

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

## The Princess Royal Hospital

Grainger Drive, Appley Castle, Telford, TF1 6TF

Tel: 01952641222

Date of Inspection: 25 April 2013

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

**Respecting and involving people who use services**

✘ Action needed

**Care and welfare of people who use services**

✘ Action needed

## Details about this location

Registered Provider	Shrewsbury and Telford Hospital NHS Trust
Overview of the service	Princess Royal Hospital is an acute general hospital and is part of Shrewsbury and Telford Hospital NHS Trust. The trust is the main provider of acute services in Shropshire, Telford and Mid Wales. The hospital provides emergency services, medical and surgical investigations and a full range of diagnostic facilities and medical treatments.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely 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
What we have told the provider to do	5
More information about the provider	5
<b>Our judgements for each standard inspected:</b>	
Respecting and involving people who use services	6
Care and welfare of people who use services	9
<b>About CQC Inspections</b>	14
<b>How we define our judgements</b>	15
<b>Glossary of terms we use in this report</b>	17
<b>Contact us</b>	19

## 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 25 April 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 reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities, talked with other authorities 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

---

This responsive inspection was triggered by information that had been shared with us from patients, relatives, staff and a range of stakeholders. Concerns were raised about patient experience, care and safety. This was particularly around discharge arrangements, staff attitudes and an increase in the number of adult safeguarding referrals around poor care and patient experiences. Concerns about the lack of regard for patient privacy and the management of pressure ulcers were also raised.

We carried out observations on wards 9, 12, accident & emergency (A&E) and the medical assessment unit (MAU). We spoke with patients and staff in all the wards and departments we visited. Where patients were not able to talk with us for various reasons, we spent time observing how care and support was delivered. Most of the time interactions between staff and patients were positive and staff took time to explain what they were doing and why. We saw some positive examples of staff promoting patient privacy and dignity. However, we also observed situations where patients' privacy and dignity was not respected.

Patients described differing experiences but the majority of people we spoke with told us they were happy with the care they had received. Some patients experienced long delays in A&E waiting for a bed to become available on a ward. Not all of the patients we spoke with felt they had been involved and consulted in relation to their care and treatment. We found that on the whole staff were aware of the needs of patients and familiar with their treatments. However, some of the care records and assessments we saw did not reflect people's needs, or were incomplete or inaccurate. This meant there was a risk that not all patients experienced care, treatment and support that met their needs.

The trust had acknowledged that capacity pressures across the hospital were impacting on people's experiences and were actively addressing the challenges with health and social care partners. Following our visit to the Princess Royal Hospital we attended a "risk summit" meeting. This is a meeting at which organisations such as regulators, commissioning bodies, performance management authorities, patient representatives and other agencies meet to share concerns and hear what the trust is going to do to put things right. The trust now has a comprehensive action plan for improvement in place. This will be monitored closely by CQC and other stakeholders to ensure that improvements are made and maintained.

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

---

## **What we have told the provider to do**

---

---

## **More information about the provider**

---

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



Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

---

### Our judgement

The provider was not meeting this standard.

People's privacy and dignity was not always respected. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care and treatment.

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

We had received concerns about a lack of respect and dignity for patients and the lack of effective communication. We recently published a survey, which was completed by 516 people who were inpatients across the trust. They raised concerns that highlighted a lack of information about their treatment and condition, inappropriate arrangements for leaving hospital and patients' overall negative views and experiences.

The inpatient wards we visited had been separated into male and female areas in order to comply with national requirements on single sex accommodation in hospitals. In the medical assessment unit (MAU) we saw a notice displayed advising patients that in order to provide patients with specialist clinical care they were not always able to offer same sex accommodation as providing the best possible treatment must take priority. However, same sex washing and toilet facilities were made available. At the time of our inspection patients were treated in the same sex bays. We saw there were limited facilities to examine patients in private in the assessment lounge. This meant that patients would not be able to have a conversation or have their observations carried out in private if the other areas were already being used. Staff told us that patients had commented that this area was not very private and had been concerned that they could be overheard.

We spent time observing care on the wards and departments we visited. We spoke with patients to obtain their views about how they were involved in their care and whether their privacy and dignity was respected. We saw that staff always used curtains around the bed when assisting with personal care. Although we saw patients' privacy and dignity was protected for the majority of the time, we saw this was compromised on three of the four wards we visited. We saw patients that were not covered properly, including one patient whose genital area was exposed. We observed several staff walk past this patient and not take any action. Another patient was in bed naked below the waist in full view of people passing. We saw a patient taken out on a trolley through a busy corridor with part of their

body exposed with no consideration for the vulnerability of the patient in a public area.

Patients told us that staff usually responded promptly and in an attentive manner when they rang the call bells and we observed this during our visits to the inpatient wards. Patient's preferred form of address was displayed above their beds and recorded in their records. We heard staff use patients' preferred form of address. However, some staff addressed people frequently by using terms such as, "Darling" and "Sweetheart"...

On one ward we heard a member of staff ask if a patient wanted to open their bowels and later discussed their diagnosis with them and relatives in a loud voice. They made no attempt to lower their voice therefore everybody else on the bay overheard the conversation, including visitors. We also saw a patient being wheeled backwards in a wheelchair across the ward after being taken to the bathroom. This meant that staff were not respectful of patients' feelings.

We observed a staff member taking blood samples from patients. Although they spoke to patients quietly and sensitively, they did not carry out the procedures in private. We also overheard staff asking another patient if they wanted the toilet as they accompanied them close to the busy nursing station. We did also observe some good practice to include a member of staff close the doors to a bay, the privacy screening and window blinds to protect a patient's privacy and dignity when they fell in the middle of the bay.

On the same ward we saw a patient who was to be transferred to that ward left in their bed at the nurse's station. There was very limited interaction with them despite numerous staff around the nursing station at the time. Eventually the patient was taken back out of the ward. A member of staff confirmed that there had been a communication breakdown and there was not a bed for the patient.

On the inpatient wards we saw that the nurses accompanied doctors when they did their ward rounds so they could better inform the patient if they asked questions. However, we found that people's involvement in making decisions about their care, treatment and support was inconsistent. Some people told us that they did not feel involved in the decision making process about their care and treatment. This meant that they may not be advised of, or understand their treatment options, risks and benefits. Comments included, "No-one explains anything to you in here". "I don't know what's wrong with me" and, "The doctors talk to me but the consultants don't even acknowledge me".

One patient told us they had told the staff on numerous occasions that they were not receiving the prescribed amount of pain relief they needed. They felt they were not being listened to. They told us they were therefore self administering medication brought in from home without the knowledge of staff. A staff nurse overheard the conversation and told us they would immediately address it with hospital doctors. On their medication record we saw entries of medication being refused but this was not followed up or alternative options explored. Another patient described two members of staff as, "Absolutely brilliant" because they always explained procedures to them and would take the time to check their understanding. However, they also told us that some staff were, "Very bossy with me". For example, telling them, "You must eat your food" when they didn't feel like eating.

We spoke with two carers in A&E who accompanied and supported a person with a learning disability. They told us the hospital staff had been, "Brilliant" and had fully involved the person with their care and treatment. We observed staff directly speak with the person and provided them with lots of reassurance. We later saw them in MAU. They were very complimentary about the transfer process and told us the staff had acted swiftly,

efficiently and fully engaged with the person they were supporting.

We did not identify any concerns on ward 9 in relation to this outcome. Although staff on the ward understood the principles of privacy and dignity, two staff referred to, "Feeding time" when they provided examples of assisting people with eating. A patient who had been diagnosed with a terminal illness told us, "The staff could not have been better". They told us the staff went through things in detail and told them to approach staff for any further explanation whenever they felt they needed to. They told us they had been involved in their discharge and had been assured by their consultant that they had been placed on a priority list for treatment. We saw they were provided with a discharge summary and medication in preparation for their return home. We observed the ward manager responding to staff and patients whilst also overseeing and managing events that occurred. This gave a sense of structure and direction and created a calm and professional environment.

Patients on ward 9 told us they were asked for their information about their home situation, care and treatment and this was acted on. We saw that admission documents directed staff to ask about key information relating to patients' needs. An assessment of a patient's social needs was recorded within 24 hours of admission. Staff told us they had regular ward rounds, handovers and multi health professional meetings to discuss patients' views of the care and treatment. These meetings discussed the views of patients requiring specific assistance at the time of discharge. Staff said they would decide with the patient and their family how they could make improvements to meet their needs once they go home. This meant that patients' views were listened to. Staff encouraged patients and relatives to understand their care and treatment, express their views or manage their own care. Patients told us that they were told about any treatment they may need and made decisions about having that treatment. This meant that people were being given information which enabled them to make decisions about their care.

We observed ward 12 to be extremely busy and staff were very task centred. The efforts made by some individual staff did not appear to be replicated across the whole ward and staff group. We saw staff had little time to spend with patients. For example, we saw a member of staff ask a confused patient what they were trying to say but did not wait for a response. We also observed a member of staff standing over a person to assist them to drink rather than providing assistance at their level. During our inspection a person also raised concerns about the lack of appropriate equipment to include raised toilet seats and shower chairs on the ward. We checked the facilities and found an absence of these aids. The provider may wish to note that people with disabilities would not be enabled to shower or use the toilet in a dignified way that met their needs or promoted their independence. Non permanent staff we spoke with were unaware of the policies and procedures of the trust regarding patient discharge and privacy and dignity.

We read some public notices at the entrance to wards. These detailed the safety and quality indicators for the ward but were all out of date or empty. The information on them was not patient friendly. There was no explanation or interpretation. This meant people could not identify wards with high numbers of pressure ulcers or of patients who had fallen. One patient told us they had not been provided with a copy of the complaints procedure despite requesting it several days earlier as they wanted to pursue a complaint. Information available in A&E was sparse. We were told that there were plans to provide an electronic patient information screen that would provide patients with information about the hospital and the local community.



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

---

## **Our judgement**

---

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs because care was not always planned or delivered to meet the individual needs or to ensure the health and welfare of people who used the service.

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**

---

Prior to our inspection we met and spoke with other key partners from the health and social care sector and other organisations to gather their views about the hospital. We also spoke with senior members of the trust. Concerns were raised about how the trust was managing the increase in patient flow into and out of the hospital and that pressures on beds had been quite severe. The length of time people were waiting to be transferred to wards or discharged from A&E and the number of operations being cancelled due to increased pressures were also raised. We received concerns from the local authority about the increase in the number of people being referred into the safeguarding process and concerns about poor patient experiences that had impacted on their care and welfare. We were aware of some instances where patients were discharged with a lack of information or the wrong information, or where family or home situations were not taken into account. Information was not always provided in a timely way when patients were discharged to ensure people's safety and continuity of care.

We looked at patient flow across the hospital. A&E was used as a holding area for admissions for medicine and surgery when there were no beds. GP admissions were diverted to A&E. This had inevitably put pressure on the department and led to breaches of the A&E standards. A member of staff told us A&E was suffering from slow discharge into the community from the wards and lack of community support services. We saw the shift co-ordinator in A&E and the co-ordinator for MAU worked closely together to manage flow as well as possible. One member of staff felt that the medical staff moved around too much and the introduction of new doctors always resulted in delays in managing patients. They told us there was a shortage of medical staff in the department and the MAU was too small to accommodate the increasing numbers of patients. We spoke with a community matron in the Medical Assessment Unit (MAU) about their role. They told us they were doing a pilot project reviewing patients that could go home with the support of the District Nursing Team. Their view was that the patients required admission, review and stabilisation prior to discharge. They thought the focus should be on the complex discharges rather than admissions and would be feeding that back to the project lead.

In A&E we observed medical and nursing staff being attentive to patients' needs when they were first assessed and treated. One patient told us, "They have been very efficient." Another patient told us, "I've been here (in the cubicle) ages and ages and I don't know who's seeing to me, I'm fed up". Although we had received concerns about patients being treated in inappropriate places (trolleys in corridors), we did not observe this during our inspection. The department was quiet and people were assessed and treated in cubicles.

We spoke to patients about their experiences of moving from A&E to other parts of the hospital. Patients should not wait for more than four hours in A&E before being discharged or transferred to a ward. The trust has experienced a high number of breaches to this target since January 2013, including one major incident being declared. Some patients told us that they had experienced long waiting times. One patient described their journey through A&E as, "Bedlam". They told us they were waiting in the bay for hours and then moved to MAU, which was also very busy. They told us that patients were being moved in and out all of the time and said that the staff were, "Rushed". One patient told us they had been, "Hours in A&E waiting for a bed to become available". Another patient told us they had been transferred from A&E where it had been "Hectic" and they had been, "Stuck on a trolley for hours". They said, "The care has not been bad however". During our visit to A&E we did not observe any delays and patients told us that on their arrival they were seen very quickly. A patient on one of the inpatient wards told us they were, "Very angry" about their care and treatment and was going to make a formal complaint. Another patient who had been in hospital for a number of weeks told us their care and treatment was, "Absolutely excellent".

We had previously asked the trust to look into concerns about the care and welfare of people in relation to one particular ward. This was because we had received concerns from different people within a very short time frame. The trust undertook three ward reviews and provided us with a report of their findings. They told us the ward reviews were chosen, "To ensure a multi-professional and patient perspective and to ensure a variety of ward activity was observed, including nursing handover, protected meal times, record keeping and personal care". They told us the patients spoken with were very positive in their feedback about the care they received from trust staff and from regular agency workers. However, patients did acknowledge that night shifts did appear different to day shifts with more time taken to respond to call bells and the ward lights being switched out at late times. The trust told us they found no serious or immediate concerns regarding patient safety. However, they acknowledged that, "Due to the significant but improving vacancy factor for registered nurses there had been incidences where patient experience had fallen short of the standard we expect". Although they reported that the ward reviews gave assurances the staff team were inexperienced and there were concerns in relation to skill mix. They told us they were therefore closely monitoring the ward.

We visited the ward and found care and treatment was not always sufficiently planned and delivered in a way that would ensure patients' safety and welfare. We observed poor practice and patients themselves reported concerns about their care and treatment. There was little evidence of structure or planning; work was task-centred and reactive instead of being patient focussed and proactive. Staff were gathered at the nursing station waiting reactively for someone to call them, or direct them to a task. Staff told us they did not always have the time to attend to patients' personal needs such as hair washing. Staff considered that this was due to the allocation of patient bay areas being insufficient to provide all personal care on their shift. Permanent staff commented that they were not confident that communication regarding discharge care would be carried out correctly. This was because of the reliance on agency or bank staff. One member of staff told us, "It's always this busy. It's a nightmare".

We looked at the care records held for a small number of patients with a range of needs across the wards we visited. Overall we found the assessment of patients' care needs was variable. On the ward where we had received concerns we found some assessments were only partly completed meaning not all patient's needs were identified. Reassessment was not always undertaken. Referral to Tissue Viability nurses or the Dietician was not documented on the notes but on the electronic bed board system. Discharge planning documentation was not completed until the day of discharge. It was difficult to see how discharge was planned from the records we viewed. One set of records had no moving and handling assessment even though the patient was immobile. One body map had been completed but it was a male patient and they had used a female body map. We looked at the records for a person who fell on the same ward during our inspection. The risk assessments did not reflect the actual care given or aids used. This meant they were at risk of receiving inappropriate care which did not meet their individual needs. Staff we spoke with did not convey an up to date understanding of individual requirements. This demonstrated a lack of planning.

We saw staff had completed records for comfort round checks undertaken. These identified and determined the frequency of checks that staff needed to make on patients. The majority of these had been completed. However, the provider may wish to note that there was not a consistent approach to the completion of fluid charts as staff had not routinely calculated the person's total fluid intake. This meant that staff were not monitoring if the person was hydrated or not.

On ward 9 we looked at records that included an assessment of the risks of patients getting sore skin and how staff should support them to minimise this risk. We saw that patients had special mattresses on their bed that helped to reduce the risks of this and they had pressure relieving cushions on their chairs. Staff we spoke with understood their responsibilities in keeping patients comfortable and monitoring and reducing any damage to their skin. This meant that patients were supported appropriately to minimise the risk of them getting sore skin. We saw assessments of risk were carried out for problems concerned with a patient's nutrition. Arrangements were in place to ensure patients were protected against the risk of lack of fluid intake and poor nutrition. We heard staff asking patients who needed supplements what flavour they would prefer. Staff explained how they completed 'comfort rounds' to check on what patients had drank and eaten. We saw records that monitored what had been consumed by patients. This meant that care was planned and delivered to meet the patients' individual needs.

We had received concerns about how people were discharged from hospital. Although there were no trends specific to individual wards, inappropriate and unsafe discharge was a key concern across the hospital and the number of safeguarding incidents related to poor discharges had increased. Concerns around the discharge process included people being discharged without equipment, key information being omitted from the discharge summary, not working with other providers, and a general lack of communication. Other concerns raised included patients being discharged without funding or care packages in place and discharged in a poorly condition and dress and at inappropriate times (late at night or early hours of the morning). Some people had to be readmitted for care and treatment. Staff in the MAU commented that they sometimes could not provide the care they wished to, such as wound care, because of the pressure to discharge patients to the wards quickly.

Community matrons were working in the hospital to identify patients who could go home with appropriate support. However, some patients had been discharged from the hospital

with no assessment made of the person's ability to cope and the support mechanisms in place at home. We therefore reviewed the records and pathway of a patient who had complex needs. They had required the support of the mental health team the day before and we found a good example of integrated care working well for that patient's needs. However, discussions identified that the estimated date of discharge was being used as a target and was being constantly moved and not appropriately planned on admission. The provider may wish to note that the discharge planning process needed to be documented as a process and not as a checklist.

Staff on one of the wards we visited commonly said that people were very, "Laid back" in Shropshire and said it takes time to do assessments. They told us occupational therapy support was short and sometimes delays in discharge were down to transport. One staff member considered that the patient flow process was compromising patient safety and thought some decisions were not made in the patients' best interests.

We were told that senior management see 'culture' and 'communication' as the priorities for improvement. The management and Board were meeting on the day of our visit to discuss these issues and ideas for their resolution. This work and the ward reviews and other work that has taken place demonstrated a commitment and effort on the part of senior management to improve the patient experience. The need for strong leadership was acknowledged and was apparent in what we saw.

## ✘ Action we have told the provider to take

### Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures	<b>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</b>
Surgical procedures	<b>Respecting and involving people who use services</b>
Treatment of disease, disorder or injury	<b>How the regulation was not being met:</b>  People's privacy and dignity was not always respected. People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care and treatment. Regulation 17
Regulated activities	Regulation
Diagnostic and screening procedures	<b>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</b>
Surgical procedures	<b>Care and welfare of people who use services</b>
Treatment of disease, disorder or injury	<b>How the regulation was not being met:</b>  People did not always experience care, treatment and support that met their needs because care was not always planned or delivered to meet the individual needs or to ensure the health and welfare of people who used the service. Regulation 9 (1) (a) and (b)

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.

## About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as “government standards”.

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service’s records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

## How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

-  **Met this standard** This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
-  **Action needed** This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
-  **Enforcement action taken** If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

---

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

---

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

---

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

---

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.



## Glossary of terms we use in this report

---

### Essential standard

---

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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

---

### Regulated activity

---

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

---

### **(Registered) Provider**

---

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

---

### **Regulations**

---

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

---

### **Responsive inspection**

---

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

---

### **Routine inspection**

---

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

---

### **Themed inspection**

---

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

## Contact us

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

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.