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

Burnley General Hospital

Burnley General Hospital, Casterton Avenue, Burnley, BB10 2PQ

Tel: 01254263555

Date of Inspections: 21 November 2013
20 November 2013

Date of Publication: December 2013

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

- **Care and welfare of people who use services**: Met this standard
- **Staffing**: Met this standard
- **Assessing and monitoring the quality of service provision**: Action needed
## Details about this location

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<th>Registered Provider</th>
<th>East Lancashire Hospitals NHS Trust</th>
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<td>Overview of the service</td>
<td>Burnley General Hospital provides a range of hospital services for adults and children. This includes general and specialist medical and surgical services along with diagnostic and support services. The hospital includes an urgent care centre and the Lancashire Women's and Newborn Centre. The latter has facilities for the urgent care of new born babies and a full range of maternity services.</td>
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| Type of services | Acute services with overnight beds  
Blood and Transplant service  
Community healthcare service  
Diagnostic and/or screening service  
Long term conditions services  
Community based services for people with mental health needs  
Rehabilitation services  
Urgent care services |
| Regulated activities | Diagnostic and screening procedures  
Family planning  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Nursing care  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
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 20 November 2013 and 21 November 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 given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by local groups of people in the community or voluntary sector, talked with other regulators or the Department of Health and talked with local groups of people in the community or voluntary sector. We took advice from our specialist advisors and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We carried out a responsive inspection of Burnley General Hospital as a result of us receiving a number of concerns about the staffing levels on the Neonatal Intensive Care Unit (NICU). We also wanted to look at how patients using the close observation beds in the Central Birth Suite were supported. We combined this inspection with a planned unannounced visit to the Urgent Care Centre in order to check the urgent care pathway at this location.

We arrived unannounced at the NICU at 6.30 am on Wednesday 20 November and returned the following day to continue the inspection in the Urgent Care Centre. The Trust was not informed of our intended activities on the second day. Following the inspection, we spoke to 19 patients over the telephone who had recently been discharged from one of the services inspected.

We spoke to a number of parents of babies using the NICU and patients who had used the close observation beds, both during and after the inspection. The feedback we received from the majority of patients and parents was very positive and people in the main described good experiences and good outcomes from their stay or visit. Parents described the care and treatment they received as "very good", "amazing" and "impressive". People felt safe and confident in the ability and experience of the staff caring for their babies. Similarly, patients who had used the close observation beds were complimentary about the service they had received.
However, some parents also told us they felt there were not enough staff on the NICU and at times the staff seemed "stressed when rushed". We found concerns about staffing levels throughout the NICU. This was evident through our discussions with parents who were using the service, from interviews with staff at all levels and from other information which suggested the staffing levels had been a cause of concern for some time. We were assured the Trust was implementing appropriate strategies to manage this situation and there was evidence the Trust management had closed the unit to new admissions when workload exceeded staffing numbers or skill mix.

We found the governance systems and in particular communication with the staff on the NICU to be limited and this had led to reports of "low" staff morale.

Patients who were using or had used the urgent care centre were positive about the care and treatment they received. On the day of our inspection there was a good flow throughout the department and patients were seen in timely manner. The staff spoken with told us they felt they had enough staff to care for patients.

We found the governance arrangements for monitoring the quality of the service provided in the urgent care centre were well organised and effective. This meant there were clear systems in place to ensure patients were receiving a good service and any problems were readily identified and addressed.

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 05 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

<table>
<thead>
<tr>
<th>Standard</th>
<th>Met this standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>People should get safe and appropriate care that meets their needs and supports their rights</td>
<td></td>
</tr>
</tbody>
</table>

Our judgement

The provider was meeting this standard.

Patients experienced effective, safe and appropriate care, treatment and support which met their needs and preferences.

Reasons for our judgement

On the day of the inspection, we asked the mothers of six babies cared for in the Neonatal Intensive Care Unit (NICU) about their experiences of the care provided. All of them told us they had been kept fully informed by the doctors and nurses about the condition of their babies and the treatment they were receiving. One mother said, "If I have any questions they explain things in plain English". Another mother said, "The staff are really nice, I can't fault them nothing's too much trouble". One mother explained how the nurses were supportive and had encouraged her to become involved with caring for her baby. Two mothers told us they had been supported by the nurses to express breast milk to be given to their baby until the baby was strong enough to feed normally.

The care records were kept by each baby's cot or incubator and were readily accessible to all members of staff. These records provided detailed information about the care and condition of each baby. Records were written contemporaneously by staff so that they were always up to date. General information for parents and visitors was displayed around the unit, including contact details for the matron and staff, visiting arrangements and patient survey results.

The staff and matron described the emergency admission process when an ill baby was admitted from the delivery suite or home via ambulance. Babies were admitted directly into the critical care area via a quiet lift area and across a short corridor. This ensured the dignity of babies, mothers or families was not compromised. The entrance door led directly to the critical care area, thus minimising any psychological or physical disruption for other families on the unit. Babies were admitted and assessed in this area and nursed here until their dependency level reduced, they were then moved to the nursery areas.

During the inspection we visited the close observation unit in the central birth suite, where additional care and support was provided for up to two patients who experienced more serious problems before or after they had their baby. The unit was consultant led and staffed by midwives who had completed further specialist training. We spoke to two
patients who had been cared for in the close observation unit. Both patients said they were satisfied with the care they had received. One patient told us that the doctors and midwives had explained everything to her. She said, "They were fantastic." We saw the care records for one patient were detailed and provided information about the care and treatment provided.

We met with the Obstetric Anaesthetist, Consultant Obstetrician and two senior midwives, who provided us with the Trust's guidelines on caring for severely ill patients. The Trust team explained in detail the care principles underpinning the care provision in the close observation unit. All staff spoken with expressed confidence in caring for patients in this unit and told us a midwife with skills and expertise in close observation care was rostered to work each shift. We saw procedures were in place for escalation and transfer in circumstances where patients' needs changed and increased. All monitoring of patients nursed in this room took place at the side of the bed by the allocated midwife. While the close observation area was being used there was a midwife based in the room at all times.

We were informed that toilet and bathroom facilities were nearby, however, due to the patients' complex medical conditions it was unlikely they would be able to leave the unit to use the toilet. Patients were moved to a different area when their condition improved.

Following the inspection we spoke with two patients who had received care on the close observation unit. Both patients were complimentary about the service, one patient told us, "They really looked after me and couldn't have done more".

Similarly, patients who were attending the Urgent Care Centre (UCC) on the day of our inspection or who had recently been discharged were generally very positive about the service. One patient told us, "They were lovely and it was a very quick service" and another patient commented, "They were fine, they were polite and made everything straight forward".

From looking at the records and from our discussions with patients and staff we observed that patients were promptly assessed on arrival at the centre to determine whether they needed immediate attention or referral to another service. Patients were then assessed by a doctor who decided what treatment/advice was needed. One patient told us, "It was really quick; I was registered and seen within twenty minutes". Reception staff told us it was usual practice to notify patients of any delays that would affect their waiting times.

We spoke with six patients who told us the nursing and medical staff had given them time to discuss their condition/symptoms and that any treatment choices and follow up medicines and advice had been explained to them. We noted a range of advice and information leaflets were also available to support patients when they were discharged home.

We observed patient's health was monitored whilst on the unit and appropriate action taken in response to changes in their condition. All staff had received training in life support and were aware of how to respond in the event of an emergency. Staff told us this was updated on a regular basis. Appropriate equipment was available, however, sometimes acutely unwell patients arrived at the centre and one staff member told us "They have to go off round the hospital looking for things". We checked the emergency equipment and found it was clean, well-organised and there was evidence that it had been checked daily by staff.
Staff told us that both medical and surgical transfers would accept referrals directly to a ward at the Royal Blackburn Hospital. However, the provider may wish to note that we were informed this was not the case for those patients who had sustained hip fractures and had been referred to the orthopaedic team. These patients were referred to A&E and therefore may have to wait a significant time in two separate units before being admitted to a ward.

We looked at a sample of patients' healthcare records who had attended UCC. We found the records were well organised, so it was easy to navigate through the documentation to locate specific items of information. Staff highlighted they had good relationships with the community health care staff and social work teams. We saw evidence of effective working with the Independent Domestic Violence Advocate in order to safeguard and support victims of domestic abuse. We were also informed that patients over 60 years of age would be contacted by a representative from Age UK After Care, either whilst attending the centre or when they returned home, to determine whether they needed short term additional support. One patient spoken with told us they had greatly benefitted from this coordinated service.

After considering our findings, we have concluded that patients' care was planned and delivered, on all units inspected, in a way which protected their safety and welfare.
Our judgement

The provider was meeting this standard.

The provider had taken appropriate steps to ensure there were sufficient numbers of qualified, skilled and experienced staff on duty to meet the needs of the patients.

Reasons for our judgement

We saw staff were always present in each room on the Neonatal Intensive Care Unit (NICU). The ratio of nurses to babies was determined by the health and condition of the babies. This meant that babies requiring intensive care had a higher staff ratio than those who were improving and gaining weight. However, four of the mothers commented on the staffing levels and told us that at times the nurses were rushed. One mother said, "There's not enough staff, the ratio isn't as high as it should be."

The staff on NICU had recently had a restructure and nurses were now allocated to one of three teams. Each team was led by a band 7 nurse and comprised of a mix of band 6 and band 5 nurses and health care assistants. Initially the band 7 nurses (manager level) had been asked to spend all their time on non-clinical duties; however, in response to high levels of staff sickness they were reverting back to a clinical leadership role the week following our visit. It was clear these plans had already been put into place reflecting the senior team's commitment to providing safe care.

Inspection of the staff rotas revealed that most shifts had planned staffing of 10 to 12 qualified staff, but sickness reduced this and on occasions there were only eight staff working. The provider may wish to note some staff told us that working with reduced staffing levels caused great anxiety and concern. Staff said that compromises had to be made and priorities revised which did not always seem safe. A range of shortfalls were described when staffing levels had fallen below the desired level. For example, nurses reported to us they had worked many shifts without a break and routine tasks such as feeding the babies and hourly observations were delayed. We were assured none of the shortfalls had adversely impacted on the care and welfare of the babies.

On the day of our inspection the staffing levels on the NICU were sufficient and we observed staff being utilised across the unit to support the work associated with admitting a preterm baby from the birth suite. We were shown a document entitled "Optimising Staffing Numbers" which provided detailed guidance to staff on ways in which staff could be utilised to provide care across the unit at times of peak activity. There was also a clear escalation procedure which incorporated a flow chart advising staff how to escalate concerns about staffing levels within the Trust. We noted the procedure had been
activated on several occasions and the unit had been closed to new non urgent admissions when workload exceeded staffing numbers or skill mix.

Further to this the matron had carried out a staffing review of the NICU which was designed to identify current and future staffing requirements and address any associated areas of concern. We were given a copy of the review during the inspection and were told the review was due to be discussed within the Trust management team. We were also informed the annual leave and sickness management systems had been reviewed and strategies utilised included swift referral to “First Assist” (welfare and counselling service) and “Fast Physio” (priority access to physiotherapy services). The matron was receiving additional support from the maternity ward matron to implement the systems.

On our visit to the close observation unit on the birth suite, we spoke to the Obstetric Anaesthetist, Consultant Obstetrician and two senior midwives, who informed us that the ratio of midwifery staff was currently 1 midwife to 31.9 births. They explained this ratio was expected to reduce to 1 to 30.2 births following a recent staffing review. This is close to the gold standard of 1 midwife to 28 births set by the Royal College of Midwives.

We spoke to three patients and two partners of patients who had received care and support on the close observation unit. Whilst one partner had the impression staff were very busy and sometimes did not always pass on messages, none of the partners or patients raised concerns about the level of staffing. One patient told us, "It was a worrying time, because my baby was also on NICU, but they were wonderful and obviously really understood how I felt”.

On our second day we visited the Urgent Care Centre (UCC). The staff at the centre were preparing to move to a new centre on the same site. The centre was staffed by hospital doctors and emergency nurse practitioners, who saw, treated and referred patients to other specialists as required. We looked at the staff rotas and discussed the staffing levels in detail with an emergency nurse practitioner. We were informed there was limited use of agency staff and although there were occasions when staff had been moved to work at the Accident and Emergency department at the Royal Blackburn Hospital, this was rare. The emergency nurse practitioner and other staff spoken to told us there was sufficient staff to meet the patients’ needs. This was corroborated by our observations on the day.

We observed patients were seen in a timely manner during our inspection, however, one patient’s relative told us they had been waiting for some time to be transferred and during this time had not been given any update information. We raised this issue with a nurse and they immediately went to speak to the relative. Other patients were very satisfied with the level of service they received, one patient said, "It is a good service. I have been seen very quickly and everything has been explained to me” and another patient commented, "It has been much better than expected, all the staff have been marvellous and very caring and pleasant”. Eight former patients contacted after the inspection expressed similar views, with six patients describing the service as excellent.

In conclusion, whilst we had evidence that staffing levels were a significant issue on the NICU, we were assured that the provider had taken all reasonable steps to ensure there were a sufficient number of suitably qualified, skilled and experience staff. We had no evidence to indicate there were concerns about staffing levels on either the close observation unit or the urgent care centre.
Assessing and monitoring the quality of service provision

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

Our judgement

The provider was not meeting this standard.

Whilst systems were in place to regularly assess and monitor the quality of service, these were not always effective and incidents had not been consistently analysed in order to reduce the potential of harm to patients.

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

Reasons for our judgement

When we spoke with patients and their relatives and asked their opinion of the overall quality of the care and service provided. The overwhelming majority described the service they had received as "excellent" or "good". One parent whose baby had been cared for on the Neonatal Intensive Care Unit (NICU) told us "The staff and atmosphere were so good and they all made me feel we were in good hands" and a former patient of the Urgent Care centre (UCC) said "They were lovely. It was a very quick service; I was seen within a few minutes".

We spent time with senior managers in both the NICU and the UCC to gain an overview of how the trust was organised and governed. We were shown how the quality assurance systems known as "governance" worked to ensure the service was monitored and managed. (Governance is a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in care will flourish).

The governance systems used at the Trust were designed to facilitate the exchange of information from "ward to board and from board to ward". This meant there was continuous flow of information from patients and frontline staff to managers and then senior managers and vice versa to ensure quality and safety was monitored at all levels within the organisation.

The Trust was divided into five clinical divisions. Each clinical division was divided into directorates with each division and directorate having a quality and safety board. Each quality and safety board fed back information to the next level and then to the overall quality and safety board which reported to the trust's board of directors. Quality monitoring mechanisms were used in all divisions and directorates to provide information on the performance of the trust. These included a variety of auditing and reporting systems.
Feedback from parents and others using NICU was gathered on a monthly 'snap shot' basis; the results were analysed and recorded in various quality committees at unit, directorate and divisional level. We looked at the results from satisfaction questionnaires which had been completed by parents between February and August 2013 and noted an overall satisfaction score of over 85% for most months. This result was lower than many of the other departments in the Family Care Division (of which NICU is part). Staff told us they sought feedback on a continual basis from parents and families and were able to demonstrate how this had improved services.

Staff described a number of developments planned to improve the way in which feedback was obtained from families in the future such as the development of a "You Said, We Did" notices board and comments cards, however this was not in place at the time of our inspection.

We noted complaints were recorded and responded to in a timely way. Staff told us that any person wishing to make a complaint or provide feedback about service improvement were given the opportunity to meet with a senior member of staff in person to share their concerns. Responses written to people who had complained would be made either by the matron or business manager dependent on the nature of the complaint.

The trust used an incident management system to record, report and monitor incidents. The system was computerised and was known as Datix and the records were known as IR1s. We saw good evidence that senior staff were alerted in real time to any IR1’s raised by staff and were aware of incidents that occurred on the Unit. We spent time looking at the system and noted trends and themes could be identified and actions taken had been recorded. Whilst we saw evidence that staff were using the system and that some action had been taken as a result of IR1 forms this was not systematic. We found a large number of IR1 forms from January 2013 to November 2013 related to shortages of staff on the Unit. Whilst we saw evidence to support that action had been taken, for example on occasion closure of the unit to admissions and the annual leave and sickness absence policy had been reviewed, we saw little evidence to support that the information had been analysed and evaluated. Feedback to staff on this issue was poor and morale was described as 'low' by senior staff. We noted staff absence levels had increased to over 10 per cent for a prolonged period of time.

We looked at the reports produced by the unit, division and directorate which in turn informed the board of the quality of service. At division level we saw evidence that key areas that demonstrated quality of care such as IR1’s, complaints, staffing issues were all reported, however, there was lack of detailed analysis at both unit and divisional level. This meant it was not clear what actions the division or unit had taken or planned to take to address the issues raised through the IR1 process.

On our visit to the UCC, we found feedback from patients was gathered by using a sample of 30 customer satisfaction questionnaires. The results were analysed and recorded in various quality committees at unit, directorate and divisional level. We looked at the results from questionnaires from October 2013. These demonstrated a 90 per cent level of satisfaction with the service. The results were further analysed by the unit manager and areas for improvement had been identified for example the need for new toys and information about waiting times. Staff told us how many of the areas for improvement had also been incorporated into the plans for the new unit opening in January 2014.

We noted complaints were recorded and responded to in a timely way. Staff told us that
any patient or person wishing to make a complaint or provide feedback about service improvement was given the opportunity to meet with a senior member of staff to share their concerns. We were told that any complaint received by the department was investigated either by the nursing or medical lead and a response made to the complainant by the divisional business manager following an independent review of the findings. This meant the system for investigating and responding to complaints had some independence from the clinical team delivering care.

The UCC used the same incident management system as NICU known as Datix. On looking at the datix systems we saw good evidence that staff were using the system appropriately and that IR1’s were reviewed, actioned and responded to in swift manner.

We looked at the reports produced by the UCC, division and directorate which in turn informed the board of the quality of service. At all levels we saw that trends and issues were reported and that action was taken to reduce reoccurrence. Whilst some areas were outside of UCC’s control we saw evidence to support that action had been taken to work with partner agencies such as North West Ambulance Service to improve care to patients.

The UCC used a Child Risk Assessment Tool (CRAT) to assess if children were at risk from potential safeguarding concerns. The department policy required that this is completed on every child under the age of 18 years. We conducted a “snapshot” audit of 10 children who had attended the unit within the preceding 24 hours. We found that in 40 per cent of cases this CRAT tool had been used. Whilst senior staff assured us the low rate of completion of the CRAT had been highlighted as an issue and they had emphasised the importance of documenting consideration of safeguarding issues in all cases, we were concerned there was the potential for children at risk of harm not being identified.

We saw good evidence of ward to board feedback through executive, divisional and directorate news letters and staff were kept informed and up to date. Staff information boards were up to date and contained a variety of useful information. Planned changes to the way in which the department was managed were in the later stages of implementation and staff told us they felt this was a positive development. Staff reported high levels of satisfaction with their role, supervision and support, with peer review embedded into the UCC’s culture.

Senior staff articulated a clear vision for the further strategic (long term) development of the UCC and linked this directly to planned education and training of staff. However we found through talking to patients and staff and reviewing the information related to the quality and safety of the unit, there remained a lack of clarity around the purpose of the UCC and the types of medical conditions it could safely treat. We spoke with patients in the waiting room and found there was no consistency in what they saw as the differences were between the UCC and the Accident and Emergency (A&E) department at the Royal Blackburn Hospital. This had the potential to cause considerable confusion. We also spoke to a consultant, who identified this as a key issue. We found there were no audits taking place of the patients that were being transferred to A&E and no way of monitoring how appropriate these referrals were or how safe the transfers had been.

We concluded there were shortfalls in the operation of the governance systems used on the NICU. Whilst staff had consistently raised IR1 forms to alert senior managers of their concerns about staffing levels, analysis of the IR1 forms was limited and feedback to
frontline staff about the action taken to manage these issues was poor. This had resulted in a lowering of staff morale and increased sickness levels. Whereas we found the operation of the governance systems used on the UCC to be well developed and clearly understood by staff.
**Compliance actions**

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
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<tbody>
<tr>
<td>Maternity and midwifery services</td>
<td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td></td>
<td>Assessing and monitoring the quality of service provision</td>
</tr>
<tr>
<td></td>
<td><strong>How the regulation was not being met:</strong></td>
</tr>
<tr>
<td></td>
<td>Whilst systems were in place to regularly assess and monitor the quality of service, these were not always effective and incidents had not been consistently analysed in order to reduce the potential of harm to patients. (Regulation 10 (1) (c) (i)).</td>
</tr>
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</table>

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

The provider’s report should be sent to us by 05 January 2014.

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.
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.

<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>
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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.
## Contact us

<table>
<thead>
<tr>
<th>Phone:</th>
<th>03000 616161</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email:</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
</tbody>
</table>
| Write to us at: | Care Quality Commission  
Citygate  
Gallowgate  
Newcastle upon Tyne  
NE1 4PA |
| Website: | www.cqc.org.uk |

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