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

**Queen Elizabeth Hospital, Woolwich**

Ranken House, Stadium Road, Woolwich, London, SE18 4QH  
Tel: 02083022678

Date of Inspection: 25 October 2012  
Date of Publication: November 2012

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>Action needed</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Records</td>
<td>Met this standard</td>
</tr>
</tbody>
</table>
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>South London Healthcare NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Queen Elizabeth Hospital Woolwich is an Acute Hospital located near to Woolwich Common. It is part of South London Healthcare NHS Trust.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Community healthcare service  
Diagnostic and/or screening service  
Long term conditions services  
Rehabilitation services |
| Regulated activities | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Maternity and midwifery services  
Surgical procedures  
Termination of pregnancies  
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’.

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>What we have told the provider to do</td>
<td>5</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Our judgements for each standard inspected:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>6</td>
</tr>
<tr>
<td>Meeting nutritional needs</td>
<td>8</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>9</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>11</td>
</tr>
<tr>
<td>Records</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information primarily for the provider:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Action we have told the provider to take</td>
<td>14</td>
</tr>
</tbody>
</table>

| About CQC Inspections | 15 |
| How we define our judgements | 16 |
| Glossary of terms we use in this report | 18 |
| Contact us | 20 |
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 reviewed all the information we have gathered about Queen Elizabeth Hospital, Woolwich, looked at the personal care or treatment records of people who use the service, carried out a visit on 25 October 2012 and observed how people were being cared for. We checked how people were cared for at each stage of their treatment and care, talked with people who use the service and talked with staff.

We were also joined on this inspection by a specialist healthcare advisor and a pharmacy inspector.

What people told us and what we found

Our inspection on 25 October 2012 followed up on outstanding improvement actions identified at our inspection on 19 August 2011 in relation to tissue viability care, equipment, medication and record keeping. At our inspection on 25 October 2012 we also checked to see how orthopaedic care was being delivered to patients and we looked at how people’s nutritional needs were being met.

Some people who used the service, including those on the orthopaedic ward told us they sometimes had to wait for call bells to be answered by staff. Patients in some other areas of the hospital felt their calls were answered promptly.

Staff and patients on one orthopaedic ward told us on occasions doctors did not see patients for a number of days and there was no daily ward round for orthopaedic patients. People told us they felt the general level of nursing care provided to them was 'good' and records confirmed people’s nursing needs had been met.

People told us generally the food was of reasonable quality and they were offered choices. People told us food was provided in accordance with their nutritional needs. Medicines were prescribed and given to people appropriately; however, medicines were not always stored safely. Staff told us the availability of equipment was good and equipment was adequately maintained. People’s records we viewed were not always chronologically sorted and therefore were difficult to follow.

You can see our judgements on the front page of this report.
What we have told the provider to do

We have asked the provider to send us a report by 14 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

<table>
<thead>
<tr>
<th>Care and welfare of people who use services</th>
<th>Met this standard</th>
</tr>
</thead>
</table>

**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**

At our inspection on 19 August 2011 we found that overall Queen Elizabeth Hospital was meeting this essential standard but, to maintain this, we suggested that some improvements were made. The trust had improvement plans in place to reduce the number of incidences of hospital acquired pressure ulcers and venous thromboembolism (VTE), and its audit results evidenced an overall drop in the number of incidences. However, there was no evidence at the time of this inspection that all planned improvements had been completed; for example funding for specialist staff had been requested but had not been confirmed; the results of the most recent audits were not available; and there was no evidence of the numbers of staff who had received tissue viability training updates that year.

The trust had a pressure ulcer work programme in place which provided support to staff including wound care link nurses, update training, and regular meetings and panels to review and learn from pressure ulcer incidents. Staff we spoke with on our inspection on 25 October 2012 told us they had access to wound care link nurses who they could seek advice from and they thought they received enough support and training to manage pressure sores well.

Following our inspection on 25 October 2012 the trust provided information to demonstrate it had reduced the number of hospital acquired pressure ulcers each month in 2012/13 by around one third compared with 2011/12. There had also been a reduction in grade three and four pressure ulcers. We also saw the trust was meeting the national target for completing a VTE risk assessment for at least 90% of patients admitted to its hospitals.

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare. Patients’ notes included an assessment of their needs undertaken on admission that included specific risk assessments, for example for the risk of developing pressure sores and the risk of falls. These assessments were used to develop individual care plans and records of the evaluation of patient’s care showed that care had been delivered in accordance with their assessed needs. Staff told us that regular checks were undertaken, for example ensuring call bells were within people’s...
reach and that patients had enough water. This approach meant that patients were not left for long periods without having contact with staff.

At our inspection on 25 October 2012 the staff we spoke with from a range of disciplines, told us that due to the demand for orthopaedic care approximately 50% of patients were cared for on wards other than the specialist orthopaedic ward. We were told this was due to bed capacity but that this did not impact on the general nursing care patients’ received as they were cared for by similar numbers of nursing staff and orthopaedic doctors visited patients on these wards. However, we found the volume of orthopaedic patients had resulted in some patients experiencing delays in receiving surgery. Senior staff told us the reason for some of these surgical cancellations were often due to more urgent cases being prioritised resulting in routine operations being delayed or cancelled. This meant some people experienced delays in receiving the appropriate care or treatment. Following our inspection the trust told us that orthopaedic surgery cancellations at Queen Elizabeth Hospital were below the national average. Figures provided to us showed the numbers of cancelled operations was comparatively low but had peaked in September 2012 which was mainly attributable to the availability of beds and overbooked surgery sessions.

People’s needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Patients told us they felt the general level of nursing care provided to them was ‘good’ despite some delays they encountered, for example delays in staff answering patients’ call bells. The majority of staff we spoke with told us the numbers of trained staff were insufficient and caused delays to patient care. For example, the senior staff on three different wards which cared for orthopaedic patients all told us they felt staffing levels were inadequate to effectively manage the needs of patients. They said that this had been the case since the trust had revised staffing levels five months ago. However, we found that despite some people experiencing delays to their care, people were generally happy with the quality of care that had been provided to them. Records we viewed also showed people were provided with appropriate care in order to meet their needs.

Despite overall positive outcomes for orthopaedic patients, feedback we received on our inspection from patients, doctors and senior nurses on all the wards which had orthopaedic patients indicated some patients did not receive regular input from orthopaedic doctors. For example, patients were not always reviewed by a doctor each day and that they sometimes waited several days between being seen by a doctor. We were also told that daily multidisciplinary ward rounds did not take place. This feedback did not indicate that these areas specifically impacted on the quality of care provided or outcomes for patients, because, for example, the readmission rates for hip and knee replacements were within national expected ranges. However, the lack of contact with the doctor in some cases meant some patients felt inadequately informed about their progress or their intended care plan.

People’s care and treatment reflected relevant research and guidance. For example, we saw the trust had systems in place for monitoring the quality of care provided to orthopaedic patients and figures provided following our inspection showed that this had delivered improvements in some required areas. For example, improvements had been made to the way older people with fractured neck of femur were managed including prioritised pre-operative assessments.
Meeting nutritional needs

Food and drink should meet people’s individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People were provided with a choice of suitable and nutritious food and drink. At our inspection on 25 October 2012 we observed that at breakfast and lunchtime on the four wards we visited, staff offered people choices and supported those that needed assistance. Some people had been prescribed nutritional supplements and these were given and recorded in the person's records. A range of drinks were available throughout the day and individual jugs of water, which were changed twice a day, were at the person's bed side. Staff monitored those people who needed more fluids to ensure they had adequate supply by recording the intake and output of people's fluids. However, one person told us that they had not had anything to eat or drink from midnight the previous night as they had been scheduled for an operation. On the morning of our inspection the person’s operation had been cancelled for at least the third time. Staff offered the person a coffee but a sandwich had to be ordered as the person had missed breakfast.

People's food and drink met their religious or cultural needs. People told us they were able to choose what they wanted to eat from a menu and this provided choices including vegetarian or halal meals.

Staff told us that all patients had a nutritional assessment on admission and that any identified nutritional support needs were documented in their care plans. Care plans were regularly updated and changes to nutritional needs were indicated. Daily notes summarised what each person had eaten and drunk on each shift. This approach assisted in identifying individuals who may be at risk of malnutrition or dehydration.

People were supported to be able to eat and drink sufficient amounts to meet their needs. All wards operated a 'red tray' service which was used to identify patients that required assistance with their meals. Staff offered support to people who were served meals on red trays to ensure people were adequately supported. A ‘protected meal times’ policy had been implemented by the trust to ensure patients were not disturbed during meal times and staff could focus on supporting people to eat and drink. However, we observed that this was not always observed on some wards as some medical staff carried out clinical rounds during these times. Staff told us that they tried to observe protected meal times, but it was difficult to turn away busy medical staff when they wanted to see patients.
Management of medicines

People should be given the medicines they need when they need them, and in a safe way

Action needed

Our judgement

The provider was not meeting this standard.

The provider did not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the storage of medicines.

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

Reasons for our judgement

At our inspection on 19 August 2011 we found improvements were required in relation to the management of medicines, these included reducing the long waits for medicines, improving the recording on medicine charts and improving the security of medicine storage facilities.

During our inspection on 25 October 2012 we found that medicines were not always kept safely. Patients' own medicines and those medicines individually dispensed for patients were kept at the patient's bedside in a locked cupboard. However, on three of the four wards we visited the rooms where medicines were stored were not locked. All of the medicine cupboards within the unlocked rooms, with the exception of the controlled drug cupboards, were unlocked, as were the medicines refrigerators.

A medicines storage audit carried out in early 2012 by the trust identified issues such as medication rooms not being kept locked. An action plan had been developed to address these issues but this did not include timescales for the implementation of these actions. It was not possible to assess what action had been taken to date to address findings of this audit as medicines were still not being stored securely for the protection of people who used the service. In addition to the trust’s audits, staff we spoke with told us and provided evidence to demonstrate they carried out audits of medicine storage, controlled drug records, the reconciliation of medicines, the use of antibiotics and medicine incidents.

Only one of the four wards we visited had records to show that the medicines refrigerator temperature was monitored and within the required temperature range. Therefore on the remaining three wards the trust was not able to ensure that medicines stored in these refrigerators were fit for use.

Medicines were prescribed and given to people appropriately. The prescription and administration records we looked at on the four wards we visited included records of medicines prescribed and given to patients. These records showed that medicines were administered as prescribed, there were no gaps on the administration records and when doses of medication had been omitted the reasons for not giving patients their medicines
were recorded. We were told that all wards received a regular visit from a pharmacist who reviewed medicine charts, ordered newly prescribed medicines, arranged medicines for discharge and provided clinical advice. This meant medicines management on each ward was appropriately overseen to ensure patients received the medication they needed.

On admission, patients’ medication was reviewed to ensure that staff were aware of the medicines the person was taking and that they continued to receive these medicines. We saw that people's own GP’s were contacted if the information needed further clarification. This ensured people were prescribed and administered medicines safely.

Medicines were administered safely. A policy and procedure, including risk assessment documentation, was available to support patients who wished to self-administer their own medicines. One patient we spoke with who was self-administering their medicines told us that they kept their medicines on their bedside table as they were medicines that they may need quickly to relieve symptoms and which presented little risk to other people. During the lunchtime medicine round on one ward we visited we saw that nursing staff followed safe practices such as staying with patients whilst they took their administered medicines. The patients we spoke with were generally complimentary about their treatment and how their medicines were managed. For example, they were provided pain relief when they needed it without delay.

There was a system in place for the recording of medicine errors. Evidence provided demonstrated that errors were recorded and investigated and that any learning from incidents was disseminated across the hospital.

Records were kept of medicines given to people on discharge. Nursing and pharmacy staff told us that there were systems in place to ensure that medicines were available and so minimise delays to discharging patients. Information provided by the trust demonstrated that the average wait for dispensing urgent discharge medicines was between 30 and 60 minutes on most days.

Patients were provided with information about how to take their medicines once they were discharged from the hospital. This was done both by a pharmacist and by nurses when people were given their medicines on discharge from the hospital. People we spoke with said that they were provided information about medicines in a way that was useful to them.

The medicines management strategy action plan had been updated in September 2012 and with some actions completed and progress reported. The action plan did not include any specific actions to address the issues identified in their medicines storage audit.
Safety, availability and suitability of equipment  

Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

At our inspection on 19 August 2011 we found the pathology specimen chute in A&E was routinely out of service and the alternative arrangements in use on the day of our visit were neither safe nor secure, and some actions in the Management of Medical Equipment and Devices action plan had yet to be completed and implemented. At our inspection on 25 October 2012 these outstanding areas were followed up and the trust submitted evidence to demonstrate its progress in addressing these issues.

At our inspection on 25 October 2012, we found the pathology specimen chute in A&E was out of service. Staff we spoke with told us the chute was usually working and electrical testing across the site on the morning of our inspection had apparently caused the problem. Staff told us they did not expect the chute to be out of action for longer than one day. As the chute was out of service, alternative arrangements to transport specimens had been made. These included staff being required to leave specimens in a red box which porters took to the pathology department regularly throughout the day. However, as identified at our inspection on 19 August 2011 and on our inspection on 25 October 2012 these alternative arrangements we neither safe nor secure as red boxes were not sealed and specimens were left in a corridor accessible by patients.

At our inspection on 25 October 2012, staff told us generally they had no issues with the equipment that was available to them, and they felt happy that the equipment provided to them allowed them to safely carry out their jobs. However, one senior staff member told us that when the hospital carried out fortnightly electrical tests, some electrical equipment temporarily failed, for example computers and pressure relieving mattresses. The staff member told us during this time, which can be up to one hour, patients mattresses deflated which increased the risk of people developing pressure sores.

There was enough equipment to promote the comfort of people who use the service. Staff
we spoke with told us that people's needs for specific equipment were assessed. For example staff told us that pressure relief mattresses, used to reduce the risk of pressure sores for patients who have to spend long periods in bed, were easily available and when requested they arrived promptly.

Patients we spoke with were happy about the equipment available to them. For example, patients told us that they knew to use their call bells when they needed staff assistance and those who were using pressure relieving mattresses were happy with those arrangements to promote their welfare.

People were protected from unsafe or unsuitable equipment. Information submitted by the trust following our inspection on 25 October 2012 demonstrated that equipment was regularly maintained and tested to ensure safety of use. In addition, the trust told us spot checks on equipment took place to ensure frequent maintenance had been completed.
People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At our inspection on 19 August 2011 we found audit results demonstrated that the required standards of record keeping were not always being met. Action plans were in place to improve health records documentation and non compliance with information governance requirements but these had not yet been fully implemented.

Information provided by the trust in October 2012 showed that the trust had audited a sample of its medical and nursing records including the legibility and content between June 2012 and August 2012. The audit identified some areas for improvement but the majority of medical and nursing records sampled met the NHS Litigation Authority requirements.

At our inspection on 25 October 2012 we looked at a sample of patients' medical and nursing records and found that the majority of patients' records were fit for purpose. For example they contained information regarding the individual's plan of care and evidence that the care had been provided. However, we identified some areas of poor record keeping for example; some doctors notes had been written retrospectively and some people's notes had not been filed chronologically which meant it was difficult to understand the patient's treatment history and intended pathway of care. We saw that entries made by other visiting departments such as physiotherapy in the notes were consistent and of good quality, providing a record of their intervention with the individual.

People's nursing notes were consistent in content and had an emphasis on risk assessment of patients. They also included a record of the regular patient checks that nursing staff had undertaken, such as ensuring call bells were within reach. Patients' nursing notes provided a clear link from the assessed care need to the care that had been provided. For example, patients care needs were numbered, and nurses had referenced these numbers when completing notes of nursing care undertaken.

Records were kept securely and could be located promptly when needed. Patients' medical and nursing records were kept in lockable trolleys on each ward near to nurses stations and could be easily located by staff when we requested them.
Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Management of medicines</td>
</tr>
<tr>
<td>Maternity and midwifery services</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>The service did not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the storage of medicines (Regulation 13).</td>
</tr>
<tr>
<td>Termination of pregnancies</td>
<td></td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
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</tr>
</tbody>
</table>

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

The provider’s report should be sent to us by 14 December 2012.

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.

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

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

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

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

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

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

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

**Regulated activity**

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

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

### Regulations

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

### Responsive inspection

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

### Routine inspection

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

### Themed inspection

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

Phone: 03000 616161

Email: enquiries@cqc.org.uk

Write to us at: Care Quality Commission
               Citygate
               Gallowgate
               Newcastle upon Tyne
               NE1 4PA

Website: www.cqc.org.uk

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