

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

Royal Sussex County Hospital

Royal Sussex County Hospital, Eastern Road,
Brighton, BN2 5BE

Tel: 01273696955

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2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Cleanliness and infection control

✓ Met this standard

Safety and suitability of premises

✓ Met this standard

Details about this location

Registered Provider	Brighton and Sussex University Hospitals NHS Trust
Overview of the service	<p>The Royal Sussex County Hospital is situated in the heart of the city of Brighton. As part of Brighton and Sussex Universities NHS Trust it provides a full range of general acute services, accident and emergency department and a maternity unit and works in clinical partnership and interdependently with the Princess Royal Hospital in Haywards Heath. The site is also home to the Princess Alexandra Children's hospital and is the major trauma centre for Sussex and the South East.</p>
Type of service	Acute services with overnight beds
Regulated activities	<p>Accommodation for persons who require nursing or personal care</p> <p>Assessment or medical treatment for persons detained under the Mental Health Act 1983</p> <p>Diagnostic and screening procedures</p> <p>Maternity and midwifery services</p> <p>Surgical procedures</p> <p>Termination of pregnancies</p> <p>Treatment of disease, disorder or injury</p>

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 8 May 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

The inspection team included an advisor with specialist knowledge of infection control, and five inspectors. During the inspection we spoke with 44 staff, in a range of roles, including matrons, maintenance engineers, healthcare support workers, housekeepers, nursing staff, consultants, doctors, directors, managers and contractors. We also observed care and spoke with 19 patients and visitors. We visited a sample of elderly care and rehabilitation wards, orthopaedic, surgical and maternity wards. We also visited the eye hospital and the children's hospital site.

On the day of our inspection we found that the hospital was clean and procedures were in place to prevent and control the spread of infections. We spoke with many patients who were generally very positive about the standards of cleanliness. Most commented that they had observed staff wash their hands frequently, and made use of gloves and aprons when necessary. For example one patient told us, "It's definitely clean, the bathrooms area is always clean which is amazing on a maternity ward".

We found some areas of the hospital where the fabric of the building had become compromised. This presented a continual challenge for staff in their attempts to maintain acceptable levels of cleanliness. The provider had in place appropriate policies that assessed environmental risks and maintained the premises in order to ensure that people's rights to privacy, dignity, choice, autonomy and safety were protected.

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

Cleanliness and infection control

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The trust had systems in place to monitor and manage the prevention and control of infection. We met with the Director of Infection and Prevention of Infection (DIPC), deputy DIPC, decontamination lead and a number of infection control link nurses. We reviewed their job descriptions and discussed with them their individual responsibilities for the organisation's infection prevention systems. Clear terms of reference were available that identified the governance structure and informed us about the range of monitoring and reporting systems used by the provider. This included how information was reported and shared by the relevant committees responsible for ensuring that people were safe from risk of infection. For example the Quality and Safety Committee, Health and Safety Committee, Safe Water Committee and the Hospital Infection, Prevention and Control Committee (HIPaCC). We looked at a selection of minutes from each of these committees but in particular those taken at HIPaCC. We noted that attendance had included a range of relevant stakeholders that included community healthcare teams alongside a mix of nursing, microbiological and consultant medical expertise.

When we looked at the organisational and assurance framework we found that it was underpinned with risk assessments and supported with a clinical audit programme that was designed to address each area of the service and then linked into the trust wide audit strategy. When we spoke to staff they told us that audit was embedded into their daily practice and there was a wide range of information available to them on the intranet site. We looked at a large sample of the audits and other data held by the provider about the prevention and control of infection. These audits included catheter care, cleaning regimes and hand washing practice. The results of the most recent hand washing audits demonstrated that all grades of staff adhered to hand washing policies. We found that the results of audits were displayed in some ward areas of the hospital but not in others.

We met with the Operational Director of Facilities and Estates and the external contractors responsible for the hospital's housekeeping arrangements. In December 2012 the contractor providing housekeeping services at the hospital had changed to an external contractor. We were told by managers and staff that this transition had presented challenges to both organisations but a range of robust mechanisms had subsequently been

put in place to monitor the effectiveness of the cleaning regimes. This included weekly and monthly meetings with senior managers of both organisations and was attended by the deputy DIPC. We reviewed action minutes taken at these meetings and found that they detailed the shortfalls in performance and identified corrective actions that had to be taken by the contractor with identified timescales. We discussed with the Chief Operating Officer, Deputy DIPC and Director of Facilities how this information was then used to assure the provider that sufficient and appropriate resources were employed to minimise and control the risk of infection to people who used the service.

We looked in depth at the range of audits undertaken throughout the hospital including in high risk and very high risk areas. We were told that where possible these had been completed jointly by representatives of the contractor and the clinical staff in the area. We were told that there was an expectation that any issues that had been identified during the audit would be rectified by the next day and be rechecked by the housekeeping staff. Staff told us that this was not happening on all wards but improvements had been noted. The contract with the external contractor included a system of audit that ensured that high and very high risk areas of the hospital would be audited weekly. These audits would be completed with a supervisor from the contractor along with a member of clinical staff. We reviewed the audits for the periods January to March 2013 and found that not all high risk and very high risk areas had been audited every week during those months. We asked to see April audit totals and found that significant improvements in the number of audits had been undertaken. Staff told us that these audits were not historically being undertaken with a member of clinical staff present but that this had improved of late. One member of staff told us that concerns had been raised about the quality of the audit tool being used and in response changes had been made.

When we spoke with staff throughout the hospital, but specifically on ward areas, we found that there was a view that the standards of cleanliness had deteriorated in the early months of the contractor being engaged. However, they told us that improvements over the past two months had been noticeable with more open dialogue now being promoted between ward teams, matrons, managers and the deputy DIPC. One improvement was the review and monitoring of bespoke cleaning schedules for each area. On one ward the ward manager told us that although there had been significant concerns when the new contractor was appointed they had noticed a vast improvement during the past month in the standards of cleanliness on their ward.

During our inspection we looked at ward areas, outpatients, sterile services, the maternity unit and the accident and emergency department along with corridors, visitor waiting areas and toilet facilities. All the areas had accessible and adequate supplies of soap, disposable towels, sanitiser and waste bins. When we asked people for their views on the cleanliness of the hospital they generally told us that they found the environment very clean. We spoke with a healthcare assistant who told us how they had been involved in 'silent watches' to observe hand washing practice amongst their colleagues. The results of this had been used at team meetings for training and discussion. Among the comments that we received were "I was pleasantly surprised about the inside of the hospital as it did not look promising from the outside" and "They are always cleaning and it's not an easy place to keep clean". One relative told us "There are signs everywhere for hand washing".

We found some areas of the hospital, particularly in the Barry building where the fabric of the building had become compromised. The provider might like to note that the impact of this presented a continual challenge for staff in their attempts to maintain acceptable levels of cleanliness. We observed that throughout the hospital it appeared generally clean and we found no build up of dust or grime on floors or on surfaces. Bathrooms and toilets were found

to be clean and we observed a lot of housekeeping staff in all areas of the hospital. One person told us “It’s really clean, they even clean under my bed”.

When we spoke with members of the housekeeping staff we found that they understood their areas of responsibility in relation to cleaning. Nursing staff told us they could access domestic staff out of hours when needed. Where this help had been requested this had worked well. There were cleaning schedules displayed on the majority of wards we visited, and the domestic and nursing staff knew where these were. In other areas, staff were able to locate cleaning schedules but these were not displayed. We found that there were sufficient supplies of personal protective equipment such as gloves available for staff and systems were in place to ensure the replacement of soap, paper towels and sanitiser on the ward. One patient who was very positive about the cleanliness of the hospital and vigilance of the staff told us “They all wear gloves all the time”.

Staff at the hospital were able to describe to us what they did in their daily work to prevent the spread of infection. All but one told us that they received an annual update of infection control training and were able to access further information on the organisation’s intranet. They were able to tell us who their contact link nurse was for infection control on their ward and were confident about how to access the hospital’s infection control team for any further advice and guidance. House keeping staff told us how their work was monitored by the supervisors. Staff were able to describe the areas and equipment that they were responsible for cleaning on the wards. They described the actions they were required to take should there be an outbreak of an infection. This demonstrated that staff knew the procedures to adopt to minimise the spread of infection.

We spoke with the decontamination lead, reviewed the decontamination policy and scrutinised minutes of the decontamination committee. We looked in depth at the associated policies that described how individual items of equipment used in the care of people should be cleaned and decontaminated. When we visited wards we scrutinised commodes, beds, hoists, slings, toilet risers and intravenous stands and found them to be clean. Staff were able to describe to us how they cleaned these items of equipment. We found that although the decontamination policy required green stickers to be used to identify clean items not all staff were using this system. This meant that not all equipment had a sticker to confirm that it had been cleaned. Some wards were using the stickers, some were not using them at all, some were using them but not filling them in, and others were using them on equipment that did not require stickers, for example on filing cabinets. Although there was inconsistency about using the stickers to identify clean equipment, when we questioned staff in a number of wards they told us that if they found equipment without the sticker they would automatically clean before use. We saw staff cleaning shared equipment such as commodes and physiotherapy items between use by different patients. This demonstrated that the appropriate standards of cleanliness and hygiene were maintained in relation to shared patient equipment. However, the provider may like to note that there was inconsistency amongst staff throughout the hospital in the use of green stickers to identify equipment that had been decontaminated and was ready for use.

When we asked staff specifically about undertaking and recording the decontamination of mattresses we found that there was an inconsistency in their understanding of the policy and associated procedures. We sampled the cleanliness of mattresses on different wards throughout the hospital, asked staff to describe the process and reviewed how decontamination was recorded. In all instances we found that although mattresses were being decontaminated there was no universal method for recording this. We were advised that the trust had recognised this and was in the process of issuing a revised policy which contained clear information for staff on how decontamination was to be recorded. This

demonstrated that the provider was taking steps to ensure that there was a uniform approach to decontaminating and auditing mattresses within the organisation. Although we reviewed the detailed initiative and supporting audit process which was being introduced across the trust we were unable to test the new system for sustainability.

There were systems for segregating linen and waste in accordance with the overarching trust policy. When we spoke with staff they understood these systems. During our inspection we saw people segregating and disposing of waste material in appropriately labelled and positioned domestic and clinical waste bins. We noted that sharps bins were clean, not over filled and mostly correctly labelled. However, when we visited the post natal area within maternity services we found that not all staff were familiar with the procedure following the introduction of new sharps bins.

Staff told us how infection prevention education was an integral part of their initial induction and mandatory training programme. The infection control specialist within our team commented that there was an overall sense that hospital staff took ownership and realised infection control was their responsibility and not just that of the infection control team and management. The link nurse network group was pro active and instrumental in providing additional educational days for all staff on an annual basis and when we asked staff on the wards they were able to identify their infection control link nurse. Ward managers told us that they assumed responsibility for ensuring that staff attended infection control training and took appropriate action when staff failed to attend.

The Sterile Services Department was governed by a range of policies monitored and reviewed by the Decontamination Committee. This committee had responsibility for assuring the provider that standards required for decontamination were being met. This included audit and monitoring of decontamination process and where appropriate the education and training of staff who undertake the decontamination of specialist equipment. We found that the correct monitoring and validation systems were in place and any specialised equipment used like endoscopes had been returned to the endoscopy unit for reprocessing in accordance with the trust policy.

Infection rates for the trust were widely disseminated via hospital news letters on the web and ward managers stated that the data was sent to them for distribution to their ward teams. We were told that the organisation took infection control seriously and when questioned staff were aware of targets for Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium Difficile* (C.Diff) cases. On many wards we saw information displayed showing infection rates for the hospital and specifically for the ward with detailed information on hand hygiene techniques for patients, staff and relatives. More detailed information on MRSA and C.Diff infections throughout the trust was available on the hospital web site. We looked at minutes of outbreak meetings and were able to see that root cause analysis had been undertaken following incidents or outbreaks.

Information leaflets were available to patients and visitors throughout all areas of the hospital. We found signs asking people to wash their hands when entering ward areas and patients told us that staff discussed the importance of hand washing with them on a regular basis. One patient told us "They always ask me if I want a hand wipe before my meals". We looked at the results of patient cleaning surveys that had been completed during March 2013 and found that 156 patient experience responses had been recorded and of that 40 had reported excellent standard of cleaning, 46% good, 12% acceptable and 2% poor.

Patients entering the hospital were routinely screened for MRSA colonisation, in line with

national guidance and the trust policy. This meant that nursing staff could take appropriate action to minimise the risk of cross-infections. We looked at the procedures in place to manage patients colonised or infected with MRSA and also for the management of C.Diff. Staff were able to describe to us the procedures to be adopted in order to negate the risks and detailed the availability and use of isolation facilities or single rooms when required. In the event of a suspected or confirmed infectious patient we found that staff were confident around the steps to take to reduce the risks of passing on infection to other patients. We found one person who had an infection being nursed with additional safeguards in place within a ward environment rather than being moved to a nearby isolation room. The nurse caring for the patient described how a comprehensive risk assessment had been undertaken to decide the best course of action for the patient. This had involved the ward team and the decision had been made to leave the person in the ward as they were at risk of falling. This demonstrated that staff considered the care needs of the person alongside the need to protect people from the risk of infection.

The Assistant Director for Facilities and Estates who holds the position of responsible person for water explained the water safety arrangements that were in place to keep people safe from water borne infections. There was a policy in place to address the management and control of water which was supported by a Safe Water Quality Management Committee that met monthly. When we reviewed the minutes for the last six months we were able to see that the deputy DIPC, Consultant Microbiologist, Operational Director and the Head of Risk Management were part of the committee in order to provide infection control expertise. Maintenance department staff told us that the department had put systems in place to check for safe water, had replaced taps and modified water supply pipe systems to minimise the risk of infection. The team leader said “We have two guys employed solely to constantly check and flush the water systems”. We were able to see that weekly water samples were supplied to an outside contractor for analysis with the results being reviewed by the Safe Water Quality Management Committee. This demonstrated that the provider had systems in place to protect people from the risk of contaminated water.

Safety and suitability of premises

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The provider had in place appropriate policies that assessed environmental risks and ensured that the premises protected people's rights to privacy, dignity, choice, autonomy and safety.

We spoke with the operational director responsible for the management of the provider's estate who described how the structure of the department had been split into three areas consisting of electrical, mechanical and buildings. We were told that the department employed 48 frontline staff, but was currently operating with a vacancy rate of 20%, due to sector recruitment issues. The director told us that the provider had used contractors and agency staff to cover these shortages.

We spoke with two members of the estates management team who described in detail the system that programmed and monitored the preventative planned maintenance schedule. This included reactive maintenance as and when issues arose. We were told that regular reports were generated that identified which tasks had been completed and those that remained open with the reasons. We saw evidence on the computer generated monitoring reports to confirm this. A team leader in the department told us "There have been big improvements in the past two years especially now that the rolling programme of maintenance has been developed".

We saw from documentation and reports that approximately 1000 to 1400 maintenance jobs were reported at the hospital in a month. These jobs were normally reported by hospital staff to a central 'estates helpdesk'. Upon receipt by the helpdesk, these jobs were allocated a job number and then prioritised in order of importance. An email was then generated and sent to the person who had reported the job advising them of timescales for completion. To support this we were shown a priority matrix that had been created to explain and establish the urgency of each job received. This matrix categorised jobs into five priority areas and staff told us it gave them clear guidance on the classifications for emergency, urgent, high priority, standard and new work.

We were shown copies of the monthly maintenance report known as a 'dashboard' for the month of March. This was used to show completed and outstanding jobs. We were able to identify how effective the maintenance department had been in completing jobs reported.

For example we saw that in March 1141 regular calls had been logged and 1047 completed by the end of the reporting month. This information had been fed into the overall hospital management board 'dashboard' and used to inform the monthly estates and facilities committee meeting. We were able to see from the documentation how the system also identified concerns that had been raised by Patient-Led Assessments of the Care Environment (PLACE) or as a result of Care Quality Commission inspections. We were told that an archive system was in place to monitor all jobs that had been carried out. We saw evidence of the archiving system to support this.

Patients that we spoke with told us that although the hospital was old and very tired in places generally they considered the building was being well maintained. Some areas of the hospital, in particular the older buildings such as the Barry building were historically coping with an old heating system in a Victorian building. Staff and patients told us that in the colder months when the heating was on the environment became unbearably hot but that staff did everything to keep them comfortable. We discussed these concerns with the Operational Director for Facilities and Estates who provided us with the estates action plan that had been developed to address these issues both in the short term and longer term. Work to implement remedial improvements was programmed to start in July 2013.

We asked staff throughout all areas of the hospital to describe how any faults or repairs were addressed by the provider. They told us how the systems had recently changed and this had improved the time taken for repairs to be resolved. A ward manager showed us the system that was used to monitor the repairs that were outstanding on their ward. Staff gave mixed reactions when we asked them how quickly maintenance issues were resolved. In cardiology, cardiac surgery, day surgery and endoscopy we were told that maintenance issues were generally fixed very quickly depending on how important they were. One member of the nursing staff told us "We had a leak in the ceiling a while ago and they fixed it within the hour". Another person said "I think that things are really good with the maintenance team now and the new call logging system works really well". However, the provider might like to note that in other areas we were told that the response times were not so good. For example one member of staff in the emergency department said ""We often get bits of plaster and paint knocked off the wall by the trolleys, but we report it and it doesn't get done. The emergency department is the 'shop front' and I think it looks bad when the public see that walls and doors are damaged". We spoke with a planner in the maintenance department who described how important it was to foster a good relationship with the clinical teams. The A and E department was used as an example of how estates staff had to work closely with A and E staff when recently replacing the flooring in the department. This ensured that there was minimum disruption to caring for patients.

As part of our inspection we tracked the processes that the organisation had in place for the handling, storage and disposal of various categories of hazardous and clinical waste. We found that there were arrangements and licences in place for the collection, classification and segregation of clinical waste that was in line with the current waste legislation. When we spoke with staff throughout the hospital they appeared knowledgeable about the policy and procedures that they needed to follow. Regular audits were undertaken throughout the hospital and we saw documentation to support that any issues were identified and rectified. We found that storage areas for clinical waste both at ward level and in external storage compounds were appropriately locked, secure and inaccessible to the general public.

In one area of the hospital we found a quantity of mattresses that were awaiting disposal being stored inappropriately in a corridor. This presented a fire hazard and also meant

that the corridor could not be cleaned effectively. When we discussed our findings with senior managers we were told that senior staff 'walked' around all areas of the hospital on a regular basis but had not identified this issue. Prior to leaving the hospital we were informed that the mattresses had been moved by maintenance staff to await collection in a more suitable location.

Staff on all wards told us that space was at a premium and often resulted in problems. We found areas, particularly in the ward areas in the Barry building where although staff knew where to take people for a private meeting we were told "It is a continual problem trying to find space" and "Sometimes we cannot order enough supplies as there is no where to store it". This meant that there was not always enough supplies on the wards and difficulty in staff finding somewhere private available for breaking bad news to people without interruption. In the maternity department staff expressed concerns that limited space meant that there was not enough space to have a single room facility if a baby had an infection but that the matter had been brought to the attention of the architects who were trying to find solutions. The provider might like to note that throughout the hospital staff reported that limited storage space was a problem.

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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