Inspection Report

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

Royal United Hospital Bath NHS Trust

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cooperating with other providers	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Royal United Hospital Bath NHS Trust
Overview of the service	Royal United Hospital Bath is an acute hospital on the edge of Bath just over a mile from the centre of the city. The hospital covers a local population numbering around half a million people in Bath and some parts of North East Somerset and Western Wiltshire.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Management of supply of blood and blood derived products Nursing care 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'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 February 2013, 5 February 2013 and 6 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

This inspection visit was prompted by information that had been shared with us. Concerns were raised about the manner in which some patients had been discharged without adequate information and support. Because of this we took a nurse with us who had expert knowledge in discharge arrangements.

During our inspection we looked at two discrete areas of care at the hospital. These were the older people's wards and the day surgery unit (DSU). We also looked at pharmacy arrangements for providing medication for people to take home on discharge.
We met and talked with many patients during our visit. Where patients were not able to talk with us for various reasons, we spent time observing how care and support was delivered. We saw and were given written evidence from the trust. This included patients' notes, hospital records and recordings of their clinical observations.

We met with consultant medical staff, pharmacists, therapy staff, registered nurses and healthcare assistants. All the staff we met with showed a professional and caring attitude towards their patients. We also met with hospital directors and senior management staff, they explained to us that the hospital had recently been under unprecedented pressure. Inpatient admissions though the emergency department had increased by 13.9% in the current financial year against the previous four year average. This had meant the hospital was using the day surgery unit to accommodate inpatients, when its intended use was for short stays for up to 23 hours.

We found the trust was not ensuring they met all patients' treatment and care needs on the day surgery unit. This was because the day surgery unit was being used as a facility to care for inpatients who would normally be accommodated elsewhere in the hospital. The environment and the care arrangements on this unit were not suited to ensuring inpatients privacy, dignity, health and welfare needs were met. Risks to their care and treatment were not being adequately managed. After our visit we raised concerns with the trust about the impact of this and the accommodation of inpatients on the DSU was stopped.

We found record keeping was not consistently completed, including records of patients' fluid intake and output and completion of the trust's own discharge documentation. Staff were not using the trust's system of documentation to support discharge planning. This meant that the system in place to ensure correct information and support resources were put in place for patients discharge was not always followed. For those patients with more complex needs this created inconvenience and risk for those patients ongoing care elsewhere

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 22 March 2013, 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

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Inpatients accommodated on the day surgery unit at the time of the inspection visit were not having their privacy and dignity maintained.

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 this inspection we looked at two different parts of the hospital. These were the older people's wards and the day surgery unit (DSU).

We asked patients and their carers about their experiences of their stay on the DSU and looked at the unit's most recent survey feedback from patients. Overall feedback was negative about the care environment impact on privacy and dignity. Patients described the unit as being "cramped", "too hot", the ward is very stuffy, they are trying to fit in too many patients."

Patients' reported disturbed sleep due to the amount of night time activity on the ward. One patient told us "people are being admitted all the time, both day and night". Staff reported the unsuitability of the care environment to the needs of a patient with a learning difficulty, who would normally be given more one to one attention, but instead had to be left on their own for long periods of time.

Staff and patients told us and we saw there were inadequate bathing facilities for the inpatients accommodated on the DSU. There was just one mixed sex shower for 22 patients which was located in an assisted toilet, which meant there were long waits for patients to shower. Although there were two separate toilets for male and female use, the other two assisted toilets were for mixed sex use. The sinks available in the toilets could not satisfactorily be used for washing as there were no plugs. On one of the days of our visit the shower had become flooded and could not be used at 3pm. The shower head was fixed and one person said they could not use it because of this.

A staff member said "its purpose built for day surgery, it's just not set out for inpatients. The spaces fit three trolleys and so the curtains fit then. If we have beds then the curtains just don't fit."

We saw there were no windows in the women's part of the ward. A patient told us "it's like living on an aircraft all the time." One patient told us "if some one uses the commode on the ward, then we can all smell it. Where is the dignity in that?"

After our visit we raised concerns with the trust about the impact of the day surgery unit care environment on the privacy and dignity of inpatients accommodated on the DSU and this was stopped shortly after our inspection visit.

On the older people's wards we saw that people's privacy and dignity were respected.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there.

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

Reasons for our judgement

During our inspection we looked at two discrete areas of care at the hospital. This was the day surgery unit (DSU) and three wards at the hospital designated for the care of older people. We met with staff, including consultant medical staff, therapists and registered nurses. They all showed a professional and caring attitude towards their patients. Senior nurses spoke with us about assessments of risk for older patients, such as risk of falling, pressure ulceration and malnutrition. They told us about the actions they took when people were assessed as being at risk, including care plans and use of monitoring tools such as routine 'comfort rounds' to check on patients welfare needs.

Some patients we met with looked comfortable and told us how helpful staff had been. We saw staff took time to explain to patients how they were going to help them. A patient told us about a recent assessment they had done with an occupational therapist so they could make themselves a cup of tea independently again. Another patient told us they were glad their intra-venous "drip" was now down, so they could "be a bit more active." Others told us they felt their care needs had not been met. One person told us they had not had sufficient drinks, another told us they were not being turned to reduce the risk of skin pressure damage. We saw other patients that had some cognitive impairment who were not having all their needs met.

We visited the DSU on all three days of our inspection and found they cared for both day cases and inpatients on the same ward. A staff member explained to us how the care of inpatients who would normally be cared for elsewhere in the hospital came about and then quickly escalated. "It started as one or two patients, then it just got more and more and more." On 6 February 2013, 21 of the 22 patients cared for on DSU were inpatients and only one was a day surgery patient. We saw inpatients on the DSU stayed for a range of durations, but many patients stayed for more than a few days, some for a week or two weeks. On 5 February 2013 we looked at five patients care pathway in detail. Two of these patients had been on DSU for more than one week, and one for two weeks.

Inpatients were from a range of specialties within the hospital. A member of staff told us this was difficult, as patients were at "all stages" in their treatment. The trust's guidelines for transfers to the unit excluded patients requiring sliding scale insulin and admissions directly from the emergency department. These guidelines were not being followed. A staff member said "at first they didn't send us anyone on the clinical inclusion list, but now they do."

Staff told us they were rushed and didn't have time to carry out all the planned checks on patients. There were no 'comfort rounds', as elsewhere in the hospital to check on patients welfare needs. Patients told us about the impact of this. One person told us at 3.30pm, they had not had a wash all day because staff were too busy and we saw they had dried food on their gown from lunch three hours earlier. Another patient told us they had been "absolutely gasping", as between 5.30am and lunch time staff had not had time to offer them a drink. We were told by staff that this shortage of time sometimes placed patients at risk. For example, we saw an incident report from the hospital where there had not been enough time to check a patient with diabetes blood sugar levels before they were taken to theatre. The patient was documented as behaving "strangely" in the anaesthetic room and when their blood sugar was checked it was at an unsafe level.

Routine systems that were in place on inpatients wards, such as a pharmacy service and equipment supplies were being managed by the DSU staff. This reduced the amount of time they had available for patient care.

Because the unit was organised to care for day patients, there was an inadequate system in place for assessment, planning and evaluation of the care for in patients. We met with five inpatients on the DSU and we were shown their records including electronic records on the computer. Four of these patients were elderly and looked frail. None of the five patients had a risk assessment for pressure ulcers completed in line with guidelines from the National Institute for Health and Clinical Excellence (NICE). Two of these patients told us they were on bed rest. One of these patients told us they did not have their position changed regularly to reduce skin pressure damage. The other patient told us some staff did assist them to change their position, but that this was "variable." Neither of these patients had a care plan about prevention of risk of pressure ulceration or turn charts to show their position in bed had been changed regularly. A third patient looked frail, they were not able to tell us if their position was changed. We looked at this patient's records. These showed two occasions when concerns about tissue damage over pressure points had been documented. The patient did not have a care plan about prevention of pressure ulceration or a turn chart. We spoke with staff, they told us they did not have access to turn charts on the DSU.

We looked at the assessment and care planning for older patients on the DSU and the older people's wards. One of the patients was not able to tell us about where they were or where they normally lived. This person and several other records documented issues relating to "confusion", including records of refusal of care. A cognitive function test called the abbreviated mental test (AMT) had been carried out for these patients. This consisted of questions about orientation, age and recall. A consultant told us if the score was lower than eight out of ten, this triggered another more detailed test.

This included more detailed questions, which led to a decision about the patient's mental capacity assessment to make a range of specific decisions. We saw two of the patients had AMT scores of six out of ten and one had a score of three out of ten. No other mental cognitive tests had been completed for these three patients. This meant no further assessment or care planning had been developed for the risks associated with their confusion.

We met with a patient who had been admitted to the DSU from accident and emergency. The person had visible bruising on them. Their records, including computer records, indicated they had fallen at home. A body map of their bruising had not been completed. On 5 February 2013, they did not have a risk assessment for falling or a care plan to indicate how their risk of falling was to be reduced. They also did not have a mobility assessment or communication assessment.

After our visit we raised concerns with the trust about the impact of the day surgery unit care environment on the care and treatment of inpatients accommodated on the DSU and this was stopped shortly after our inspection visit.

Cooperating with other providers ✖ Action needed

People should get safe and coordinated care when they move between different services

Our judgement

The provider was not meeting this standard.

Patients discharged from the hospital cannot be confident that the hospital will communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care.

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

Reasons for our judgement

At this inspection we looked specifically at the way the hospital worked to ensure patients care needs would be continued by other care providers after discharge from the hospital. Concerns had been raised with us about the manner in which some patients had been discharged during a period of 'whole community black escalation' (where the hospital was not in a position to provide a service to any further patients and so were urgently discharging existing patients).

The director of nursing told us that during the 'whole community black escalation' patients were discharged in the manner which they would normally have been discharged. The only exception being they had arranged for some patients to see a social worker after discharge, when this would have normally have taken place before discharge.
The trust's policy on discharge states "an initial assessment and plan must be completed within 24 hours of admission…..the patient /carer must agree the discharge plan. This must be documented in the multi disciplinary notes……the discharging nurse from the ward must ensure that the patient and carer receive instructions on care required after leaving hospital…the discharging nurse from the ward, must complete the discharge checklist which is included in the nursing documentation." .

To review discharge arrangements we chose three patients in three different older people's wards. Two were about to be discharged and the other had been discharged the previous day. We spoke with staff, read their records, met with the discharging consultant, spoke with the pharmacist and the staff at the care home to where they were discharged. We also reviewed care records for 13 patients discharged to, among other places, nursing homes during the black escalation and spoke to senior staff at two care homes to where they were discharged and relatives.

In none of these cases had trust's discharge form been completed, as required by the hospital's discharge policy. Copies of discharge summaries written by the medical staff were available in 15 of 16 records where the patient had been discharged. These contained information about diagnosis and treatment. They did not include any key

information about patients' care and treatment needs as covered in the trust's discharge planning form. For example a patient's current continence status and any aids they used, how they were to be assisted to move or if they were able to take their medication independently, or needed support with medications, such as administering eye drops. There was no other documented information provided to receiving homes.

Staff told us they had provided some information verbally. A few patients' records documented discussions between the hospital ward staff and relevant other persons, prior to the patient's discharge. For example one person's records showed the ward had contacted the patient's intermediate care team to discuss their specific needs before they were discharged home. Another patient had clear information about their nursing needs provided at the end of their medical discharge summary. Other discharge summaries we looked at did not include similar information. A patient who had been suffering from infectious diarrhoea and vomiting was discharged to a nursing home. Information about their infection had not been communicated to the nursing home. There was no information in the patient's notes about the decision to discharge in relation to their infection. We talked to ward managers about nursing and care information provided to external providers. They said they would provide such information verbally over the phone or when the provider came to assess the person. They told us such information was not consistently documented.

We contacted two nursing homes to where these patients had been transferred. We did this to check whether appropriate information, dressings and medications had been sent by the hospital. The feedback given to us by these homes included many examples of insufficient information and medication to ensure continuity of care.

Homes had received patients discharged to them of whom they had no previous knowledge. At times, including the 'whole community black escalation', homes were given very little notice. We were told by the nursing homes that medical discharge summaries were usually provided. These contained sufficient information about diagnosis and treatment. Information about nursing and care was largely absent. This meant the homes did not have sufficient information given by the hospital to ensure safe care and patients' needs were met. For example, one patient arrived with anticoagulant injections, but there was no instructions for how this medicine was to be administered. One patient was sent out with insufficient insulin, so they ran out within the first day. Another patient had been returned to his nursing home with a verbal handover by telephone stating that 'care remained the same'. This patient had arrived with unlabelled medication that was not prescribed for them. The nursing home staff described how they had to telephone the hospital ward three times, to ascertain that this medication had been sent with the patient in error and belonged to another patient. This person had been admitted for choking. Their consultant had prescribed the use of a thickening agent for use in drinks to reduce chocking risk. No written information about the need to use the thickening agent, or supplies of the thickening agent had been sent to the home.

Nursing home staff and patients' relatives told us as a result of so insufficient information they had to observe people for a couple of days to determine what their needs were and then write their care plans. We were told staff from the homes contacted the hospital for additional information to care for these patients safely. In one case a discharge summary included brief information about a dressing which was needed. It also stated the patient "preferred a soft diet". The care home did not know if this was preference, or a medical need.

One nursing home told us two families had stated they were "very unhappy" with the discharge arrangements. One patient had a ward meeting where the plan for discharge

was made and agreed with the family, physiotherapists and other care workers. This plan was then not followed. When they visited their relative they found that there had been no discharge information provided by the hospital. The patient, who was over 80, had to tell the nursing home staff what medications were needed and the type of care they required. One of their essential medicines had not been sent to the nursing home with their discharge medication.

We looked at the care records file of a patient recently discharged from Coombe ward. This person had been tested twice on the AMT with scores of zero and seven respectively. Although the second score was lower than eight out of ten, the more detailed cognitive test had not been carried out. The patient relatives could not be contacted and they had been discharged home to the care of a neighbour who had the key to their home. This meant the staff could not be fully assured this person's discharge to their home was safe.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment by means of accurate and up to date records.

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

Reasons for our judgement

We concentrated at looking at older patients records at this inspection. We looked at 21 patients' records to see if there was sufficient information to allow staff to care for them safely. In connection with most of these records we spoke with a range of staff, including nursing, medical and management staff. This was to check we had reviewed all relevant sources of information, including the electronic record system.

The trust's health records management policy stated "any information that is stored, produced or recorded for patients must be printed and added to the paper held record." The health record content policy states "details of any assessments and reviews undertaken must be recorded to provide clear evidence of arrangements made for future and ongoing care". During the inspection we found there were three methods of recording patient's information, these were the electronic computer records, paper files and information recorded on whiteboards in the ward area. Staff were not clear about the appropriate route to record information.

We saw some patients' records included some detailed information about their current assessments and responses to treatment. These included actions taken when a patient was acutely unwell. Records showed evidence of appropriate checking of patient's medical conditions, such as blood tests. Documentation showed staff regularly reviewed a range of information about patients' responses to treatments.

We found patients' records omitted other information in relation to their care and treatment. This could have put patients at risk of unsafe or inappropriate care. The lack of certain records also meant it was not possible to monitor or evaluate all standards of care and treatment.

Assessments were carried out using standard forms but relevant individual information had not been included. For example one patient we met with told us they were not able to lie on one of their sides. They did not have any assessment about this and we could not see a section where such information could be documented on the trust's standard documentation.

In the majority of the records we reviewed we found there were no plans of care to show how staff were to meet people's care and treatment needs. This included care plans to reduce a patient's risk of falls, pressure ulceration and malnutrition. We saw one patient's records documented occasions when they had experienced incontinence. We saw requests had been made for urine samples to check for infection. The patient did not have a care plan about how their continence was to be managed, for example by supporting them in going to the toilet more regularly and offering additional fluids.

We asked staff how they planned care. They told us they used a white board to track actions which needed to be taken. This whiteboard was behind the main nurses' station. It showed the name of the patients together with lists and coloured dots to indicate progress towards their discharge. Staff told us they had a handover at the beginning of each shift about patients' care and treatment needs, but this did not form a permanent record. On some wards, each patient had a whiteboard above their bed to provide staff with key information, such as about support the patient needed with moving. These were wiped down and so were not a permanent record to facilitate evaluation of care and treatment.

Where patients had fluid balance charts, in many cases these were not completed. Fluid charts did not evidence patients were given regular drinks, so charts could not be used to monitor or evaluate care provided. For example, one patient's records documented they were confirmed as having Norovirus. This virus causes vomiting and diarrhoea and in older people puts them at risk of dehydration. The patient's notes documented "fluids encouraged". There was no evidence from the patient's fluid chart records that this was the case. Most of the fluid charts we saw had not been totalled every 24 hours, so they did not show if a person's input and output balanced or were satisfactory for their current needs. We asked staff and managers how they would know if a patient had appropriate level of fluid intake and they were unable to tell us.

Records of changes of position for people at risk of pressure ulceration were variable. Some records, for example comfort round records, were fully completed on some shifts, but not on others, with no records as to why this might be for the patient. We saw some turn charts where records were made by some shifts, for example on night duty, but not others. Again there was no documented rationale for this in the patient's records. We saw in one patient's records that their turn chart had been discontinued, but again there was no reason for this documented in their records.

Some records did not agree. One patient had a record indicating they had a very low mental cognitive test score, but a different record completed on the same date which documented they had capacity to make a certain decision. A patient's standard assessment record changed between 4 February 2013 to 5 February 2013, from stating there might be issues relating to their discharge, to stating there were no such issues. There were no notes in their other records to show what factors had occurred to affect this change in their condition.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Inpatients accommodated on the day surgery unit at the time of the inspection visit were not having their privacy and dignity maintained. Regulation 17 (1) (a).
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Patients being cared for and treated on the day surgery unit (DSU) were not having their care needs adequately assessed, planned and delivered. The care and treatment arrangements on the unit were not organised around the range of care needs of the patients accommodated there. Regulation 9 (1) (a) (b) (i) (ii).
Regulated activity	Regulation

This section is primarily information for the provider

Treatment of disease, disorder or injury	**Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010** **Cooperating with other providers**
	How the regulation was not being met: Patients discharged from the hospital cannot be confident that the hospital will communicate necessary information about their care and treatment to ensure continuity of care and minimise risks arising from the transfer of care. Regulation 24 (b) (i).
Regulated activity	Regulation
Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment by means of accurate and up to date records. Regulation 20 (1) (a).

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 22 March 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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