctors were available during weekdays, although it was more difficult to contact them at nights and weekends.

In the theatre areas we saw staff treating patients with patience and kindness. The World Health Organisation (WHO) surgical safety checklist was being used. The WHO surgical safety checklist is a procedure for use in any operating theatre and reduces risks to patients. However, not all recommendations for safer practice were being implemented. For instance there was no briefing before an operating list commenced or a de-briefing afterwards, which is recommended as good practice. When we spoke with the operating theatre staff they told us there were no formal processes for either. Additionally, we saw some issues over the wearing of jewellery, including an anaesthetist wearing a watch in one theatre. This was not in line with the hospital's policy which stated no-one should wear jewellery whilst in theatre. This is because it posed an infection risk. We also observed that in one theatre we did not see the 'scrub' nurse count the instruments used in the operation with a colleague at the end of an operation. A scrub nurse assists the surgeons.

We are aware new policies relating to safer surgery and swabs, needles and instrument counts are waiting to be agreed by the clinical effectiveness steering committee before they are put in place. Staff will also receive training about them.

We found there was no dedicated theatre for day-case patients. This led to changes to the way theatre lists were scheduled and had an impact on the discharge times for day case patients. We spoke with patients in the unit, some of whom told us they had to wait longer for their operations than they thought. One patient had needed medication as they had become anxious. The trust may wish to note that this was causing anxiety for patients who were waiting for their operations and was not an effective use of theatre time. Staff on the unit told us it was sometimes difficult to get medical assistance when the unit had to stay open at night time and weekends. This happened when there was an increase in demand for beds.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The service protected people against the risks associated with the unsafe use and management of medication.

Reasons for our judgement

To assess the management of medicines we spoke with patients who had been admitted to the hospital, pharmacy and nursing staff. Patients were complimentary about their treatment, how their medicines were managed and had no complaints. They said that they were provided information about medicines in a way that was useful to them. Patients told us generally they were provided with their medicines when they needed them without delay. However, one patient told us that the administration of their intra-venous antibiotic was delayed by two hours when administered during the night.

When we spoke with nurses, they told us that clinical pharmacy services were provided on the wards on a daily basis. Nurses said patients' medicines were checked promptly after they were admitted and pharmacists regularly reviewed their medicines. We saw recorded evidence of supplementary information and advice added by the pharmacy team to prescription charts. Nurses told us how medicines could be obtained urgently. However they said pharmacy advisory services were not readily available to them out of hours. They also reported that regular medicine supplies were received onto the wards and medicines were promptly received when ordered, including medicines for patients prior to their discharge from the hospital. The trust informed us it was looking at options for the future provision of pharmacy services. Extended hours would be considered as part of this development.

When we looked at prescription charts we saw evidence that when medicines were prescribed they were obtained and started promptly. We also found that record-keeping practices in relation to medicine administration were satisfactory. We noted that when medicines were not administered at scheduled times; nurses used a record coding system. Nurses explained that the coding system in place did not always fit the reason for not giving the medicine, so that they needed to write additional records. The provider may wish to note that the prescription chart coding system may benefit from review.

Whilst we were on the wards we noted that arrangements for the storage of medicines overall were satisfactory. However, the provider may wish to note that improvements should be made to storage arrangements in relation to the monitoring and recording of medicine refrigerator temperatures and by regularly changing clinic room door keypad codes to enhance security. We noted that whilst there was provision for patients to manage and store their own medicines whilst on the wards, self-medication by patients

when appropriate was not yet promoted by the hospital.

Details of a pilot scheme for the self-administration of medicines by patients were given to us following the inspection. We saw that this would be concluded by May 2013 and would be used for patients who were safe to self administer medicines across the trust by August 2013.

Staff told us there were systems in place to regularly monitor and improve the quality of medicine management at the service, that these were carried out by senior nursing and pharmacy staff and issues arising were raised directly with the departments. Nurses told us the audits had led to improvements in medicine management.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were times when there was not enough qualified, skilled and experienced staff to meet people's needs

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

In general patients were very complimentary about the care provided by all the staff in the hospital. A patient on one ward told us the staff were always cheerful. Another patient told us, "I think there's enough staff to care for us."

On another ward a patient told us, "They're (nursing staff) really helpful but they're rushed off their feet all the time. They can't come straight away when you call them. Last night there weren't enough staff on to look after us. If patients are really ill then there's a problem. I've seen it happen."

We spoke with doctors and nurses. Both groups of staff were concerned about nursing levels in all the areas we visited. A senior doctor informed us they were worried about the nurses in the Critical Care Unit (CCU). They told us, "They (the nurses) are very committed but they all work so hard and beyond their remit. I'm especially concerned about the skill mix of staff at night time. I would like to have a nurse with me on all the ward rounds I do but it is not possible because they're always so busy." We were told ward rounds without nursing staff occurred on the Emergency Assessment Unit because of the same reason.

The senior doctor also told us of their worries about having to use agency doctors because it had been difficult to recruit to posts. Because of this they covered additional shifts themselves and 'borrowed' colleagues' middle-grade doctors in order to provide the cover necessary for safe patient care.

We knew there had been concerns about nursing levels on CCU in the past. We found the unit was funded by NHS Lincolnshire and staffed to care for up to six patients at a time. The patients in CCU generally required a staffing ratio of one registered nurse to two patients. However, we were informed by staff that sometimes they could care for up to eight or nine patients in the unit with no extra staff. This had led to additional stress for staff and not being able to take their designated breaks. A nurse on the unit told us they had worked five shifts during their week of annual leave in January to ensure the unit was staffed safely. In addition we were informed that also in the month of January, a total of 16

shifts for day, night and weekends had not been covered.

In the accident and emergency department a senior doctor told us they felt there was a shortage of nurses on duty at times. The senior nurse we spoke with felt they needed an additional registered nurse on duty to ensure a nurse was always designated to undertake triage in the unit.

In other wards we were informed that staffing was a general issue. We found morale amongst staff was mixed. We were told it was better when nursing students were on duty as they could help the usual rostered staff. We were told that shifts to cover for staff annual leave/sickness were filled by bank and agency. Bank staff are the trust's staff who work on an irregular basis when they are needed. Agency staff are those who the trust employ on an occasional basis when bank staff are unable to cover the shifts.

On one ward we were informed by a nurse that staffing was, "not appropriate to meet patient's needs." We were told an email request had been sent to all wards the previous week to look at the staffing needs of the ward on one day, depending on dependency levels of patients. They had responded and requested the ideal staffing level being 'possible to cope with'. They told us there was no point in stating what they would really like because they would never get it.

A specialist nurse concerned with the care of patient's skin and pressure areas told us they would feel much more confident about how patient's skin was cared for if the numbers of registered nurses was increased on each ward and the skill mix was improved. They told us low staffing levels also raised issues with regard to access for training which they were concerned about as not all staff received regular training sessions. However staff did have access to e-learning.

In the theatre suite we found there was a full compliment of staff working. For example in each theatre there were two trained 'scrub' nurses, a runner (a person used for getting anything extra required for the operation), and an operating department practitioner (ODA). In addition there was an anaesthetist and a surgeon. There were also two members of agency staff on duty.

The person in charge of theatres told us agency staff were used on a monthly basis rather than on a 'when needed' basis. That meant the regular staff were aware of the agency staff's skills and knowledge base and could work as a full member of the theatre team.

We were aware the trust had been experiencing difficulties recruiting to vacancies across all its sites. Not all the advertised posts for both medical and non-medical staff had been recruited to in the current financial year.

The trust told us as part of their staffing improvement, a 'virtual ward' will be implemented at each hospital including Grantham. This will be a team of permanent nursing staff that will be used to support the usual staff team in wards and departments. It will consist of registered nurses covering twenty-four hours a day. They will be used to cover sickness, absence or where there is an increased demand. The trust informed us this will be safer than using agency cover. The teams are currently being recruited to.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard because not all staff had received appraisals and junior doctors at times lacked the support they needed to undertake their role confidently.

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

All the patients we spoke with told us of their confidence in the staff who cared for them, they felt they were competent and knew what they were doing.

We spoke with a range of staff on each ward and department we visited. This included nurses, doctors, therapists and ancillary staff. The majority of staff, but not all, told us they felt supported in their role and could always ask colleagues questions if they were unsure of something.

One member of nursing staff told us, "The ward manager will always help us." A junior sister informed us, "We will always find someone to support staff." A junior member of nursing staff told us, "My manager is really good. Her door is always open and I can talk to her at any time."

A registered nurse told us how they had felt really well supported by their ward manager when they had returned as a registered nurse following a period on the same ward previously working as a Health Care Support Worker (HCSW).

Nursing staff informed us they had access to e-learning modules and we saw they had received training sessions on topics such as infection control and fire. They described the courses. We also talked with nursing staff about courses on dementia and Parkinson's disease. One HCSW told us about the dementia course she had attended. With a colleague they will cascade the information to others in their team.

One HCSW told us their name had been put forward to attend training sessions but they were often cancelled. Another HCSW we spoke with said they had received training on how to undertake electrocardiograms (ECG), and a three day course on dealing with patients who had had a stroke. Face-to-face training is either carried out in the hospital or at other locations.

When we spoke with therapists they told us they had completed all their mandatory training. The physiotherapist said they had also undertaken a course on clinical governance. Clinical governance is the system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and making sure high standards of care are delivered to patients.

We also asked staff about appraisals. Appraisals are a way that managers look at how well their staff are doing their jobs and identifies any training and development needs; this normally happens once a year.

We found appraisals had not been completed for all staff in 2012. Some staff had got dates planned for this to take place whilst others had not. On one ward we were informed that appraisals had not been undertaken for some of their team due to lack of staff. They told us, "Patients always have to come first."

On another ward a HCSW told us they had worked on the ward for eight years and only had one appraisal. Another HSCW told us they had asked to complete a vocational training course in 2012 as part of their appraisal as they wanted to learn more. They had not been able to do that but had not been given a reason for it.

In the theatre suite we found new staff completed a local induction checklist. The trust's training department followed this up after 4 weeks to ensure that this had been completed. This was a generic checklist used across the trust. There was no induction specific to theatres. A member of staff confirmed that all new staff had a period of working with other members of the team for at least four weeks. New staff were not allowed to undertake any duties until they were 'confident and competent.' There was no formal process of assessment of competency, no formal training programme or competencies in place. Following our inspection we were informed by the trust there was no formal theatre induction at Grantham but senior management had taken immediate action to review the induction package for Lincoln County Hospital's theatre suite. This was thought to be appropriate and applicable to Grantham. They were therefore amending and updating the plan in line with the requirements of Grantham with a view to introducing it in March 2013. We were also informed some theatre staff had accessed a records training day run by the coroner which they had found very helpful.

Staff in the accident and emergency department said they had received 'conflict and aggression' training; newly appointed staff still required it.

Doctors we spoke with said they had access to all the training they required and in the main were well supported. A junior doctor in the accident and emergency department told us, "My consultant is always available during the day time hours. I'm well supported and can access all the training that is put on. However, when I'm on the wards I don't feel so supported. On one of the wards a senior nurse told us, "The junior medical staff find it quite challenging." Two junior doctors also told us this.

A consultant told us, "My FY1 (junior doctor) has on occasions felt under supported as I have no middle grade doctor.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

Reasons for our judgement

The patients we spoke with during our inspection were aware the hospital held records about them. Most patients said they didn't want to look at them. One patient told us they had read theirs. Staff we spoke with on two wards said they had offered to read them to patients if they wished.

In the ward areas, patients' notes were divided into two. The nursing and medical notes for patients' current admissions were stored separately to those of any previous admissions. This made files less bulky and easier to use by all the health care professionals involved in patient care. Most of the documentation in the files was easy to follow, although some of the doctors' handwriting was difficult to read.

All staff wrote in the same patient record, which ensured continuity and a team approach to care delivery. Patients' needs were being assessed and plans were in place on how to meet those needs. However, some of the care records had not been personalised to reflect individual needs of patients and dates and signatures were sometimes missing. The trust may wish to note that all care records should be individualised, dated and signed by those completing them.

We found on one ward a risk assessment had not been completed to reflect that a patient was prone to choking and they were not able to use the bell to call for assistance. They were worried about this. We brought this to the attention of the sister on the ward who said she would rectify this immediately.

When not in use patient files were stored in special trolleys. These were kept behind the nurses station to help maintain confidentiality and to ensure ease of access by all the healthcare professionals.

In the theatre suite and the Critical Care Unit we saw daily audits had taken place to ensure the trolleys used for cardiac arrests and for patients having difficulty breathing had been checked. This ensured all the equipment needed in such emergencies was always ready to be used.

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 activity	Regulation
Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were times when there was not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard because not all staff had received appraisals and junior doctors at times lacked the support they needed to undertake their role confidently. Regulation 23 (1) (a)

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 24 April 2013.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

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 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.

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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