Inspection Report

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

Trust HQ

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Date of Inspections: 16 February 2014
15 February 2014
14 February 2014
13 February 2014
12 February 2014
11 February 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	South Western Ambulance Service NHS Foundation Trust
Overview of the service	Trust HQ provides emergency and urgent care and some non urgent patient transport services for the residents and transient population of Cornwall, Isles of Scilly, Devon, Dorset, Somerset, Bath and North East Somerset, North Somerset, Wiltshire, Bristol, Gloucestershire and South Gloucestershire. The Trust is divided into three divisions; East, West and North.
Type of services	Ambulance service Mobile doctors service
Regulated activities	Diagnostic and screening procedures 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'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

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 11 February 2014, 12 February 2014, 13 February 2014, 14 February 2014, 15 February 2014 and 16 February 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

What people told us and what we found

During our inspection we visited six ambulance stations across the South West region, the Trust Headquarters and a hospital with an accident and emergency Unit. We listened to call handlers dealing with emergency calls. We spoke with 10 patients and 6 relatives. We spoke with 38 staff including call handlers, managers and ambulance crews. We also spoke with commissioners.

Patients we spoke with were positive about their experience of using the service. Comments included "kind", "professional" and "caring". One patient told us "They do a fantastic job." All of the patients we spoke with spoke highly of the staff.

We saw that staff were professional and able to demonstrate how they obtained patient's consent for treatment and the process they followed if a patient refused care or treatment. All of the patients we spoke with told us that their consent had been obtained prior to treatment. One patient told us "They asked my permission and explained themselves well."

We saw the provider had suitable well maintained equipment, facilities and vehicles which ensured patient's safety while they received treatment. There was equipment suitable for treating child patients as well as adults. Patients spoke highly of treatment received. One said "I would give them 11 out of 10."

We found the service was well-led with arrangements in place to monitor quality and effectiveness in the provision of care. A robust complaints system was in place.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We asked ambulance staff how they obtained consent for treatment from people and how it was recorded. One member of staff told us "We speak to people, get their permission." Another said "I set out people's choices. I explain what needs to be done and why."

We spoke with patients who had been treated by ambulance crews. One patient told us "The guys in the ambulance treated me very well. They asked my permission and explained themselves well." One member of staff told us "I always introduce myself, ask them if they know who we are, get their preferred name and use it, then I get a picture of what's going on."

We spoke with ambulance staff who told us that they had received training in the Mental Capacity Act 2005 (MCA) within the last twelve months. We saw the Trust's mandatory training workbook contained a section on capacity. The MCA is a legal framework which protects vulnerable people and supports them in decision making. Staff showed us flowcharts which they used to help them assess patient's levels of capacity.

We saw leaflets regarding the MCA entitled Assessing Mental Capacity. These leaflets were carried on ambulances. The leaflet explained that where a patient lacks capacity, it is permitted to act in their best interests in providing emergency care. The Trust had contacts with local mental health services across the south west.

We looked at 12 patient care records and saw that these included a section which confirmed whether consent had been obtained prior to treatment. The provider may wish to note that on four of these records the consent box had not been completed. Staff noted that it was not always possible to obtain consent, for example if a patient was unconscious. We saw that there was a free text box on the patient care record where staff told us they could record whether a patient suffered from dementia or had any learning difficulties.

Staff told us that all of the Trust's paramedics had been provided with an updated copy of Joint Royal Colleges Ambulance Liaison Guidelines (JRCALC). JRCALC examines consent in detail and includes best practice guidelines, disclosure of information, research, legal disclosure, best interests, and patient confidentiality. JRCALC also covers implications for consent in relation to sexual assault, safeguarding and mental health.

We saw that the 'Management of clinical records' policy contained information related to the importance of informed consent in relation to clinical referrals. This document reminded clinicians that consent for sharing information should be sought. We saw evidence that this consent for sharing information had been sought.

The provider had a policy on Mental Health and Mental Capacity. Staff showed us how they accessed this policy on their computer system. The policy had been prepared and reviewed by the Trust's clinical effectiveness group within the last twelve months. We also saw a copy of the Trust's 'Appropriate conveyance' policy which had been issued in April 2013. This included how to deal with a situation in which a patient refused to be conveyed in a vehicle. These policies meant that the provider had carefully considered patient's capacity to consent to treatment.

We listened to call handlers who were dealing with emergency calls in the control centre. We did this in order to find out how they obtained patient's consent. We found that the call handlers were calm, caring and professional during often very difficult calls. One member of staff told us "Calling 999 and asking for an ambulance is a form of implied consent. I always actively listen to what people tell me."

We found that staff had considered the difficulty of obtaining patient's consent if they had different communication needs. An ambulance crew member told us "We have access to a multi lingual language line." Another said "I write things down and show people what I mean if they are deaf."

We asked how staff responded when a patient refused care and were told that the patient was made aware of the risks of refusing treatment. Staff told us they explained the situation and took their time with people so that they could make a decision. A staff member said "If someone refuses treatment I ask them to sign a form." Another told us "Sometimes people refuse to go to hospital and even though we know it is in their best interest we have to accept their decision."

Ambulance staff we spoke with told us that if a patient possessed a treatment escalation plan (TEP), then a signed original copy was always taken with them to hospital. A TEP is a document which sets out decisions patients have made in advance of medical emergencies which may arise. This meant that patient's advance wishes had been considered.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

It was not possible during our inspection to travel in ambulances and observe care being provided. We visited emergency departments in a local hospital and asked staff about their experience of the ambulance service. All of the staff described their experience of liaising with the ambulance crews as being very good. One member of hospital staff told us that ambulance crews "are always professional, use humour to good effect and do a great job."

We observed the arrival of patients by ambulance at the accident and emergency department of a hospital. We spoke with 10 patients and 6 relatives and asked them about their experience of the ambulance service. We saw the handover system was well organised and supported by written evidence of care. We found that patient's needs were looked after because the two services worked closely together and shared relevant information.

Everyone we spoke with was very positive about their experience. Comments patients made included "kind", "professional" and "caring". One patient told us "I think ambulance crews are amazing."

We observed patients arrive by ambulance. A computer screen at the accident and emergency department showed the expected time of arrival of ambulances and details of each patient's condition. The ambulance crew met with a co-ordinator at the accident and emergency department on arrival. The crew made sure the care records were up to date whilst the co-ordinator arranged for examinations by a nurse, doctor or specialist. There was a range of rapid response teams available if required. For example, staff told us a stroke team would be on standby due to the importance of providing treatment within a short timescale. This meant that patients received timely treatment that met their needs.

Ambulance staff told us about joint team work undertaken between the Trust and the hospital. This included bariatric care for obese patients, stroke teams, cardiac teams and infection teams. This meant that patient's individual needs had been considered and a range of relevant treatment options were available.

Ambulance staff explained to us that they considered the individual needs of baby and

child patients as well as adult patients. They showed us oxygen masks in a range of different sizes which were available on board ambulances in order to provide effective care to babies, children and adults. This meant that the care and welfare of all patients, taking regard of age and size, had been considered.

Staff told us that the ambulance Trust considered a number of clinical interventions for patient care. The Trust recommended that all of these should be given for the best outcome. We saw information displayed in ambulance stations and in the accident and emergency department about this system which included details of treatment for head injuries, strokes and heart attack care. Staff told us that care records were monitored to check if the care and treatment had been administered correctly.

One patient told us they had been asked about their medical history and any allergies they had. This meant that people were treated as individuals and their different needs had been considered prior to treatment.

All the patients we spoke with were pleased with the short amount of time the ambulance had taken to arrive. One patient said "They seemed to arrive just as I finished speaking to them". All of the patients we spoke with told us the ambulance was well organised and clean and they had felt safe being driven by and accompanied by the ambulance crew.

We spoke with a member of staff in the control room about ambulance response times. They told us "You can see the screens on display which show our response times. I feel satisfaction in making sure we get to patients as quickly and safely as possible." We raised the issue of meeting the performance target of eight minutes to attend the most urgent incidents. A member of staff showed us the comprehensive improvement plan in place to address this. We spoke with commissioners who confirmed that they were satisfied with the progress the Trust was making.

We listened to calls being taken in the control room and heard patient's individual needs were always considered on every call in a most professional and calm manner. Control room staff showed us a triage tool called NHS Pathways used to assess emergency calls. NHS Pathways helped identify the nature of the response required. Control room staff told us how they asked questions to elicit relevant information about the patient's medical history. We heard staff use a range of questions to obtain more details such as the nature of any injuries and related pain. Staff always checked first whether they could speak with the patient themselves if possible, rather than through a third party. Staff told us "It's always more accurate to get the information straight from the patient themselves."

We looked at the NHS Pathways call handler competencies and indicators tool. We saw that this tool included on screen prompts which helped call handlers to capture relevant individual details during emergency calls so that patients could get safe and appropriate care that met their needs and supported their rights.

We spoke with ambulance staff about how they assessed a patient's needs. Staff showed us a written patient record form which was used to capture important details of people's conditions. This helped staff to adopt a consistent approach across the whole Trust. One member of staff told us "I introduce myself and explain the reason I'm there, I ask what name people preferred to be called, then I use that name. I get as much detail about their condition as I can."

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

For the purpose of this report, ambulance vehicles were assessed as the premises in which care and treatment took place. We visited ambulance stations across the five counties of Devon, Dorset, Wiltshire, Somerset and Bath and North East Somerset. We also visited the Trust Headquarters. The provider had taken steps to provide care in an environment that was suitably designed, secure and adequately maintained.

We saw evidence that emergency evacuation plans were in place both at Trust Headquarters and at ambulance stations. Personal Emergency Evacuation Plans (PEEP) had been prepared. PEEPs consider individual's needs to ensure the safe evacuation of everyone in the event of a fire or other emergency.

The ambulance vehicles we looked at were clean, recently serviced and maintained to a high standard. Vehicles with four wheel drive capability were also available for adverse weather conditions or challenging terrain. Staff told us that all the vehicles had a deep clean once every six weeks or as required such as after a major incident. We saw evidence which confirmed this.

One member of staff expressed concerns about the impact of high mileage on vehicles where one crew was required to cover a large geographical area. For example, one vehicle was two years old and had already completed 160,000 miles. Staff told us that vehicles were replaced every five years. We saw evidence that vehicles had been serviced at regular mileage intervals. This meant that the impact of high mileage on the safety of vehicles had been considered.

We saw that vehicles had alarm systems and satellite navigation. Each vehicle had a communications radio and a mobile phone on board. We saw that the provider had a system of daily vehicle checks in place. Equipment lists were available for each vehicle which detailed what they should carry on board. We found evidence that staff had completed this checklist before their shift began to ensure vehicles were safe and had the required equipment. Checks included the ambulance interior, exterior and patient areas.

Staff responses about repairs to vehicles were mixed. For example, we saw that where a

concern had been identified in relation to the brake lights on an ambulance, this had been recorded and reported for repair. During the inspection a member of staff identified that there was a problem with the seal trim on a windscreen on their vehicle, which they reported immediately. The majority of evidence showed that repairs had been made quickly.

The provider may wish to note that one member of staff told us that one vehicle had a faulty siren switch. They felt this potentially put them and others at risk. They said that this had been reported but they had been told that no action would be taken because the vehicle was due for replacement in the next ten weeks.

One member of staff at a different ambulance station told us "If a fault is identified with a vehicle, the ambulance is immediately taken to the garage for repair. We've got breakdown cover." The provider had arrangements in place to supply a replacement vehicle if the ambulance could not complete a journey.

One ambulance we looked at had a full clinical waste bin and a full sharps bin on board. The ambulance had been out of use in the garage for 28 days. The provider may wish to note that clinical waste had not been safely disposed of in a timely manner. When we brought this to the attention of staff it was rectified immediately. We looked at other clinical waste bins in other vehicles and found they had been emptied. A member of staff told us "Our policy is to make sure sharps bins are emptied when they are two thirds full."

We saw adequate supplies of personal protective equipment (PPE) including latex free gloves and decontamination hand gel. Staff told us they had been trained in the use of equipment. We saw records which confirmed that all staff had received training in the use of the equipment as part of basic life support training.

We saw the Trust followed national guidelines for safety and patient care in the use of equipment. For example, the Trust had recently achieved an award from the National Institute for Health and Care Excellence (NICE). This showed the Trust had taken appropriate steps to treat patients with the recommended equipment.

We saw that ambulances had first aid kits and specialist equipment which was easily accessible. We saw evidence that senior Trust managers met regularly to discuss the availability of equipment. This ensured matters regarding equipment supply could be addressed appropriately for patient safety.

We saw evidence that suitable equipment would be used appropriately by staff during patient care and treatment. For example, at ambulance stations we visited we saw that equipment guidance was displayed on notice boards. One member of staff we spoke with told us "I stay up to date through regular training, both mandatory and specialist training." We saw evidence that some ambulance staff had recently completed a course entitled "Transport of the critically ill patient".

We saw that ambulances had ramps or tailgate lifts which could be lowered in order to assist wheelchair users or people on stretchers. This meant that people could enter and exit the vehicles in a safe way.

The Trust had arrangements in place to provide safe and effective care in the event of a failure in major utilities, fire, floods or other emergencies. Vehicles with four wheel drive capability were available for adverse weather conditions. We saw the Trust had a business

continuity plan and was co-operating closely with other government departments as part of Operation Neptune's response to the recent flooding in the south west.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We visited the Trust's Control Centre to look at the systems in place to manage risk and ensure the safety of people who received care. One member of staff told us "I constantly review calls received here and if necessary check why we didn't meet a performance target. I'll look at why this happened – rural location, floods, traffic. Any local issues will be raised with the crew." We saw written evidence to confirm this.

We saw a range of methods to obtain feedback from people. These included quarterly Out Of Hours Service surveys, six monthly telephony audits, monthly "Making Experience Count" patient satisfaction surveys and ongoing feedback received via the Trust's website, by letter or by telephone. The vast majority of feedback was extremely positive. We read comments such as "I wanted to thank the 999 lady on the phone who talked me through saving my husband" and "the crew were very caring, sympathetic and instilled confidence".

Where feedback was not positive, action had been taken to address the issue raised. For example, concerns had been raised about delays at an accident and emergency department. Close liaison had resulted with the hospital Trust to reduce these delays.

All the patients and relatives we spoke with were complimentary about the service. At the hospital accident and emergency department we saw that the close liaison between the ambulance crews and the hospital staff had led to the achievement of a customer nominated award for delivering great service in September 2013.

We spoke with a new member of staff. The training they had received was supported by senior staff's observations and a sign off process. This meant that the Trust had a quality checking system in place on their induction process to ensure high standards of care.

We saw that the Trust had a policy and clear methodology on the investigation of serious incidents. There was a robust decision making process which verified the scale and importance of the incident and an analysis of the causes was carried out. Lessons learned were documented. For example, the improvement of inter-hospital transfer procedures had resulted from this process. The Trust could now transport an anaesthetist with a patient

from one hospital to another if required. This meant that the Trust liaised with other health professionals to continually improve the service provided.

We saw evidence that the Trust had sought professional advice and implemented it. For example, advice on the type of vehicle suspension for different types of emergency vehicles had been sought. We saw a vehicle suspension factsheet was available at ambulance stations. Staff told us that different types of suspension were now in place.

We found that the Trust had an effective incident reporting system in place. For example, analysis of incident reports had highlighted occurrences of defective skylights in some models of ambulance. This issue had been identified through the central incident reporting process and addressed.

We saw that health and safety audits had been conducted at ambulance stations on an annual basis. This audit examined the fire plan, fire risk assessment, security inspection, equipment, work environment, vehicles and an inventory of Control of Substances Hazardous to Health (COSHH). At one station, improvements to the garage area had been identified and were underway.

The Trust had conducted daily audits of all emergency calls received. These audits showed that appropriate action had been taken. We saw a copy of an audit which identified a call which did not meet the minimum standards. This has been subject to an internal adverse incident. The patient had not suffered as a result of the way the call was handled; they received a response in excess of their clinical need. This audit demonstrated where the Trust had identified the requirement for an investigation.

We saw evidence that regular audits of the emergency vehicles took place, together with infection prevention audits, monthly station reviews, clinical audits on patient care records, road traffic collision audits, medication and pain management audits, specialist audits on strokes, heart attacks and obstetrics.

We were shown the risk register which assessed risks, the controls in place and the actions to be taken. Handover delays at hospital had been identified as a serious risk. A number of controls were in place and the issue was being regularly reviewed with commissioners.

The Trust was exceeding two of the national standards for response to calls that accounted for the vast majority of the calls they received. The Trust was narrowly missing the third performance standard that applied to less than 5% of calls. The Trust had an improvement plan agreed with Monitor for these calls. Monitor is a government body which helps to regulate NHS Foundation Trusts. We spoke with commissioners who said "Since the action plan was agreed in November 2013, improvements continue to be made by the Trust. The Trust is progressing in the right direction."

Some staff told us that, until recently, there had not been any systems for learning from incidents unless staff were directly involved or there was a fundamental concern. However, in the last few weeks a new newsletter had been circulated called 'Reflect'. We saw this newsletter contained case studies of incidents that had occurred and the action that had been taken by the Trust to improve practice. An ambulance crew member commented that "'Reflect' is very educational."

We spoke with the Trust's Chief Executive Officer about the impact of the recent floods

across the south west on the safe provision of care by the Trust. They told us "Our performance standards still exist despite adverse weather. We are still meeting our targets. We are in constant liaison with other ambulance Trusts and government departments about how we operate in these challenging conditions."

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

We looked at the way the Trust managed complaints and concerns.

The complaints policy had been updated on an annual basis to include the ways in which complaints should be managed in accordance with Trust procedures. We saw that complaints had been considered as part of the Trust's business continuity plan. We found evidence that complaints were discussed regularly at the Trust's learning from experience group where senior managers from a wide range of different departments met to discuss continuous improvement.

The provider maintained a dedicated team which acted as a single point of contact for concerns and complaints. This was known as the patient experience team and included a complaints manager, two complaints officers and three administrators.

We spoke with the patient experience team. One member of staff told us "We receive both compliments and complaints about the Trust on daily basis. We always get back to people very quickly and try to resolve issues to patient's satisfaction where possible."

The patient experience team explained they acknowledge complaints within three working days. We were told "Our team discusses resolution of the complaint on the telephone with the complainant. We check whether we can resolve it immediately to their satisfaction or whether it needs to be escalated." Staff explained that complaints could be escalated to a senior manager at local ambulance stations for investigation. Staff also told us "We will meet up face to face with the person if necessary, either at their home, at Trust HQ or on neutral ground."

We saw that the complaints system was brought to the attention of patients using this service, and their relatives. People who used the service were provided with a feedback form which included contact details of who to speak with should they have any concerns. We saw there were copies of these forms available at ambulance stations and in ambulances.

Some patients who used this service may not understand how to use this system. In order to help these patients, staff told us that they had access to a multi lingual language line

and that information was also available in larger font sizes, together with further information on the Trust website.

A record was kept of all complaints, comments and compliments received. We looked at these records and saw that 688 complaints had been received between 1 April and 30 November 2013. During the same time period, we saw that the Trust had received 859 compliments. Records showed that learning points from complaints had taken place where appropriate. For example, we saw evidence that ambulance crews had received operational advice after an incident.

We looked at the way the Trust had investigated a complaint made. We saw that they had followed an investigation plan and recorded all the actions taken. An action plan had been produced including identifying training needs for staff and we saw that this had been completed. This showed us the provider responded appropriately to concerns raised.

We observed ambulance crew interactions with patients at the accident and emergency department. We saw ambulance crews provided patients with details of how to make a complaint or a compliment should they wish to do so. We saw that they were polite, professional and used humour which patients told us they enjoyed. We heard an ambulance crew member ask a patient "How would you rate our service today?" to which the patient replied "11 out of 10."

Staff demonstrated a good understanding of the complaints procedure. For example, ambulance crews we spoke with showed us leaflets which they provided to patients in order to obtain feedback about the service. One member of staff told us "We give out these cards. People always want to thank us rather than complain about us."

Information on how to raise concerns and access to advocacy services was available on information boards in the accident and emergency department. Information was made available in formats to suit patient's understanding, for example larger font sizes.

All of the patients we spoke with who had used the service told us they were satisfied and did not wish to make a complaint, but that they were aware of how to do so if they wished. One patient told us "I will be writing a letter of thanks."

About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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