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

### Stoke Mandeville Hospital

Mandeville Road, Aylesbury, HP21 8AL

Date of Inspections: 03 March 2013
06 February 2013

Tel: 01296315000

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

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<td>✔ Met this standard</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✔ Met this standard</td>
</tr>
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<td>Safety, availability and suitability of equipment</td>
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</tr>
<tr>
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<td>✗ Action needed</td>
</tr>
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www.cqc.org.uk
**Details about this location**

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<th>Buckinghamshire Healthcare NHS Trust</th>
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<td>Stoke Mandeville is part of Buckinghamshire Healthcare NHS Trust. It provides a range of medical, surgical and accident and emergency services</td>
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<td>Type of service</td>
<td>Acute services with overnight beds</td>
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| 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  
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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'.

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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 6 February 2013 and 3 March 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 people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We were accompanied by a specialist advisor.

What people told us and what we found

During our visit on 6 February 2013 we visited ward 6, the respiratory ward, wards 8 and 9, medicine for older people, St Andrews part of the National Spinal Injury Centre, Accident and Emergency (A&E) and the Clinical Decision Unit (CDU). We also visited A&E and CDU out of hours on Sunday 3 March 2013. We inspected the regulatory activities of treatment of disease, disorder and injury, diagnostic and screening and surgical procedures.

Most people were positive about the care they received. Comments from people on different wards included "couldn't ask for better" and "care is very good". However, some people expressed dissatisfaction with general communication especially in A&E with regards to waiting times.

We found discharge planning processes were clear on all wards. On wards 6, 8, 9 and St Andrews there were regular multidisciplinary team meetings to ensure all aspects of discharge were considered for patients before discharge.

We looked at equipment in A&E and CDU. There were systems in place to ensure maintenance was carried out. Staff said sometimes it was difficult to rapidly access specialist equipment.

We found appropriate staffing levels were not always maintained on wards 6,8 and 9. This meant some staff were under extreme pressure to meet people's needs. Support for staff in the form of supervision, training and appraisal was not available for all staff on wards 6,8,9 and St Andrews.

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 23 April 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Stoke Mandeville Hospital to protect the health, safety and welfare of people using this service.

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

| 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.

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

**Reasons for our judgement**

On wards 8 and 9 we spoke with seven patients. They all said the care was of a good standard. One person said "staff treat me very well". Another person told us "couldn't ask for better". People said staff attended promptly when they used the call bell and at night. People said the ward was noisy at night due to other patients and "deliveries at night". This made it difficult for people to sleep. Three people said they had not been given enough information about their treatment plan, however this could have also been because they were confused at the time information was imparted. Nevertheless people said they were not well informed. One person said "don't know what is going on with my leg, nobody has told me". Another person said they had been on the ward four weeks before "being told about my condition". One person said it was difficult to speak with the doctor privately as they "come in with their entourage". They meant the consultant was accompanied with their team during the ward round. People were satisfied with the standard of care but frustrated by the lack of information about their treatment or condition.

On ward 6 we were told the ward had a lot of patients with high dependency needs such as breathing support. We spoke with three patients. They all said they had been kept informed about their treatment, although had different experiences about the standard of care. One person said "care is very good" and "doctors answer my questions". We spoke with a partner of one person, they said they were frustrated with the care of their partner, particularly regarding management of a pressure area. We discussed this with a senior nurse and following a review of the patient's records. The trust acknowledged in this case 'the involvement of the patient and family was not what we would have expected and this has been addressed.'

One staff member said the handover notes should be updated on the electronic system daily however, this did not always happen due to lack of time. We saw the current handover sheet dated '4/2/13', which was one day out of date. This meant all staff may not be up to date with changing patients' needs.

On St Andrews ward we spoke with two people. People had mixed views about their care
and treatment. Some people had complex needs for example, breathing support. One person felt the "care wasn't bad", however, their wishes were not always considered. They said they "were not turned when they wanted to be..."I spend too much time in one position". We reviewed the patient's care plan; it stated turning 'every three to six hours'. The turning chart recorded turns most frequently as every six hours; which was just within the care plan. We reviewed the records for the patient we spoke with; the care plans and risk assessments were in place though they did not fully reflect the person's individual needs. The care plan and records for changing the suprapubic catheter stated it should be changed every four weeks, however the change had been inconsistent. All the care plans were past their review date of '28/01/13', though they were reviewed by the end of our visit. We identified there was no information in the care plan relating to the patient's stoma care. The patient said they had requested to see the stoma nurse however, staff said they were not aware of this request and there was no record in the notes. The staff we spoke with said they knew what care the patient needed as the information was included in the handover sheet at each shift. The staff relied on this and verbal handover to ensure they were up to date with changing patient's needs. We found the care plans were task oriented as oppose to person centred and did not include how the person was feeling about their care.

We observed aspects of care during our visit, for example people being assisted with feeding. Staff appeared calm and respectful in their interactions.

A&E and CDU
At the time of our inspection visits the emergency department was undergoing extensive building work; this was expected to be complete by mid March 2013. Consideration had been given to make best use of the space during the transition; this included the erection of screens to make a temporary corridor, which preserved people's privacy and dignity, when people needed to be transferred between different areas of the department. There was temporary signage in place for people accessing the service. The provider may find it useful to note people said they were confused by the signage and in some cases people were waiting in the 'wrong' area. For example, in the A&E reception instead of the out of hours area. During our second visit we observed up to four patients on trolleys in the main area as cubicles were not available. Screens were available to give a degree of privacy when needed, at other times they were unscreened so that staff could observe people.

During our two visits we observed the department through busy and quiet periods. We spoke with 15 people. Everyone we spoke with said they were happy with the care provided. Though there were mixed views about the standards of communication, particularly regards to waiting times and the quality of the triage. People described the triaging as "very cursory" and "didn't tell me much". We spoke with a child and their parent in the dedicated paediatric area. They told us everyone had been good at ensuring the young person was spoken with as well as the parent. We observed staff were polite and considerate. For example, in the resuscitation area we saw a person was made comfortable and staff imparted information at a pace to suit the patient's needs.

Two people in CDU expressed concern the call bell was not answered as quickly as they would like. We reviewed the records of one patient; they showed the person had regular contact with staff, tests undertaken and were seen by the medical consultant before discharge to the ward.
Cooperating with other providers

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

On all the wards we found people’s health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Wards 8 and 9
We spoke with one person who said they were due to be discharged and arrangements had been made to ensure their home was safe to be discharged to. We saw the person’s records which recorded the person was ready for discharge and included input from the occupational therapist regarding aids and adaptations in place prior to discharge. We observed the daily multidisciplinary meeting. We found there was an effective exchange of information between nurses, physiotherapist and occupational therapist to facilitate the discharge process.

Ward 6
We looked at the record of one person who had been admitted from a care home. There was clear communication from the home regarding the person’s needs. In the hospital we noted the person had initially been admitted to the intensive care unit (ICU). At discharge from the ICU to the ward a transfer of care sheet was completed. This was to ensure appropriate information was relayed to the ward.

St Andrews
We were told discharges were planned in detail due to the extensive needs of patients. Multidisciplinary notes demonstrated discharge planning to ensure a safe discharge. We found there was a comprehensive assessment and planning process prior to discharge. This involved taking into account views of other experts involved in the patient's care for example, psychologist and surgeons. We spoke with one person who said they were aware a discharge planning meeting had been scheduled with them and their family's involvement. Discharges were managed and planned with the involvement of the patient and their family.

A&E and CDU
We observed there was a patient hand over system between the ambulance staff and A&E
staff. The department had a dedicated a rapid assessment nurse who reviewed all non-urgent patients brought to the unit by ambulance. The system seemed to be working efficiently and this was confirmed by members of the ambulance crew we spoke with. However they told us there were occasions when delays occurred at busy times. We observed two handovers from the ambulance to nursing staff. There was a verbal handover, to support the paperwork, of the patient's condition. We heard the ambulance crew informing the nurse one patient was deaf and had dementia. We noted the nurse took this into account when communicating with the patient. This demonstrated appropriate exchange of information to ensure people's needs were met.

Staff said they were clear about discharge arrangements for vulnerable patients. If there were concerns identified the person would stay in CDU until safe discharge could be arranged. Staff said they liaised with the person's next of kin prior to discharge to ensure the individual's safety.
Safety, availability and suitability of equipment  

Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

The trust had a planned preventative maintenance plan for all medical equipment, according to the manufacturer’s recommendations. This was scheduled and monitored electronically and we were told it was up to date.

People were protected from unsafe or unsuitable equipment because the provider had a clear reporting strategy for staff to follow if equipment was found to be faulty. It would be tagged with a work sticker and the medical engineering department informed. We were told the system worked well but occasionally items had to be “chased” if they had not been processed fast enough for departmental requirements. We looked at a range of equipment and found some items were labelled with expired service or portable appliance test stickers. Staff told us a new contractor had started bringing equipment maintenance up to date. We saw one item, an arterial blood gas machine, labelled as ‘out of order’. However, this had not been dated and staff were not aware of how it was being managed or if any action had been taken. This had the potential to result in an adverse outcome for a patient.

At the time of our visit on 3 March 2013, the computerised tomography (CT) scanner was out of order. We were told a risk assessment had taken place and the expectation was the scanner would be functional by the end of the following day. A short term resolution had been found in that patients in need of a CT scan were transported to Wycombe Hospital for the test. We were also told the magnetic resonance imaging (MRI) scanner was on site and operational; this could also be used if appropriate in place of the CT scan.

We were told there was sufficient basic equipment in maintained order but more specialist equipment, for example, a gynaecology lamp was sometimes difficult to acquire in a reasonable timeframe. This meant there could be delays in treating patients with certain conditions.
Staffing

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.

Staff on wards 6, 8, 9 and St Andrews were under considerable pressure to meet people’s needs. A significant number of shifts were filled with bank or agency staff. However, the impact on the workload of permanent staff was high. There were not enough qualified, skilled and experienced staff to meet people’s needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the ‘Action’ section within this report.

Reasons for our judgement

The trust used a nationally recognised tool known as the ‘Safer Nursing Care Tool’ to determine the staffing levels on the inpatient areas. This was used to calculate the optimum and minimum staffing levels. We were told the staffing levels for wards 6, 8 and 9 were reviewed in the last six months. We found that staffing levels for the month of February for wards 6, 8 and 9 were, at times, below the minimum level and while at times the number of staff may have been at the correct level the skill mix was not always as desired.

Wards 8 and 9

We observed staff were busy and they also said “it gets very busy”. One staff said there was not enough staff to meet the needs of patients. We were told a lot of patients required two staff to attend them and this impacted on staff availability to undertake other duties. One staff member said they “don’t always give the care the way we should”. They explained older people often needed to take “things slowly” and required more time to provide explanations. Staff felt they had to constantly rush tasks. Nurses told us they regularly had to stay one to two hours after their shift to complete paperwork and ensure patients’ needs were met.

We were told bank or agency staff were employed when needed, however agency staff were not permitted to carry out certain procedures such as intravenous administration. This impacted on the permanent staff who consequently would carry a heavier clinical workload. The trust provided data to indicate during the month of February 2013, 22 shifts were below optimal staffing levels and 24 were below the minimum staffing levels. We were told there was no ward clerk and this meant nursing staff had to manage phone calls and other administrative tasks which also impacted on the time they had available for clinical duties. Staff were under considerable pressure to meet people’s needs.

Ward 6
During our visit we found it was difficult to speak to staff without impacting on patient care and interviews had to be cut short. We spoke with three staff. One nurse told us a bid to increase staffing levels had been recently agreed due to an acceptance of the higher dependency needs of patients with a respiratory condition. Nursing staff told us they often had to work up to two hours over their shift to complete paperwork.

The trust provided data to indicate during the month of February 2013, 25 shifts were below the optimal staffing level and nine shifts were below the minimum staffing levels. One staff member told us there was no ward clerk which also impacted on nursing and healthcare assistant duties. However we reviewed the notes of the ward meetings and found there was one entry which indicated ward 6 had a part-time ward clerk.

The notes of the ward 6 senior staff meeting (dated ‘4.1.13’) recorded there was a 'lack of senior skilled staff impacting on junior staff'. The action to manage the situation was by rostering shifts to include 'a senior experienced nurse along side a junior nurse'. This was intended to ensure people's needs were met appropriately. Staff were under pressure to meet people’s needs.

St Andrews
One patient said the ward was "clearly understaffed" and they observed "nurses got more and more tired as the shift went on". One patient said an agency staff member did not know how to dress them and "it took two hours". Staff confirmed there had been staff shortages, although gaps were often filled by agency. However, agency staff did not always have the skills required to care for patients, this put a greater strain on the permanent staff. We were told recruitment was ongoing and the ward used regular agency staff to ensure a degree of continuity on the ward. One of the matrons told us the skill mix on the ward was currently under review. Staff were under pressure to meet people’s needs.

A&E and CDU
We were told A&E was fully staffed with medical and nursing staff. However one staff said they used a lot of agency staff. Other staff told us there had been an increase in patients since the emergency department at Wycombe Hospital had closed. However there had also been a corresponding increase in the number of staff to cope with demand. We were told the figures suggested that the actual increase in the number of patients had not exceeded the expected forecast.

We did not see anyone offered food during our visits. One nurse said "it was sometimes difficult to remember to order snack boxes, let alone have time to feed patients who may require assistance or special diets". However, we observed patient’s other comfort needs were met in a timely manner. Overall there appeared to be sufficient staff to meet people’s needs.
Supporting workers

Our judgement

The provider was not meeting this standard.

The provider did not have suitable arrangements in place to ensure all staff were supported through appropriate training, supervision and appraisal, to enable them to deliver appropriate care.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Wards 8 and 9
We spoke with five nursing and healthcare assistant staff (four permanent). All staff said they did not "have supervision". They told us there were no team meetings, although one staff said they attended team meetings through the transition period (the move of wards from Wycombe Hospital).

One out of four staff said they had an appraisal in the last year. One staff member said "morale was not so great". Two staff on ward 9 said they did not feel supported in their roles. However, ward 8 staff said they were supported by their manager. We spoke with one doctor who told us they felt supported in their role through supervision and training.

We reviewed the notes of the January 2013 ward 8 and 9 meeting. The notes included a message about 'future training and clinical supervision in 2013.' This indicated supervision was not currently in place.

Ward 6
We spoke with three staff. One said they had an appraisal in the last year and one said they had an appraisal seven years ago. One staff member told us supervision had been discussed at ward meetings however, was not yet in place. We were told individual training was being rolled out following a process of training needs analysis. This was confirmed by the notes of the team meeting dated ‘19/12/2012’. They indicated the ward leadership had identified issues and was implementing systems to support staff. For example, two team leaders were to identify staff training needs and cascade an appraisal system. The notes of the sisters meeting dated ‘5th February 2013’ stated appraisals had still not commenced. This meant staff were not supported through an appraisal system.

One staff member told us a lot of colleagues were upset with the staff changes and move
from Wycombe Hospital but they were hopeful things would improve when the new matron came into post. One staff told us mandatory training was undertaken by e-learning at home but it was difficult to claim the time back. Staff morale was generally poor.

We reviewed the notes of the senior staff meeting, dated '4.1.13'. These included an entry stating 'area of concern is the lack of senior skilled staff impacting on junior nurses…felt very unsupported and overwhelmed with concern and anxiety'. This was to be managed by ensuring rosters had a senior nurse alongside a junior nurse. This recognised that some staff were not supported in their roles.

St Andrews ward
We spoke with five staff, four of whom were nursing or care support staff. A newly qualified member of staff said they were on the preceptorship programme and were well supported. Another new staff member said they had not initially been put on the preceptorship programme though after four months this had now been addressed. They both said there was no supervision. One long term member of staff said they had never had an appraisal and another said they had an appraisal four years ago. One new staff member said they had not had any training, including moving and handling before their first day on the ward. While there was a system in place for supporting newly qualified staff, other nursing staff were not supported through supervision or appraisals.

One nurse said they attended training when needed and there was group supervision when new equipment was deployed. Staff told us a large amount of training was provided as e-learning, in order to complete it, it was often undertaken at home in their own time.

We spoke with one physiotherapist who said they had good support and annual appraisals. We spoke with one doctor who also said they were supported through regular one to ones with senior colleagues.

The trust said group supervision was provided in the National Spinal Injuries Centre, in the form of presentations, known as Schwartz Centre Rounds. There were records of multidisciplinary staff attendance and evaluation of the presentation by participants. However no staff we spoke with mentioned this as a form of supervision.

A&E and CDU
We spoke with six staff. Five staff said there was group supervision. Some staff told us they attended team training days, these incorporated team meetings. This was confirmed by one of the matrons who said there were three protected team meetings a year.

One staff said they had one appraisal in four years. Other staff told us they had annual appraisals and regular supervision. All staff said mandatory training was taken very seriously and everyone attended. All staff spoke highly of the support provided by the practice development nurses. Most staff said they were supported, however one staff said there was a culture of "us and them, with senior staff not speaking to junior staff".

We asked the trust to provide evidence of the supervision process. They reported 'We do not currently record clinical supervision training in this way and are unable to provide this at this time.' Other evidence they provided was a draft, undated clinical supervision protocol, however there was no record that it has been approved or implemented. There seemed to be a mismatch between the trust's perception of supervision and staff perception.
The trust provided staff appraisal figures which reflected the percentage of staff that had had an appraisal between February 2012 to January 2013 broken down by division: medicine, specialist services, surgery and intensive care - 28.44%, 54.07%, 55.92% respectively. By professional group these were: nursing and midwifery, HCA, medical and dental - 47.15%, 36.46%, 21.56% respectively. This meant low numbers of staff across all groups had been appraised in the last year, particularly in the division of medicine.

The trust reported overall statutory training attendance for November 2012 for integrated medicine, specialist services and surgery and critical care was 54%, 71% and 66% respectively. This meant low numbers of staff, particularly in the division of medicine, were up to date with mandatory training.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td></td>
</tr>
<tr>
<td><strong>How the regulation was not being met:</strong></td>
<td></td>
</tr>
</tbody>
</table>
| There were not enough qualified, skilled and experienced staff to meet people's needs, Regulation 22. |}

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation or section of the Act</th>
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</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Supporting workers</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider did not have suitable arrangements in place to ensure all staff were supported through appropriate training, supervision and appraisal, Regulation 23 (1)(a).</td>
</tr>
</tbody>
</table>

For more information about the enforcement action we can take, please see our Enforcement policy on our website.
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.

<table>
<thead>
<tr>
<th>Met this standard</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action needed</td>
<td>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.</td>
</tr>
<tr>
<td>Enforcement action taken</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.
## 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:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services - Outcome 1</td>
<td>Regulation 17</td>
</tr>
<tr>
<td>Consent to care and treatment - Outcome 2</td>
<td>Regulation 18</td>
</tr>
<tr>
<td>Care and welfare of people who use services - Outcome 4</td>
<td>Regulation 9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs - Outcome 5</td>
<td>Regulation 14</td>
</tr>
<tr>
<td>Cooperating with other providers - Outcome 6</td>
<td>Regulation 24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse - Outcome 7</td>
<td>Regulation 11</td>
</tr>
<tr>
<td>Cleanliness and infection control - Outcome 8</td>
<td>Regulation 12</td>
</tr>
<tr>
<td>Management of medicines - Outcome 9</td>
<td>Regulation 13</td>
</tr>
<tr>
<td>Safety and suitability of premises - Outcome 10</td>
<td>Regulation 15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment - Outcome 11</td>
<td>Regulation 16</td>
</tr>
<tr>
<td>Requirements relating to workers - Outcome 12</td>
<td>Regulation 21</td>
</tr>
<tr>
<td>Staffing - Outcome 13</td>
<td>Regulation 22</td>
</tr>
<tr>
<td>Supporting Staff - Outcome 14</td>
<td>Regulation 23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision - Outcome 16</td>
<td>Regulation 10</td>
</tr>
<tr>
<td>Complaints - Outcome 17</td>
<td>Regulation 19</td>
</tr>
<tr>
<td>Records - Outcome 21</td>
<td>Regulation 20</td>
</tr>
</tbody>
</table>

## 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.
(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.