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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Tel: 01392261500

Date of Inspections: 24 January 2013
23 January 2013
22 January 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ 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 non urgent patient transport services for the residents and transient population of Cornwall and Isles of Scilly and Devon, Dorset and Somerset. The trust is divided into two divisions, East (covering the counties of Dorset and Somerset) and West (covering the counties of Devon, Cornwall and Isles of Scilly).
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 22 January 2013, 23 January 2013 and 24 January 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We (the Care Quality Commission) spoke with seven patients and two relatives. We spoke with managers, non clinical staff, call handlers and front line staff. In total we spoke with 40 ambulance staff. We also visited two local hospitals and spoke with three staff. It was not appropriate for the inspection team to observe front line staff at the scene of an emergency or during patient transport. We did listen to call handlers during 999 calls. We visited four ambulance stations and a training college.

All the patients and relatives we spoke with were very complimentary about their experience. One patient said their experience was "absolutely first class" and described staff as "calm and reassuring". Another patient said the standard of care was "excellent". They described the staff as "efficient and very kind". One patient summed up their experience by saying "It was everything you could want it to be."

Staff were professional and demonstrated how they treated patients with respect and dignity. One member of staff said "We listen to the patient. It's drummed in. We explain what we're going to do and keep the family up to date." All the staff we spoke with felt well supported to perform their role.

Records showed that appropriate procedures were followed with regard to the safeguarding of vulnerable adults and child protection.

Structures and processes were in place to manage service quality and risk. We saw evidence of the outcomes of these systems.

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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with seven patients and two relatives in emergency departments in two local hospitals. All were very positive about their experience. One patient told us how the staff "introduced themselves, asked my name and how I was feeling". Staff "explained what they were going to do down to shaving a couple of hairs on the back of my hand". They summed up their experience by saying "It was everything you could want it to be."

Another patient described the ambulance staff as "exceptionally nice, polite and pleasant". They said that the staff "listened to me at home" and were "nice to my husband". They added that the staff "came and said goodbye and wished me well". They concluded by saying "I couldn't really fault them."

Another patient told us how the staff had "fully explained what they were going to do and why". Following the handover of one patient we observed the member of ambulance staff shake the patient's hand and say "All the best then buddy. Take care." This interaction was well received by the patient.

We asked call takers to explain how they treated people with dignity and respect. One member of staff told us about how they used "active listening" techniques and made "good notes". This meant that they did not have to ask unnecessary questions where they had already gathered the information. One member of staff told us how they took care to remember a caller's name and were "polite and treated every call individually".

Another member of the control centre team told us about how they "explained the situation" and that people "responded well to honesty". They added "I get quite a kick out of giving the personal touch."

We spoke with a group of five ambulance staff and asked them to explain how they treated people with dignity and respect. One member of staff said "We treat all people the same, irrespective of colour or creed." Staff described how they kept people "covered", "used the

blinds on the ambulance" and "removed them to the vehicle ASAP" to give privacy. Staff told us how they asked people what they would like to be called and asked female staff to attend to female patients.

We asked staff how they involved people in making decisions about their care. One member of staff said "We don't assume consent." Another said they used the expression "I'd like to …" before proceeding with care. For example "I'd like to take your blood pressure." Another said they used the phrase "Are you happy…?" Another member of staff said "We listen to the patient. It's drummed in. We explain what we're going to do and keep the family up to date."

We asked how staff responded when a person refused care and were told that the person was made aware of "the risks of not doing it". Staff "explained the situation" and were "patient" with people so that they could have time to make a decision. Staff added that people were asked to sign a form when they refused care. One manager said "We've trained our staff that all care must be done with consent."

We asked one member of staff about how they supported people to maintain their independence. They told us about how they gave people time to do what they could for themselves as appropriate. Staff also told us about their strong relationships with GPs and community health and social care teams which enabled them to make arrangements to support people to remain in their own homes.

We were told how ambulance staff worked with community health and social care teams regarding treatment escalation plans. A treatment escalation plan (TEP) was a record used to document a person's advanced wishes in relation to how care should be provided should they become very unwell or their condition deteriorate. We were told that details of TEPs were held on the ambulance management information system. Any concerns about the use of a TEP were fedback to the local authority safeguarding team.

Ambulance staff showed us a communication book they carried with them. This contained pictures which staff used if a patient could not speak English. Staff also had access to a telephone based interpreter service. Staff told us they had recently attended a Muslim patient and had asked permission to remove their dress, and replaced it as soon as possible.

Staff told us about the increasing number of people with dementia they were caring for. Staff explained the techniques they used to support people and their families. The provider may find it useful to note that a small number of staff said they had not received training on dementia. We noted that the trust had met with dementia carers to gain feedback on their experience.

We saw a range of information leaflets for people relating to common emergencies. Staff told us they found these very helpful particularly if a person was to remain in their own home. The leaflets could be accessed in a range of formats and languages.

We visited emergency departments in local hospitals and asked staff about their experience of the ambulance service. One nurse said that ambulance staff had a "good rapport" and that people always appeared "looked after" and "covered up".

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with seven patients and two relatives in emergency departments in two local hospitals. All were very positive about their experience. One patient described their experience as "absolutely first class" and described staff as "calm and reassuring".

One patient told us they had used the ambulance service a "few times" recently and the standard of care was "excellent". They described the staff as "efficient and very kind". Another patient told us they had been asked about their "history and allergies".

All the patients we spoke with were very satisfied with the time taken to respond to their call. One patient said the ambulance had arrived "almost immediately". All the patients we spoke with said that the ambulance was clean and they had no concerns about how it was driven.

We spoke with a manager from another NHS organisation who had a lead role in the commissioning or buying of NHS ambulance services. They described the trust as "a great organisation to work with" and added that they were "very good with the resources that are available". We raised the issue of varying performance between rural and urban areas and the manager explained the improvements being made to reduce the variation. The manager recognised the increase in demand for ambulance services and was very satisfied that the trust was doing all that could be expected within financial constraints. An ambulance manager talked us through a comprehensive business programme which included a range of improvement initiatives. We were also given examples of the impact these improvements had made on the service.

Call takers used a triage tool called NHS Pathways to assess 999 calls from the public to determine the type and timeliness of response needed. We spoke with call takers and asked them about their experience of using the triage tool. They explained that their role was to use the tool to assess the response needed whilst other control centre staff simultaneously managed response resources such as ambulance staff and vehicles. We were told that the first questions asked established if a person was breathing and conscious so that a timely response could be made in the event of a life threatening situation. Staff told us how they asked questions to gather relevant information about the person's medical history. They also told us how they were able to expand on certain

questions and "probe" in more detail; for example when assessing a person's pain. Staff told us about the importance of giving clear "worsening advice" should a person's condition deteriorate before the person had been seen.

We asked ambulance staff about how they assessed a person's needs. We were told that staff did not have a consistent approach but that all staff made a similar assessment. Staff told us about how they introduced themselves and asked what the person liked to be called. They then completed a "primary survey" to assess the situation, asked questions to understand the patient's medical history and carried out observations. Staff explained how this approach varied dependent on the number of staff at the scene.

We were shown a copy of the "patient care record" which was used to document care. Staff said that the record had recently been changed and was "much better than the last one". A copy of the record was left with the person if they were staying at home and a copy was given to staff if the patient was taken to hospital. We were told that there were "a couple of ways to set out" the record but it was "pretty standardised".

Staff told us about the trust's "Right Care, Right Place, Right Time" approach to making sure people received the most appropriate care. One member of staff described this approach as "really important" and said the standard of care was "really quite good". Staff were aware of the performance requirements of the trust but didn't feel "any pressure" on their ability to provide safe care. Staff told us how they were supported to spend time caring for people in their own home if that was the best option. One member of staff said "We make the best decision for the person." and "We're very well supported with that." Another member of staff added the "trust has high standards" and "We all do the best we can."

Some of the staff we spoke with raised concerns about back up for staff working alone in a single handed response vehicle. We were told that the procedure to follow for requesting support had recently been changed. Staff were concerned about the restrictions on when they could request support and the time taken for it to arrive. One manager said "I don't think we've got it right yet." Staff told us that they had fed back their concerns to managers.

We were told that the trust was using a "care bundle" approach for common conditions to ensure optimum care. A care bundle was a number of clinical interventions all of which should be given for the best outcome. We saw information displayed in ambulance stations about a number of care bundles including stroke and heart attack care. Staff told us that their care records were monitored to check if the care bundle had been administered correctly.

We visited emergency departments in local hospitals and asked staff about their experience of the ambulance service. One nurse described the service as "very good" and said that ambulance staff "know what we need to know and how to put it across quickly". They described the documented handover as "basic" but said that the verbal handover was "very good". They were complimentary about how staff handed over "poorly" patients to ensure information was "picked up quicker".

One nurse was positive about how the ambulance staff worked together to ensure patients were handed over in a timely way during busy periods. They said that "One crew would look after patients to release other crews."

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

All the people we spoke with were positive about the staff with many describing them as "kind" and "professional". We asked one hospital patient if they had felt safe in the ambulance and their response was "Perfectly, the staff were continually reassuring."

We spoke with a manager with a lead responsibility for the safeguarding of vulnerable adults and child protection across the Trust. We were told about the joint working with agencies involved. They explained the process for making safeguarding referrals and how staff were able to do this both by facsimile or electronically. We were told that the trust asked for feedback on referrals. Records received by CQC confirmed that appropriate processes were being followed.

We saw records that showed that appropriate action had been taken when allegations of potential abuse had been made about ambulance staff. We asked staff if they had any concerns about the conduct of their colleagues and all said no.

All the staff we spoke with were aware of potential signs of abuse and the action to take in the event of a concern. All staff received training on the safeguarding of vulnerable adults and child protection. Staff had access to a safeguarding policy and procedure. Staff had also received training on the Mental Capacity Act and deprivation of liberty safeguards. We noted that the patient clinical record included reference to the patient's capacity to make a decision.

Ambulance staff gave us an example of when they needed to raise concerns about a child they saw during a call to a patient. They accessed the safeguarding forms on their computer system and sent the completed form to their head quarters. They told us they received a response within 24 hours.

We discussed the use of restraint and were told that the need for a policy had been considered but not implemented as restraint was not used in practice. A manager explained that restraint was only used in the form of routine safe moving and handling procedures such as the use of seat and stretcher belts. Staff were supported with this issue with input from the health and safety team and ongoing learning regarding the

Mental Capacity Act. Staff also received conflict resolution training so that they could learn strategies and techniques to manage behaviour that challenged the service. When we raised the issue with staff one ambulance person said "We can't restrain somebody."

We were shown protocols and procedures that detailed the process for the care of patients detained under the Mental Health Act and those needing support under the Mental Capacity Act. When we spoke with ambulance staff they were able to illustrate how these arrangements worked in practice.

The trust had a whistle blowing policy which meant that staff could raise concerns without fear of recrimination by the service.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We spoke with seven patients and two relatives in emergency departments in two local hospitals. All were very positive about their experience. One patient told us about how a member of staff had been "giving guidance to a learner" and they had found this "reassuring". They described the staff as "competent and confident".

People told us they felt confident staff knew what they were doing. Comments included "I was in safe hands." and "They were excellent, they knew what they were doing."

One member of hospital staff described ambulance staff as "knowledgeable" and the ambulance crews as "really good". Another member of hospital staff described the ambulance staff as "all pleasant to deal with".

We spoke with a range of staff about the support they received in order for them to meet the responsibilities of their role. We spoke with non clinical staff, call takers and front line staff. The trust had a training and education policy which clearly set out the training requirements for all staff.

We were told that all staff were allocated a mentor on joining the trust. Each member of staff was given an induction workbook to work through on appointment. The workbook included: an introduction to the organisation; moving and handling; managing risk and information governance. Staff also received additional training on equality and diversity and fire safety. Staff were expected to complete the workbook within nine months. The trust target for the completion of the induction workbook was 100%. The provider may find it useful to note that at the time of inspection data showed that approximately 61% had been achieved. We were told that the issue had been discussed at a recent senior management meeting and an action plan had been agreed. All the staff we spoke with were positive about their induction experience. One member of staff said that after their induction they were "really prepared for it (their role)". We were given an assurance by the responsible executive director that the target would be met by the end of March 2013.

We were told that all staff received an annual appraisal and that a learning and development plan for achieving objectives was produced. All the staff we spoke with confirmed that this happened in practice. The trust's aim was 100% completion and 85%

was agreed as reasonable. At the time of the inspection the data showed that the trust had achieved approximately 85%.

We spoke with the manager at an ambulance training college. They told us that all staff had a mandatory training workbook to be completed over a three year period. Areas covered included: health and safety; moving and handling; equality and diversity; risk management; safeguarding the public, infection control; conflict resolution; fire safety and stress management. Clinical staff also covered the areas of emergency preparedness and medicines management. The book included written exercises. Staff told us that they discussed their progress with the book at one to one meetings with their line managers and learning and development staff.

Front line clinical staff were expected to complete annual recertification of advanced life support and conflict resolution skills. In the January 2013 education report we noted that completion ranged from 5% to 79% of staff in different geographical areas. The report stated that operational priorities had led to training cancellations and that strategies were in place to ensure compliance with external regulations.

We observed an ambulance crew moving a patient with a slide board. They used appropriate moving and handling techniques to move the patient safely. They checked the patient was comfortable, explained what they were doing and re-assured them. Staff told us that when they got new equipment they were trained so they knew how to use it safely. Another member of staff said "We get training on anything that's new to us."

Non clinical staff also told us about how they had been supported to maintain their professional registration; for example financial accountancy.

We asked staff about the supervision arrangements that were in place so that they could talk through any issues about their role or about the people they provided care for. Staff told us about the role of the Clinical Supervision Officer (CSO) and how they were supported in the workplace. Staff told us about how they were able to access support 24 hours a day, every day. Front line staff were positive about the time spent working alongside the CSO. One member of staff told us about how they were able to access supervision in relation to safeguarding from the local authority.

We noted that the training and education policy referred to the need to meet disability and equality and legislation to ensure that reasonable adjustments were made where appropriate to support staff. We spoke with staff who were very complimentary about the support they received on returning to work following maternity leave. One member of staff also told us about the support they had received when preparing for retirement. They had since returned to work in a part time role.

We spoke with a number of staff who had joined the trust in a junior role and had been supported to gain promotion. Other staff told us about how they had been given secondment opportunities to other roles.

One non clinical manager was positive about the support they received in team meetings. They added that there was "very good communication". Two staff told us they "loved" their job. Another said they enjoyed the "camaraderie and banter".

From speaking with managers there was a strong culture of staff "welfare". All staff were understanding of the need to support colleagues to take breaks and put arrangements in

place for support in challenging situations. During our inspection plans were put in place to assist staff with the demands of adverse weather conditions.

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 use the service and others.

Reasons for our judgement

We spoke with a senior manager who explained the trust's approach to managing risk and quality. We were shown the trust's quality strategy which indentified five elements; these were clinical effectiveness, safety, experience, access and value for money. There were clear structures and processes in place to ensure that outcomes and quality were robustly monitored. Feedback on the quality of the service was summarised in a bi monthly report to the board. The report clearly indicated how the trust learnt from experience. For many of the issues identified the report detailed what had changed as a result. For example, an increase in injuries to staff as a result of moving patients had been indentified and causes investigated. Changes had also been made to the triage system.

A major theme of the report was feedback on patient experience. We were told that a "Have your say" leaflet had recently been introduced to gain patient feedback. Leaflets had been given out by ambulance governors at specific feedback events such as the Devon County Show and Dorset Steam Fair. We were told that there were plans to increase their use and make the leaflet available in hospitals and GP practices. Between April and November 2012, 12 responses had been received and 10 had made positive comments. The trust was also developing its use of the patient opinion website. All the patients and relatives we spoke with were very complimentary about the service.

We were told that a staff satisfaction survey had been completed in November 2012 and results were being analysed. We were told that the 2011 survey had not identified any significant issues and an action plan for improvement had not been needed. We were shown questions that had been developed for inclusion in the 2012 survey. These included the areas of patient care and health and well being.

The trust also had a clear process for the monitoring of compliments, comments, concerns and complaints. Following their investigation the trust identified opportunities to learn from the experience.

We tracked the investigation of a serious incident. There was a clear decision making process to confirm the severity of the incident and an analysis of the causes was carried out. Lessons learned were documented. We followed up on the outcome with front line

staff and they were able to confirm that changes had been made to practice.

As a result of analysis of serious incidents the management of serious infection had been identified as an issue. We saw that a "clinical notice" had been circulated to staff giving an overview of the condition, signs and symptoms and action to take. A management group had been set up and training given. The issue had also featured in a weekly bulletin from the Chief Executive.

The trust had comprehensive audit systems. This included participation in national audits relating to quality standards and local work regarding stroke care.

The manager explained how the trust had learnt from reviews of major incidents. We saw a report which showed how the trust had considered the findings of the Hillsborough report.

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

We saw that the provider reported its ongoing performance of its response to emergency calls against national standards to its commissioners and to the regulator of foundation trusts.

There were three principle emergency call response time standards that the trust was required to meet. These were measured quarterly across the whole of the geographical area. 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 only applied to less than 5% of calls. The trust had an improvement plan for these calls and was monitoring its anticipated performance.

Staff told us how they were able to put forward improvement ideas via a staff suggestion scheme. We tracked progress made relating to a suggestion to introduce bravery reward stickers for children. The suggestion was implemented.

In two ambulance stations we looked in the sluice room where waste was disposed of. In both the sink area was not clean. We were told that mop heads were single use only. The mops we saw were noticeably soiled and mop buckets were not clean. One ambulance station garage was not organised in a systematic way. The provider may find it useful to note that the monthly audit of premises had not identified these issues.

We saw a copy of the ambulance cleaning protocol and were told that ambulances had a steam or "deep" clean every eight weeks. We noted that in one ambulance the last deep clean had not been recorded. We were told that monitoring of the system would identify this oversight and action would be taken.

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.

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