

***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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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

**Safeguarding people who use services from abuse** ✓ Met this standard

**Staffing** ✓ Met this standard

**Assessing and monitoring the quality of service provision** ✓ Met this standard

## Details about this location

Registered Provider	Brighton and Sussex University Hospitals NHS Trust
Overview of the service	Brighton & Sussex University Hospitals NHS Trusts accommodates one of the largest maternity services within NHS South East Coast. Maternity, Obstetric and Gynaecology services are provided on both of the trust main hospital sites. Pregnancies less than 34 weeks and higher risk cases typically transfer to The Royal Sussex County Hospital. Both sites have inpatient/outpatient and community maternity services including an early pregnancy unit and maternity day assessment unit.
Type of service	Acute services with overnight beds
Regulated activities	Accommodation for persons who require nursing or personal care 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'.*

	Page
<b>Summary of this inspection:</b>	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	4
<b>Our judgements for each standard inspected:</b>	
Respecting and involving people who use services	6
Care and welfare of people who use services	8
Safeguarding people who use services from abuse	10
Staffing	12
Assessing and monitoring the quality of service provision	14
<b>About CQC Inspections</b>	16
<b>How we define our judgements</b>	17
<b>Glossary of terms we use in this report</b>	19
<b>Contact us</b>	21

## Summary of this inspection

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### Why we carried out this inspection

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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.

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### How we carried out this inspection

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We reviewed all the information we have gathered about Royal Sussex County Hospital, looked at the personal care or treatment records of people who use the service, carried out a visit on 7 November 2012 and observed how people were being cared for. We talked with people who use the service, talked with carers and / or family members and talked with staff.

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### What people told us and what we found

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We took the opportunity to speak with many women during our visit and found that they were generally very complementary about the care and dedication of the staff looking after them. We were told that communication was good, staff referred to individual birth plans and women felt supported and listened to. A woman and her partner told us that they were aware that there was a virtual tour of the maternity unit on the hospital's website. We spoke with women attending antenatal appointments, during labour and on the post natal ward. All told us that they were very happy with the care they had received. One person commented, "It was really good." Another said "I feel really supported and safe here".

Women were happy to talk with us and confirmed that they were generally very happy with their care. They said they been provided with enough information and had their treatment fully explained with them. One woman commented, "I wanted to be quite flexible on the day." Another told us that they had brought their birth plan in when they were due to give birth, and staff had referred to it during her labour. They all told us that they would recommend the unit to friends.

You can see our judgements on the front page of this report.

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### More information about the provider

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Please see our website [www.cqc.org.uk](http://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

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### Our judgement

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The provider was meeting this standard.

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

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### Reasons for our judgement

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Throughout our visit we saw that women were treated in a calm, friendly, supportive and professional manner. Curtains were drawn during the delivery of any personal care and we observed staff knocking on doors before they entered rooms. We heard medical staff introducing themselves to people as they entered rooms and cubicles.

Staff confirmed that they had received training on privacy and dignity and said this subject was constantly discussed at their staff meetings. Staff confidently gave us examples of how they personally ensured that they promoted privacy and dignity for women in their care. When we spoke to a clinician he described how women were asked if they would like to be transferred to The Princess Royal Hospital, rather than automatically making an assumption that it would be acceptable.

We found Information in various languages on the website and widely displayed throughout the ward and antenatal clinic areas. At the entrance to all areas of maternity care a display of the word "welcome" in a large number of languages had been used to decorate the walls. For women who had very little or no spoken English, an interpreting service was available. The interpreters attend women in labour.

Facilities were in place for women to access midwives with specialist knowledge to support them through pregnancy, labour and postnatal. These specifically trained midwives provided services which included smoking cessation, substance misuse, teenage pregnancies, access to services for travellers and bereavement counselling.

Women told us they were asked to identify their preferred place of birth. They said they were aware that this plan could change at any time, according to their individual needs. We saw and reviewed a range of communications given to women throughout their pregnancy. This included how their preferred place of birth could change if specialist services were required or when one of the hospital sites needed to divert services. The provider may like to note that women told us that although they fully understood and accepted the reasons for this they would have appreciated more detailed information

about each site and its facilities. They said this would help alleviate any unnecessary stress when last minute changes were made, affecting what they thought was going to happen.

One of the mechanisms in place for capturing the views of women was the birth stories service which was provided by two senior midwives for women who felt they had a traumatic experience related to the pregnancy or birth. The midwives supported the women to go through the records and their memories and understand why decisions had been made and what actually happened. Records showed that this service was very positively received and had been instrumental in highlighting recurrent themes. As a result of the work being done, concerns around issues such as poor communication were being addressed and the number of complaints had reduced.

Throughout our visit we reviewed the maternity records of four women who were on the postnatal ward. We also looked at the records relating to their babies. We found that the notes made by midwives were usually very detailed and recorded women's preferences in relation to the care they received. For example, one record showed that the woman had not considered using the birthing pool but with careful explanation and encouragement by the midwife she had agreed to try it. The notes reported how beneficial the woman had found this in managing pain during the later stages of her labour.

When we visited the labour ward we were shown and told about the service provided to women and their partners when a baby died during pregnancy or birth. Women who were over 14 weeks pregnant were cared for on the maternity unit by a dedicated midwife, who remained with the family throughout. A special suite was available close to the emergency facilities but outside the labour ward itself. Here mothers were able to have the level of privacy and support they want as they said goodbye to their babies. Chaplaincy services were available with special memory books being created for the parents to keep. Staff described to us how important it was to be able to provide people with practical items like handmade shawls, cribs, as well as supporting them emotionally.

We spoke with a midwifery supervisor about services available to women and their partners when the birth had not gone according to their plan or expectations. We were told that all women who needed a caesarean section were offered a chance to reflect during their postnatal stay. Staff explained how many women undergoing emergency caesarean sections were not always able to recall the exact details about what was going on immediately prior to the surgery. This debrief offered them an explanation of why the surgery had been necessary.

During our visit we spoke to women who had recently given birth. One woman described how she had not responded well or bonded with the first midwife who had been attending her when she arrived on the ward. However, she was complimentary about how her comments had been taken into consideration and the subsequent midwife who remained with her until the birth of her child had been "wonderful and superb". Women told us that all levels of staff went to great lengths to explain care and options throughout their labour and directly after birth. They said they felt their privacy and dignity had been respected especially during a time like childbirth, when sometimes it could be challenging. We asked relatives to tell us about their experiences and we were told that "yes, I was fully involved and kept informed and involved". Another told us "I was involved probably more than I had expected but I know my wife appreciated that".

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

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**Our judgement**

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The provider was meeting this standard.

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

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**Reasons for our judgement**

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We looked at a number of records relating to the antenatal, birth and postnatal care of women at the Royal Sussex County Hospital. All records were well completed and showed that women were involved in the planning of their care and the care of their newborn babies.

Records showed us that full assessments were made during the antenatal period to ensure that any risks or concerns were identified early and could be acted upon. Notes showed that prior to admission in labour, a midwife or obstetrician had considered and assessed a woman/s mental health, alcohol and drug use, previous obstetric history and their body mass index. Information regarding fetal movements was contained within the hand-held notes that women were given when they book with the maternity service. Obstetric ultrasound facilities are available at several locations within the maternity service and we saw that the results were documented appropriately in the hand-held notes.

On admission to the unit all women were assessed by a midwife to ensure the information remained current. Advice was given and the woman either encouraged to return when labour was more established or admitted for monitoring and ongoing assessment. We saw that when risks changed these were identified, recorded and acted upon. For example, when a woman was assessed as being at low risk of a venous thrombotic event (VTE – a blood clot forming inside a vein) but needed an emergency caesarean section, then a reassessment was recorded on the drug chart and an injection given to prevent blood clots forming, if appropriate.

The hospital used an Obstetric Theatre and Recovery Integrated Care Pathway, to enable staff to record any assessments, observations or care in a simple and clear format. Most were properly completed, although some abbreviations we were not familiar with were used and some were quite difficult to read.

When we visited the labour ward we noted it was very calm, peaceful and quiet. All delivery rooms were occupied and the unit was busy but orderly. Staff were answering phones and giving advice to women regarding concerns about whether to come into the unit. We saw that staff were reassuring to relatives and partners and when we spoke with staff about pain relief in labour and were told it was very well managed. We were able to see that there was an anaesthetist always on call, should a woman want an epidural or need an anaesthetic.

We spoke with three women who told us they had been fully informed about their treatment and care either in advance of giving birth and or during labour. They had been provided with good information, been able to ask questions and had felt listened to. Where required they had been asked to consent to treatment they had received. They had also been happy with the pain relief offered during the birth. They told us that they had been fully informed about the options and any possible side effects, and had been given time to consider which option they had wanted to choose. Where this had changed during the labour they had been made aware of the options available to them.

We saw that where either elective or emergency surgery was necessary that the woman was properly prepared and appropriate safeguards put in place to prevent harm. We saw that the World Health Organisation (WHO) Surgical Safety Checklist for maternity was in use. The records we saw showed that in all cases the sections before and during the operation were properly completed.

The trust uses and Obstetric Early Warning System (OEWS) during the postnatal period based on a woman's vital signs being compared to expected levels. The form used shows clearly where the woman's observations have fallen outside the usual parameters and provides guidance as to the action the person making the entry must take. We saw that these were properly completed.

Staff told us and records confirmed that all women were examined by a midwife daily and the findings recorded. Where concerns were identified action was taken. Pain relief post delivery was discussed and women were offered appropriate analgesia. Their choices and decisions regarding their care and pain relief were found to be correctly recorded in their records. A comprehensive handover tool had been designed and developed by a senior member of staff and was in place. This tool promoted a framework for ensuring that handovers were structured. This included a clear clinical picture, appropriate patient history, full assessment of current needs, plan of action and then in summary - how best to share the information.

We looked at the baby records of several new born babies. All had been seen and examined prior to discharge. Midwives assessed the baby each day and had recorded any changes or concerns around feeding, skin colour or observations. Where concerns were noted, a specialist from the neonatal unit had been asked to review the baby. We saw that where possible babies who were likely to be unwell at delivery were born at this hospital. Babies born at the other trust site and needing more specialist care were then transferred. Very sick babies were then transferred to either the Royal Alexandra Children's Hospital, Brighton or to a paediatric intensive care unit.

**People should be protected from abuse and staff should respect their human rights**

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## **Our judgement**

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The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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## **Reasons for our judgement**

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We looked at the organisations overarching safeguarding policy and procedure and found that it included the local authority multi-agency safeguarding procedures. The Trust was able to demonstrate that it worked collaboratively with the local authority to safeguard and protect the welfare of people who used the service.

Women we spoke with and some of their relatives raised no concerns about their care or safety within the hospital. They told us that they were consulted about their care and asked to consent to care and any treatment as and when appropriate. They reported that in their view access and security of the unit was well managed. They also said that they felt there were enough staff to maintain a safe environment but acknowledged that staff were always busy.

Identifying individual competencies and responsibilities regarding the safeguarding of women and children was incorporated in the trust competency framework and training analysis. We saw how this identified the individual training requirement for all employees within the maternity provision and the level of training required. In the case of midwives this included assurance that midwives were aware of the issues surrounding domestic abuse and how to implement universal screening. Midwives were also required to be fully conversant with the mental capacity act and how it affected their practice. There was also an expectation that midwives were aware of their responsibility in undertaking and participating in safeguarding audits.

We spoke with the women's and children's governance lead who maintained responsibility for monitoring training specifically within maternity services. A major part of this role involved reassuring the organisation that that neonatal nurses were fully conversant with the safeguarding team and understood their remit within the organisation. We discussed the refresher training held across the Trust to ensure neonatal staff were aware of the issues which make an adult vulnerable and how to make a safeguarding referral. She was able to confirm to us that training data management systems recorded 86% of staff had received updated training on safeguarding. We observed how this training was recorded, monitored and reported both within the department and to a wider governance audience within the trust. This included any concerns regarding non attendance of staff required to attend.

When we spoke with staff during our inspection they were able to confidently demonstrate an understanding and awareness of safeguarding procedures. They were able to identify the safeguarding lead in their department and had knowledge of Deprivation of Liberty Safeguards (DOLS) legislation and procedures, including Mental Capacity Act assessments. They confirmed that they had attended training for this and how to identify, report and record any concerns. Staff told us that information, procedures and forms are easily accessible for them on the trust intranet.

We saw that there were clear procedures in place for staff to follow when a concern or allegation was raised. These procedures were monitored by senior management to ensure that issues were acted on and followed up correctly. Incidents were audited by the trust and lessons learnt from these incidents were communicated to the staff across the trust to reduce the risks of further incidents occurring in the future. The ward manager told us that staff were made aware of both the hospital's safeguarding policy and the procedures for raising concerns. This was done on their induction and staff were regularly reminded of these through team meetings and trust wide initiatives to promote these policies.

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

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## **Our judgement**

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The provider was meeting this standard.

People are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

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## **Reasons for our judgement**

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During the course of our inspection we looked at the maternity dashboard which is now part of the single operating model and reviewed monthly by the trust. This dashboard summarised key aspects of the service delivery. We saw that the dashboard dated 07 November 2012 confirmed that within the trust capacity issues were apparent. Mothers had been diverted to the maternity service on an alternative site on 30 occasions over the past six months. The service had also closed to admissions in the past six months on four occasions. This information had been used to support a business case recently presented to the Trust Board acknowledging how the Trust needed to work towards adopting a midwife to birth ratio of 1:30. It was currently running at 1:34. Senior staff confirmed that 15.12wte midwife posts and 4.28wte support staff had been approved by the Trust Board to support this initiative.

We looked at the staffing rota and spoke with senior staff on the maternity unit. We were told that there was a senior midwife who was designated as the labour ward co-ordinator (LWC) each day and was supernumerary. This reflected published guidance 'Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour' (Royal College of Obstetricians and Gynaecologists 2007). This states "To ensure 24- hour managerial cover, each labour ward must have a rota of experienced senior midwives as labour ward shift coordinators, supernumerary to the staffing numbers required for one-to-one care."

We asked staff who talked about working longer hours than they were paid for and taking short breaks. Without exception staff felt that although the service was working at full stretch they were still delivering a safe service for women. We spoke with a midwife who told us how some women are unable to have a home birth due to staffing levels. We were told that whilst community midwives usually attended labouring mothers during the day, at weekends and in the evenings a midwife had to go out from the labour ward to provide support. They said that sometimes this left the labour ward short staffed and the supervisor or manager had to attend.

When we spoke with a maternity care assistant and a nursery nurse they both reinforced how busy the unit was. They said that there were particular difficulties when the labour ward was very busy and staff had been moved from the post natal ward to support staff on the labour ward. They gave an example of when this had recently happened but described how senior staff had come up to work on the post natal unit during this period. Both

members of staff told us that they had felt well supported. They had been able to attend staff meetings on the unit and had regular formal or informal supervision with their manager. They talked of an 'open door' policy should they need to discuss anything supported by a formal appraisal system.

We saw records that demonstrated that not all women had immediately received the level of support they expected or needed to cope with early breast feeding. One woman told us that staff were very busy and "I had to wait until there was time".

Midwives were employed across the trust and provided specialist support. These include a teenage pregnancy midwife who worked with under 18 mothers, a substance misuse/traveller midwife who works with these vulnerable women, a breast feeding midwife, bereavement midwife and education team.

The level of low intervention deliveries has been below the target level of 605 since April 2012. For October 2012 it was recorded as 40.3%. During the same period since April, the level of emergency caesarean sections has remained almost entirely 'in the red' and appeared to be rising. In October 2012 the level was recorded as 18.6% compared to a target of 13%. These figures are not necessarily concerning but a trend to move away from the target significantly may be indicative of lower than ideal staffing levels.

The trust complies with current Royal College of Gynaecologists (RCOG) guidelines with 60 hours of consultant presence on the labour wards. The level of obstetric consultant and medical cover met the current recommended levels.

## Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

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### Our judgement

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The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

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### Reasons for our judgement

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We reviewed the systems that the trust used for managing risk and incidents. These were clearly defined in the Risk Management Strategy with board assurance frameworks in place and led by the Chief Nurse. We could see that they used incident reporting as a mechanism for minimising and reducing risks. This was set out in detail in a range of policies providing clear guidance on roles and responsibilities. There was a robust system in place for ensuring that incidents were discussed at individual and team level and supported by a range of governance, safety and quality committees to promote learning and change.

The organisation appeared to promote an open honest culture that investigated incidents, identifying what went well and what were the learning outcomes. Staff reported that they were supported to be confident and competent about reporting incidents, with opportunities for them to reflect and learn in a no blame environment. They told us that they knew how to report incidents using the Datix system and that they were kept informed about outcomes, trends and changes in practice.

Maternity services for the Trust have recently been successful in attaining level One for Clinical Negligence Scheme for Trusts (CNST). This scheme was set up by the government to try and improve safety and quality of care for service users in maternity. It provides the NHS with support when a claim is made against them where care is claimed to be negligent. In order to achieve level one the Trust needed to demonstrate that it had sound processes in place to enable staff to provide the highest level of care.

Staff talked to us and showed us the monthly staff newsletter for quality and safety in the Maternity services called "Quality Tweet". This publication explained how the maternity dashboard was used to highlight performance across both sites. Key risks were identified along with complaints and any lessons learnt. Staff told us how they could see at a glance any themes identified by women who had contributed to Birth Stories.

We found that there was a strong clinical audit programme embedded into practice, working to ensure that quality and safety standards were maintained. Multidisciplinary audit meetings were being held monthly. During 2012 audits had been undertaken and presented by Midwives, Obstetricians, Anaesthetists, Neonatologists and medical students. All these audits were cross site data collection unless the service was only

offered on one site. The robust and comprehensive audit plan designed for maternity services linked into the Trust wide audit strategy.

We asked staff to tell us how the organisation communicated lessons learned and quality improvements with them. We were told that regular departmental meetings were held at which all staff were welcomed and minutes were taken and published. Monthly divisional quality and safety meetings focussing on women's services were held monthly alongside perinatal mortality meetings and audit meetings.

During our visit we took the opportunity to speak with staff who were attending a conference to discuss 'working in a birth centre'. There was opportunity for interactive sessions enabling staff to discuss the implications for women, staff and the change to working practices. We found the style of the meeting to be very open and staff were actively encouraged in identifying the importance of establishing a philosophy of care. Staff were enthusiastic and told us how it was pivotal in assisting with the capacity of the service, provided additional choice for women and improved the job satisfaction for the staff.

We reviewed the systems that were in place to specifically address complaints. Whilst the service generally records a low level of complaints we viewed two and found the trust had responded appropriately in each case. In one instance we saw that as a result of complaint findings and lessons learned from this, changes had been embedded into the everyday practice of staff. One example was reflected in the exemplary handover tool that had been developed within the unit. This handover tool called "CHAPS "provided very clear guidance on how handovers should be targeted, clear and information shared in a timely and appropriate fashion.

We saw that the trust took steps to engage with women and reviewed evidence relating to the outcomes of satisfaction surveys and improvements that had been implemented. We reviewed a number of specific feedback processes that maternity and neonatal services used to capture women's views and experiences. A comprehensive questionnaire is sent to parents who have used the neonatal services six weeks after the birth and are then encouraged to attend the parents forum which is held quarterly. This was followed up with a quarterly evaluation survey sent out to new parents to enable them to comment on all aspects of their care.

There were a number of Patient Groups working with the hospital to bring about change from patient experiences. These included the Maternity Services Liaison Committee, whose membership has a broad interest including hypnobirthing NCT and others. The Patient Experience Panel also worked to capture the views of patient representatives to highlight concerns and promote change.

We were informed about the NHS patient surveys carried out nationally and saw that the trust monitored actions required as a result of this. In addition we saw that the trust also carried out their own surveys and engagement with staff delivering care within the service. Staff told us that they felt listened to and able to express views and ideas. The matron was able to provide a recent example where staff suggestions for improving the environment of one of the bathrooms had been adopted. When we asked women on the ward they told us that this restful and calm room was a delight "When you needed some relaxation".

## 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.

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**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.

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**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.

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**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

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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)

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### **(Registered) Provider**

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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'.

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### **Regulations**

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We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

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### **Responsive inspection**

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This is carried out at any time in relation to identified concerns.

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### **Routine inspection**

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This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

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### **Themed inspection**

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This is targeted to look at specific standards, sectors or types of care.

## Contact us

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Phone: 03000 616161

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Email: [enquiries@ccq.org.uk](mailto:enquiries@ccq.org.uk)

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Write to us  
at: Care Quality Commission  
Citygate  
Gallowgate  
Newcastle upon Tyne  
NE1 4PA

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Website: [www.cqc.org.uk](http://www.cqc.org.uk)

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