Inspection Report

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

Medway Maritime Hospital

Windmill Road, Gillingham, ME7 5NY

Tel: 01634833824

Date of Inspection: 19 August 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	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Management of medicines	✖ Action needed
Staffing	✖ Enforcement action taken
Supporting workers	✖ Enforcement action taken
Assessing and monitoring the quality of service provision	✖ Enforcement action taken

Details about this location

Registered Provider	Medway NHS Foundation Trust
Overview of the service	Medway Maritime Hospital is part of the Medway NHS Foundation Trust, providing care to the whole population. The site includes a range of services for people from Medway and Swale, and from other areas in Kent. It is situated in the town of Gillingham. The Trust's website gives details of the services offered, such as Maternity care, Orthopaedics, Neonatal Unit, Accident and Emergency, and Macmillan Cancer Care Unit.
Type of services	Acute services with overnight beds Acute services without overnight beds / listed acute services with or without overnight beds
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'.

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 19 August 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 received feedback from people using comment cards. We reviewed information given to us by the provider, were accompanied by a pharmacist, reviewed information sent to us by other authorities and reviewed information sent to us by local groups of people in the community or voluntary sector. We talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

What people told us and what we found

This inspection was carried out to inspect only the Regulated Activity for Maternity and Midwifery Services provided by the Trust. We made the decision to look at this one area of the Trust after noticing a slight increase in the numbers of notifications of incidents which included ante and post natal women, and neonates.

In each area of the unit we looked to see if the service was safe, effective, caring, well-led, and responsive to people's needs.

The inspection was carried out by a team of five CQC inspectors, one compliance manager, two pharmacist inspectors and four clinical advisors. These included a practice matron with theatres experience; a senior midwife with management experience; a hospital manager; and a consultant obstetrician. We visited the maternity wards, delivery suite, antenatal clinic, and three locations in the community, over the space of four days and one evening.

During the visit we talked with groups of staff including doctors, registrars, consultants, midwives and supervisors of midwives. We also talked with staff on an individual basis. We had conversations with 14 women receiving care, and talked with seven relatives.

We found that women were involved in decisions about the birth and where they wanted this to take place. However, there was no clear pathway for women to know how to register with the service when they found out they were pregnant. This resulted in delays for some women to access antenatal care.

All of the women that we talked with expressed their satisfaction with the standards of care

they received and spoke highly of the midwives and other staff who attended to them. However, the management of care was affected by insufficient numbers of midwives, both in the hospital and in the community. This was particularly evident in the provision of post natal care, where midwives struggled to keep up with the demands on them.

We found that medication was administered appropriately, but some of the medication management had elements of poor practice. There was no pharmacy input for the maternity services.

Staff training programmes were available but were not completed satisfactorily by all staff. Midwives in the community were unable to access training easily due to ineffective IT systems. Hospital and community midwives said they did not have time to carry out on-going training programmes and felt unsupported in their job roles. Whereas junior doctors felt supported in their training and found the hospital a good place to work.

We found that systems of governance and management oversight were inadequate. There was poor communication between different directorates. The hospital did not have a service delivery plan for the maternity services, and had not taken into account the changing demographics in the area and how to meet the needs of women in the future. The electronic systems in use were unsupportive and did not serve the needs for the directorates to liaise competently with each other.

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 02 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Medway Maritime Hospital to protect the health, safety and welfare of people using this service.

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.

People's privacy and confidentiality were not always respected; and their ethnicity was not always taken into account.

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

Women in the local community were not supported in understanding the antenatal care and choices available to them.

The hospital did not assist women in the local area to know how to book in for antenatal care when they first became pregnant. The midwives told us that the majority of women carried out their own pregnancy tests at home, but then lacked the knowledge of how to access antenatal care. Many visited their GPs, and found that the GPs did not book them in, but gave them the telephone contact numbers. Women were largely expected to book on line via the internet. This posed difficulties for women who did not have access to a computer; who did not have English as their first language; or who were not computer literate. This resulted in a delay for some women to commence their antenatal treatment. We did not find that the hospital had taken any proactive measures to improve this situation. There was no action plan in place to reach different sectors of the community and provide information.

Women's first visits were carried out in the community, or in the hospital if women had difficult medical histories, or previous obstetric problems. We found that the midwives obtained comprehensive information about the women's medical, obstetric and social histories, and provided them with information about the options available to them for the birth. This included home births, hospital births, and a midwifery-led unit in the hospital called The Birth Place.

We saw that The Birth Place provided a comfortable and pleasant environment for women with a low risk of complications. The suite contained five delivery rooms, three of which included birthing pools. Each delivery room had en-suite toilet and shower facilities; and a pull down double bed so that the woman's husband/partner could stay with them after the

birth. People that we spoke to appreciated this facility and the relaxed environment.

Women who experienced concerns during their pregnancy could contact the community midwives or the hospital. They were admitted to a triage area on the delivery suite, where they were assessed by midwives and/or registrars as necessary. When we were shown into this area, we noticed that the triage area contained three small cubicles, with curtains to provide some privacy. However, the curtains had not been pulled round for one patient, which could have increased their sense of vulnerability. The cubicles were close to each other, and it was impossible not to hear what was being said to patients in the other cubicles. This meant that people's privacy was compromised when they might be hearing difficult information. It also meant that other women – who might already be anxious and nervous – could be impacted by the stressful news given to others, increasing their own anxiety. This did not provide a caring environment.

We saw that the bedside lockers on the wards did not contain any lockable areas. This meant that women who wished to carry out self-administration of medicines (such as women with diabetes who managed their own insulin), were unable to store medicines safely. It also meant that there was no lockable space for any valuables.

The midwives arranged for interpreters for women who were unable to speak English. The interpreters assisted them at their antenatal appointments wherever possible, and the aim was to provide women with the same interpreter so that they could build up some rapport. However, it was not always possible to access the interpreters when women went into labour, for example, during the night. The midwives said that they tried not to use relatives, in case there were any phrases that they might not interpret correctly. They were sometimes able to find another staff member who spoke the same language; otherwise they managed with facial expressions, signs and body language. This showed that the midwives were concerned to provide safe and effective care.

We talked with a total of nine postnatal women during the four days, both on the wards and in the community. They said that they had been given clear information from the time of their arrival, either for induction, or in labour. They felt that the midwives and doctors had explained what was happening at each stage of the process, and they said that their dignity was maintained.

The theatre nurse on our inspection team noticed that women who had Caesarian sections were treated with respect and supported through the operation; and the theatre staff were careful to keep them covered up as much as possible to protect their dignity.

We noticed that the delivery suite included a bereavement room for mothers who had lost their babies. The room did not have any sound proofing and was not in a discreet area away from the delivery rooms. This meant that women and their partners would be able to hear the cries of other new born babies, heightening their sense of loss.

Similarly, we found that for women in 4-bedded bays on the wards, there was nowhere private for staff to speak with them confidentially or break bad news, unless a single room was vacant. Sometimes the staff had to use the staff room which meant asking staff to leave during their break times. This meant that while the staff team were aware of being responsive to people's needs, they did not have always have the ideal facilities available.

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.

Women did not always experience care, treatment and support that met their needs and protected their rights.

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

Women were not always given treatment in a way which promoted their safety and welfare, although the staff were very caring and supportive.

All of the patients and relatives that we spoke to said that the care they received was good. They particularly attributed this to the dedication and commitment of the midwives, both in the hospital and in the community. Some of the comments we received were: "The care has been brilliant. I have been supported all the way through. They explained everything to me. The midwife helped me with my first breast feed." "I had excellent help in hospital even though they were very busy. They showed my husband how to change a nappy." "I wanted to go to The Birth Place, but I had some problems; but they helped me through." And "The staff are very busy but very caring."

The low numbers of midwives available had a clear impact on the delivery of care, particularly in the postnatal period. Hospital midwives said: "We care, but we are not able to provide the care we want to." And "We cannot give the care we want to when we are trying to care for so many. People need reassurance and time." A community midwife said "All the midwives are flat out and working to capacity. It is our passion for the job that keeps us going." The hospital midwives said that they lacked the time they needed to give new mothers help with breast-feeding, changing nappies, reassurance, and assistance with toileting or having a shower. They said that the maternity care assistants were "fantastic" and they "could not manage without them" but there was usually only one maternity care assistant on duty on each ward. They did not have time to provide education for new mothers, such as sterilising bottles, making up feeds or bathing babies.

The community midwives visited mothers on the first day after their discharge from hospital. They found that new mothers needed considerable input, especially with breast-feeding and bathing babies, because they had not had sufficient support in hospital. They also found that they needed to spend time listening to mothers and helping them with their worries and concerns. This meant that they needed to spend longer than their expected times to carry out the visits.

We saw that antenatal and postnatal classes were available in the community and we joined in briefly with an antenatal class. These provided parents with a good foundation in understanding the processes and caring for the baby, but only a proportion of parents attended these classes.

Low staffing numbers impacted on the care of women waiting for induction. We found that midwives on the wards, in The Birth place, and in the antenatal clinic, were moved to the delivery suite on a regular basis to help out because the delivery suite was so busy. One of the midwives said "This happens all the time"; and this was corroborated by conversations between other midwives and members of the inspection team. If a midwife was moved from the antenatal ward, this meant that there were times when it was not safe to bring in women for planned inductions because there were not enough midwives to care for them.

We found that the unit had a comparatively high number of Lower Segment Caesarean Sections (LSCS), with the figures from April – July 2013 showing an overall percentage of 26.83%. This included elective LSCS, and emergency LSCS. The unit had two obstetric theatres which were managed by the hospital's main theatres. Elective LSCS were carried out on three days per week in a designated theatre with five operations each day. The other theatre was available for emergency LSCS. The theatre manager was involved in all the day to day running of the theatres, and supported the teams clinically when required.

We noticed that some of the World Health Organisation (WHO) checks, which are standard in operating theatres, were not always carried out robustly. These checks should be carried out with the whole theatre team together, and ensure that correct operating procedures have been checked and are in place. These were not always carried out with the whole team in place and were unreliable. This meant that safe care could be compromised by unsatisfactory procedures.

We talked with obstetric consultants, who confirmed that women who had previously had LSCS were encouraged to give birth vaginally where possible. All operations carry an element of risk, and this showed concern to give mothers the opportunity to deliver their babies normally where they were able to. We saw that the unit had a high number of women who were assessed at high risk during their labour. These were categorised from 1-5 (using The Birthrate Plus tool), with 1 as low risk and 5 as high risk. The percentage for categories 4 and 5 showed an overall total for the preceding year of 52.8%. This meant that the unit had a high percentage of mothers within the high risk categories, demonstrating the complexity of cases in this area.

The decision to carry out five LSCS on three days per week caused a significant increase in the work on the postnatal ward on those days. Patients who had undergone LSCS had observations of their blood pressure and other monitoring checks every 15 minutes for the first hour; hourly for the next four hours, and then four hourly. The midwives on the postnatal ward said they were constantly moving dynamaps from one place to another. (Dynamaps are used to provide accurate and reliable blood pressure monitoring). When we visited the ward there were only two dynamaps, but seven mothers who needed frequent checks. The midwives said they were also frustrated by inadequate procedures for receiving equipment back after repairs. Both in the hospital, and in the community, midwives commented that "If we send something for repair it seems to be gone for months." Without the required checks, the mothers would be at increased risk of developing obstetric or medical conditions which could be missed. This meant that safe care which was responsive to people's needs was unreliable.

We looked at emergency equipment for mothers and babies, which included a defibrillator on the postnatal ward, the resuscitation trolley on both wards, and some resuscitaires used for babies. This equipment should be checked and cleaned daily. The records showed that emergency equipment was not checked appropriately. For example, the defibrillator had date checks recorded as 10/11/12, 07/07/13, 08/07/13, 10/07/13, 12/07/13, 14/08/13, and 18/08/13. This did not demonstrate reliable procedures, and potentially put mothers and babies at risk that equipment may not be in correct working order when an emergency occurred.

On one of the wards we observed an open box on the floor of the dirty utility room which contained used intravenous bags of fluid with intravenous giving sets still attached. The door was not locked, and the room was accessible to anyone. Some women had family members with children visiting them, and this could have posed an infection control risk and other health risks to anyone coming into contact with them.

We looked at patient records on both wards and in the delivery suite. We found that most of these had suitably detailed entries, showing the progress of women throughout their labour and the postnatal period. A patient who had arrived as an emergency admission had not brought her antenatal notes with her, but said that the doctors had taken a full history from her on admission. This was an example of good practice. However, three women out of 15 records checked had not had VTE assessments carried out. These are standard checks for the risk of developing venous thrombosis. This showed a lack of thoroughness in some of the antenatal care. The midwives used recognised scoring tools (known as MMEWS and SBAR) to identify patients at risk of deterioration, and to refer them to doctors when necessary.

We found that there was a lack of standard practices between the two wards. For example, on one ward women with intravenous fluids and urinary catheters did not have an on-going fluid balance chart maintained. A lack of monitoring meant that women with high risks, or with other medical conditions could be adversely affected by an inadequate fluid intake or output. On the other ward fluid balance charts were maintained.

The unit did not have a dedicated high dependency unit (HDU), but seriously ill women were transferred to the hospital's main HDU or the intensive care unit (ICU). A consultant told us that the staff liaised well across these departments, ensuring that midwives or obstetric medical staff attended to these women, as well as the HDU and ICU staff. This showed a commitment to providing safe and effective care.

We found that medical staff had good liaison processes in place for dealing with unexpected medical situations. For example, a woman with a serious illness who arrived at the hospital at 36 weeks pregnant, and was unknown to the hospital staff had been quickly assessed and given the treatment she needed. This had involved a review by the medical team, liaison with a tropical medicines unit, a discussion with the pharmacist, and treatment in the intensive care unit. The patient made a full recovery and the baby was born safely a few weeks later.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

Appropriate arrangements were in place in relation to obtaining medicines, but medicines were not stored or managed safely.

During this inspection we looked at medicines, medicines storage, and records relating to people's medicines. We talked to pharmacy staff and nurses working on two maternity wards, in The Birth Place and in the delivery suite and spoke with two patients, who both stated that they had given been sufficient information about their medicines.

Appropriate arrangements were in place in relation to obtaining medicines. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual patient basis. There were arrangements in place for the units to obtain medicines outside of normal hours. Medicines for discharge were either ordered from the pharmacy (40% were dispensed within two hours and a further 56% were dispensed within two to four hours); or they were dispensed direct from the ward by two midwives. Therefore medicines were available when people needed them.

Medicines were prescribed and given to people appropriately. Appropriate arrangements were in place in relation to the recording of medicines. The prescriptions and records of administration that we looked at were clear and complete. This showed that people were receiving their medicines as prescribed.

Medicines were not kept safely. On one ward the intravenous fluids were stored on the floor under a sink. The temperatures of the medicine refrigerators were not being monitored at weekends on any of the units and on one ward only one temperature was being monitored. This was not in accordance with the Medway NHS Foundation Trust policy which required both minimum and maximum temperatures to be recorded daily. The temperature of the freezer on the delivery suite and the ambient temperatures of medicine storage areas were not being monitored. Therefore the trust could not assure itself that medicines had been stored at the correct temperatures and were safe to use.

Medicines were stored securely in locked cupboards in all the maternity areas visited, however there were no facilities for the safe storage of medicines that were being self-administered by patients. This meant that unauthorised people could have access to these medicines. There were no policies, procedures or risk assessments in place to enable people to self-administer their own medicines. However people were given the opportunity to self-administer medicines if appropriate.

Medicines were not managed safely. Pharmacists did not visit the maternity areas and there was no evidence of medicines' reconciliation on admission or that clinical interventions were made as laid down by the Medway NHS Foundation Trust medicines management policy. Some of the discharge medicines supplied by the wards were not always labelled in accordance with the Medicines Act 1968, the Human Medicine Regulations 2012 or the Medway NHS Foundation Trust medicines management policy.

Emergency medicines were kept on both wards and the delivery suite; we saw evidence that they were not being checked regularly. Expired medicines were found within one area and in the medicines refrigerator on Pearl ward. Medicines that had been individually dispensed for patients had not been returned to pharmacy in accordance with the trust's medicines management policy. The opening dates of liquid medicines were not being noted and therefore it was not possible to determine if these medicines were fit for use.

Patient group directions, which were in place to allow the use of medicines without a doctor's prescription were dated July 2006. No review of this documentation had taken place in accordance with the Human Medicine Regulations 2012.

There was no clinical pharmacy service to maternity areas. This meant that the trust was not following the Medway NHS Foundation Trust medicines management policy or the Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services. The pharmacy department did not record the pharmacist interventions on a regular basis, other than once a year, so there was no information about the quality of prescribing and other medicines management issues, or evidence that trends were being identified and action taken to prevent their reoccurrence.

There was no evidence provided that medicine errors/incidents were being reported in accordance with the Medway NHS Foundation Trust medicine management policy and no evidence that learning from medicine incidents was being disseminated across the trust.

The pharmacy department had conducted an annual medicines security audit on maternity areas in May/June 2013. Some issues had been noted, but no action plans were provided to indicate that these were being addressed. The ward staff were not checking controlled drugs every 24 hours in line with the Medway NHS Foundation Trust medicine management policy; controlled drug record audits were being completed on a three to six month basis, but there were no action plans put in place when issues were identified. This did not demonstrate safe or well-led management.

Staffing ✖ Enforcement action taken

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

The trust did not have sufficient numbers of qualified, skilled and experienced staff to meet the needs of women receiving care.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

The hospital did not provide sufficient numbers of qualified, skilled and experienced staff to meet patients' needs.

We visited each ward and department, and three venues in the community. In each place the inspection team were informed that there were not enough midwives to give effective care. The midwives themselves expressed their frustration that they were not able to carry out care to the standards they wished to, simply because there were not enough of them.

The antenatal ward (Pearl ward) had 23 beds used mostly for antenatal patients, but also for some postnatal patients whose babies were in transitional care (i.e. receiving treatment from the special care baby unit). Some babies needed to stay for special care for a few days, (for example, to be given intravenous antibiotics), but did not need to stay on the special care baby unit. At the time of the inspection the ward was staffed with three midwives, one maternity care assistant, and a ward clerk. The transitional babies were given care by a neonatal nurse from the baby unit. We saw from the rotas that the night shift comprised two midwives, one maternity care assistant and one neonatal nurse. The establishment figures were for three midwives for day and night duty, but there was a shortage on the night concerned due to sickness. We were told that "no agency" was allowed to cover for a shortage of staff.

A midwife with many years' experience told us that she was required to act as a preceptor for four student midwives in addition to her midwifery duties on the ward. She stated that all inductions of births were commenced on Pearl ward before patients were moved to the delivery suite. This had been a recent management change, as they used to go straight to the delivery suite. The midwife raised concerns that staffing levels had not been adjusted to reflect this change in the level of their work. The delivery suite co-ordinator decided the priority of admissions for patients waiting for inductions.

We were present on the ward on a Monday morning, when a patient who had been admitted to the ward on the previous Saturday with a spontaneous rupture of membranes came to ask when her induction was going to take place. Her membranes had been ruptured since Saturday, and to prevent possible infection the labour should have been commenced within 24 hours. We were told that the induction had been delayed because of insufficient numbers of midwives.This showed a lack of safe, well-led management, that was not responsive to people's needs.

At another time we were present in Pearl ward when a manager came and asked one of three midwives to go and help in the delivery suite. A midwife told us "We were already short before this, and needed help ourselves. There are women at home waiting to be induced and we have to keep putting them off as there are not enough staff to care for them." This left two midwives to manage the care on the ward. We also found that the ward manager was not present on the ward because she had had to work the previous night to cover for lack of other staff.

The postnatal ward (Kent ward) had 23 beds and an additional four bed bay to use if necessary. At the time of the inspection the ward was staffed by two midwives, two staff nurses, one maternity care assistant and one housekeeper. The forthcoming night shift had one midwife, one staff nurse and one maternity care assistant. We were told that the night staffing had been increased to include two maternity care assistants, but the rotas showed that there were still some nights when there was only one on duty.

We looked at rotas for all departments and saw that there were needs identified on several days or nights per week where additional staff were required. These shifts were covered by staff working extra hours, by flexi bank staff, and sometimes by NHS Professionals (this is a specialist organisation within the NHS which supplies temporary staff).

The delivery suite had 10 Delivery rooms and a 4-bedded bay which was used for both ante and postnatal women for additional care as needed. The usual allocation for the delivery suite was for seven midwives day and night, but we were told there were "never less than six". The delivery suite also included the triage area, which was staffed by a senior midwife (Band 7) and another midwife.

We found from talking to staff and from examining rotas that there was an almost constant demand for extra midwives to staff the delivery suite. This meant that midwives were moved from the other wards and departments to ensure there were sufficient numbers in delivery. We saw that there had been two closures of The Birth Place during July 2013 because of inadequate staffing, when midwives had been moved to the delivery suite. We visited The Birth Place during a night shift and found it was staffed by two midwives. We were told that it should have been staffed by two midwives and one maternity care assistant, but there was no maternity care assistant for this night. This meant that The Birth Place was restricted in the numbers of women that the midwives could care for during labour.

The community midwives said that they "Loved giving continuity of care in the community." However, they were only expected to take 20 minutes per appointment, except for booking and first postnatal visits. This impacted on the quality of care as they often needed more time; and showed that they had insufficient numbers of midwives to carry out the care to the high standards they wished to continue.

We viewed a "Nursing and Midwifery Workforce Review" which had been carried out in

June 2013. The Trust used the Birthrate Plus tool which is a nationally recognised tool to assess the staff establishment to birth ratio. This showed that the total establishment ratio for clinical staff to the birth rate was currently set at 1:34. Total establishment figures included midwives, registered nurses (RNs) and maternity care assistants (MCAs). This was equivalent to 150 whole time equivalent midwives. This is considered low staffing by national standards. The review identified a 1:34 ratio for "midwifes to mothers." However, the assessed figure just for midwives was a ratio of 1:39. We discussed this with representatives from the Trust, and they clarified that the Birthrate Plus tool allows for a 90/10 split of 90% midwives, and 10% other clinical staff. However, this was not clearly stated in the document.

We were told that the unit was working towards a ratio of 1:33 by the end of 2013; 1:31 by March 2014; and 1:29 during 2014-5. This is equivalent to 175 full time equivalent midwives.

A new group of 10 midwives had been recruited to start work in September. These were newly qualified Band 5 midwives who would need additional mentoring and supervision. This would severely impact on the work load of the existing Band 6 midwives, who (in one midwife's words) were "already stretched to capacity". We saw that the Band 6 job description stated "She/he will provide mentorship to less experienced midwives and other staff in a hospital setting." There was a plan for further recruitment of 15 midwives by 2015.

We found that the skill mix of staff did not always provide the support that was needed. For example, the wards had one or two maternity care assistants. The midwives spoke highly of their hard work and dedication. However, we did not see evidence of any plans to increase the numbers of these staff. We also noticed that midwives were busy with responsibilities such as obtaining blood results, while maternity care assistants were providing care; instead of freeing midwives up from administrative roles that other staff could do for them. This was also evident in the community, where midwives said they had to spend time chasing up blood results, which could have been carried out by a clerk. The community midwives said that the clerks who assisted them were "excellent", and they could not manage without them, but midwives were still carrying out tasks that could have been done by others. We talked to consultants who said that they had been asked to carry out tasks which an administrator could do, and which held them up from being able to focus on their skills as obstetricians.

We found that there were sufficient numbers of consultants and registrars, and junior doctors (SHOs). The midwives said that they rarely had any problem with accessing medical help when it was needed. It was only occasionally that there was any delay, and this was if both registrars on duty needed to be in theatres at the same time. The registrars did not have any concerns about being able to access consultants. At the time of the inspection, a consultant stayed on the premises until 10.30pm before going on call for the night. Two of the consultants said they had been discussing the future possibility of having a resident consultant on call, as there were increasing numbers of women at high risk receiving obstetric care.

This showed that the staff were dedicated and caring, but the management was ineffective as it was not responsive to people's needs.

Supporting workers ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Medical staff received appropriate support and training to deliver care and treatment safely.
Midwives lacked support, and were unable to keep up with training requirements. This meant that the hospital could not confirm that they were able to provide care and treatment to an appropriate standard.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Staff did not all receive appropriate professional development.

We talked with a number of junior doctors, who said that there was a good relationship between the doctors and the midwives. They said that they felt supported by registrars and consultants, and were able to develop their skills and knowledge through the training processes provided. New doctors said that they had had a helpful induction, and found that there was good on-call support. One said "This is a good place to work"; another said "I have been able to learn a lot in the maternity triage area." A third doctor said "The senior doctors and consultants are approachable and supportive." We saw that the medical staff assisted one another with developing their skills and competencies. Some said that it was difficult to find the time to keep up with training as their time was very pressured.

We were informed that there were two groups of doctors, trainees and non-trainees. This included 15 middle grade doctors, six trainees, and nine seniors. Their supervision was restricted to the doctors who were qualified trainers. They used the programmes QUEST 1 & 2, which are recognised by the deanery. The doctors were divided into groups of: Obstetrics and Gynaecology; GP trainees, and Foundation 1 and 2 (F 1 and F2). All of the doctors had an allocated educational supervisor. There was a minimum requirement for three meetings per year to assess the programme. Day to day training was the responsibility of all the consultants, and involved "hands-on" training. The registrars were assessed until they felt competent and confident with procedures. A package was put into place to assist them if they were not competent in any areas. This also applied if, for example, a registrar was assessed as competent in some areas, but said they lacked confidence. The registrar would then be supervised with all of their duties by a consultant until they felt fully confident. Any decision-making was passed via a consultant until

registrars had been assessed as competent.

Junior doctors said they were not usually given feedback from adverse incidents, although these were discussed at monthly meetings. They did not see the maternity dashboard, which provides an overview of the unit's performance, and were unaware of the percentage of LSCS and inductions. All of the doctors that we spoke with were confident that they could raise concerns if they needed to do so, and said that they would contact the clinical director or the consultant on call.

The consultants carried out informal training programmes in the seminar room adjacent to the delivery suite. This included an allocated subject on Fridays; and teaching on a relevant topic on Monday lunchtimes that doctors or midwives could attend. The junior doctors had regular individual supervision, and were supported with mentoring and appraisals. We saw the records for doctors' appraisals, and these were up to date.

New midwives said that they had completed an induction which included mandatory training. We noticed that the induction for maternity staff was generic and was not role specific. Employees were all provided with an "Employee pocket book training guide" which showed them when their next refresher training (known as "Prompt") was due. Much of this training was carried out by e-learning, which posed particular problems for midwives and other staff in the community. They were unable to access the hospital learning programmes via the computers in community centres, and had to either visit the hospital, or use their own computers at home. Two midwives said that they could not access the systems from home as the designated passwords did not work; and there was not always a computer available if they came into the hospital.

Staff were provided with two days per year to update mandatory subjects such as fire safety, moving and handling, infection control and safeguarding children; and two days per year to carry out training in additional subjects. One midwife told us that a group of midwives were attending a training day in London about alcohol and pregnancy. We looked at the records for mandatory training for the last year. This showed that midwives were not keeping up to date with required subjects. Each subject had a designated time span for completion. For example, adult and neonatal resuscitation training was yearly; child protection and safeguarding vulnerable adults was three-yearly; and infection control was every two years. Infection control was divided into levels 1-3, and staff were allocated different levels to complete in line with their job roles.

Midwives told us that Prompt training was maternity based and included key subjects such as resuscitation and breast-feeding. We were told that "Prompt training gets cancelled a lot, for example, if the delivery suite is too busy and so staff are not available, or if there is no trainer available."

The records showed that there were significant gaps in training updates. The directorate average for clinical staff who were up to date with all of their training was 52.35%. Some subjects had noticeably low results such as 31.58% for clinical manual handling. For non-medical staff, 28% had completed fire level 1 training, and 47.96% had completed fire level 2 training. These figures did not demonstrate that staff would be confident and competent in carrying out all aspects of mandatory subjects, and did not demonstrate safe, effective and well-led management.

We noticed that some subjects were not considered as mandatory for staff to complete, such as bereavement training. This meant that staff had to complete this as an additional

training subject, even though all maternity staff could be involved in caring for mothers who had suffered intra-uterine deaths, stillbirths, or the deaths of neonates. The records showed that only 20 midwives had been trained in bereavement, and they had completed the training in their own time. We saw that non-clinical workers were not required to have Mental Capacity Act 2005 training, although this could have been of benefit to them if they were assisting women with limited mental capacity, for example, women with learning difficulties.

Midwives said that they were responsible for their own training updates, and for pursuing additional related subjects of their choice to add to their knowledge and competency. While this allowed them to train in their own time and using preferred methods, this was felt to be unhelpful in some ways, as they said that they were not assisted to carry out their training. Newly qualified midwives said that they were required to ask a senior midwife to mentor them. While this provided them with choice, some said they found it difficult to know who to ask. Newly qualified midwives on their preceptorship were provided with a competency training pack to complete, which included subjects such as cannulation, and suturing. They observed these skills at first, and then participated. The skill was signed off by whichever midwife assessed them for their competency at that time. They said that they appreciated that there was an allocated trainer to look after all the students and preceptorships at the end of their training.

None of the midwives that we spoke to were aware of the maternity dashboard and current issues. They said that the culture of the unit was for midwives to manage themselves. Some midwives said that they did not feel supported when they were unsure of what to do, and were visibly distressed when talking about their experiences. Their comments included that they "Might get shouted at and made to feel like an idiot"; and "There is lots of whip-cracking but not hands-on help from senior management."

Midwives in the community spoke positively about the safeguarding team, who reviewed each midwife's caseload every three months to make sure they had not missed anything. But community midwives did not feel they had good contact with the trust and felt disassociated from senior management.

We looked at supervision records which included yearly appraisals. The overall records showed that 100% of midwives had had their appraisals completed in 2012. However, when we looked at the figures in more detail, we found that some midwives had not had appraisals completed for as long as three to four years. This showed that maternity staff were not appropriately supported in their work and different job roles; and the systems in place were ineffective.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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 not meeting this standard.

The trust did not have effective systems in place to regularly assess and monitor the quality of service that people received.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We were unable to evidence that learning from incidents and investigations took place and that appropriate changes were implemented.

We assessed this outcome by viewing over 70 documents, and by talking with staff at all levels, including consultants and management.

The maternity unit did not have a service delivery plan in place. Despite the trust's awareness of the changing demographics in the local area, a quality strategy for the service was not evident. The demographic changes included increased numbers of women presenting with obesity; more teen pregnancies; and more women from different ethnic groupings. These groups significantly increased the number of women at high risk in their pregnancy and delivery. We did not find a clear strategy, which had been communicated, discussed, reviewed and audited, and this meant that there was a potential for the service to be reactive to events and issues rather than having proactive plans in place.

The maternity dashboard did not show the patients' ability to access antenatal services, and did not include the demographics. It was not a clear and transparent document for all staff to see and access, even though it should provide the service managers, clinicians and other staff with the opportunity to flag issues and be a drive for improvement. Staff were unaware of its use and importance. The Directorate referred to the dashboard as the "Nursing and Midwifery Accountability System – (NMAS)". We saw three different dashboards for performance in use, rather than one overall dashboard which was kept up to date with the previous month's figures. The trust used three dashboards of which one was for information for the Maternity Services Liaison Committee; the second was for The Royal College of Obstetricians and Gynaecologists; and the third was for The Medway NHS Foundation Trust .

We found that previous action plans in relation to the analysis of previous incidents had elements which had not been achieved; but the action plans had been dropped rather than being re-assessed.

Each trust director assessed all 16 essential standards of quality and safety (linked with the regulations for the Health and Social Care Act 2008) every quarter against their directorate; and each directorate had an executive lead. However, the trust did not evidence good communication between the directorates. This meant that directorates were working in isolation from each other in some areas. An example of this was when we asked to view some recruitment files and other associated documentation. We asked for these at 09.30, and had still not received some of the documentation requested by 15.30. We were told that this was because the documentation was not easily accessible for the person obtaining the documents that we requested. All of the documents requested related to maternity services and should therefore have been accessible.

Similarly, we found that the IT systems did not support the directors or staff generally. For example, the community midwives could not enter patient's first visit details on to the electronic system apart from a front page booking sheet. The first visit included a detailed history of the patient's medical, obstetric and social history. These forms had to be taken to the hospital by a clerk, as they could not be entered from the community. We also found that women's hand-held notes were not added on to an electronic system. This meant that if they attended a visit to the hospital or in the community without their records that the midwife did not have access to the information obtained at previous visits. This was particularly of concern if a woman attended hospital due to an illness or injury, and staff could not see how her antenatal care had been progressing.

We found that supervisors of midwives and senior staff did not have clear systems or a specific pattern for auditing notes and records. One said that they "Saw a number of notes during each day, and would speak to the staff member concerned if notes were incomplete." This showed a lack of auditing systems in place to ensure that documentation was thoroughly and correctly completed.

We found that the maternity unit had many management staff, but not enough hands-on staff. Staff felt supported by their own teams but not by the management. They said it felt like "a glass ceiling" and "nothing got beyond a certain point." They also felt that lines of accountability were unclear.

It was not clear how the voice of staff was heard within the service. We were not shown any evidence to demonstrate that the trust or the directorate had promoted the trust's "Listening into Action" initiative, which had now been in the hospital for over a year. The initiative sought to hear directly from staff on issues of good practice, and those where improvements could, and should, be made. The directorate had not analysed the results from the trust's scores from the national NHS staff survey to elicit specific comments and scores from its own staff. It also had not used the "Pulse" survey within the Listening into Action initiative, to directly ask their own staff for their thoughts on areas for improvement. We asked for the staff survey information several times over the first two days of the inspection and it was not provided.

We saw that the "Friends and family" test had been used in different maternity departments. This provided women with the opportunity to state if they would be likely to recommend the unit to other women as a good place to have their babies. We saw that 309 out of 334 responses (92.5%) for June 2013 stated that women would be "likely" or

"extremely likely" to recommend the unit. We saw that most comments were very positive, with comments such as "All staff have been supportive, friendly and caring" (about the delivery suite); and "I was really happy with the care my son and I received" (Kent ward). However, there was no evidence to show that negative comments were discussed, or that appropriate action was taken to prevent the re-occurrence of unsatisfactory experiences.

There was little evidence of a commitment to leadership of safety and improvement training for both senior leaders and staff generally. This had not been remedied through the trust's "Quality Strategy" board, and its complementary approach to organisational development. For example, we found that serious incidents were discussed at consultant level, and to some extent by other medical staff; but midwives said that they did not receive feedback about these incidents, and there was no clear route to show the learning that was taking place

We found that training refresher courses did not always reflect national guidelines for their frequency to maintain safety. For example, doctors were required by the trust to carry out resuscitation training for adults and neonates every four years. However, the cardiopulmonary resuscitation standards for clinical practice and training issued by the Royal College of Anaesthetists, Royal College of Physicians of London, Intensive Care Society and the Resuscitation Council (UK) state that clinical staff should update their resuscitation skills annually. This showed that the trust was not adhering to national guidelines, but that directors were abiding by their own decisions.

One key aspect of quality management related to the impact of cost pressures and the needs for savings to be achieved. Within the trust this was known as the "Transforming Performance Programme." We did not find that cost-saving projects had a comprehensive impact assessment undertaken by the service and involving clinicians where appropriate.

We found that the Board of Directors had recently introduced a buddy system in which the Board members (both Executive and Non-Executive Directors) were allocated to visit areas within the hospital. This was so that they could see care being given, talk with staff, and assure themselves of the care being given. The Board paper describing these visits did not show who had visited each area, or when. There was no clarity on pursuing actions to be taken in the light of the findings; or who was accountable for changes to be implemented. This meant that the visits lacked purpose and were not productive to build on former progress.

We found shortfalls in other areas of management such as the pharmacy arrangements. There was no clarity about who was directly accountable for pharmacy while the Chief Pharmacist and the deputy were both on holiday. Pharmacy staff did not know who the Accountable Officer was for controlled drugs.

We found that there had been a strong focus on a possible merger with Darent Valley Hospital, although this had been put on hold. This had deflected the trust from a focus on the hospital's own performance and leadership.

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
Maternity and midwifery services	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The trust did not provide women with a straightforward pathway for referral for antenatal care, meaning that vulnerable women could be left with substandard care. Women from different ethnic backgrounds were not given clear assistance to access antenatal care. However, information provided during pregnancy and labour was managed appropriately. The trust showed a lack of awareness of protecting women's privacy and confidentiality in some areas. (Regulation (1a) (2 a,h)
Regulated activity	Regulation
Maternity and midwifery services	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The planning and delivery of care did not ensure the safety and welfare of women throughout the whole of the maternity processes. Procedures for dealing with emergencies were affected by a lack of well-led and effective management to ensure that women's safety was maintained. Day to day checks

This section is primarily information for the provider

	and records were unreliable and impacted on women's welfare and safety. (Regulation 9 (1b) (2))
Regulated activity	Regulation
Maternity and midwifery services	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The trust did not have appropriate arrangements in place for medicines' storage, for self-administration, or for dispensing medicines. The trust did not follow published guidance about safe management of controlled drugs. There were no records to show that medicine errors were appropriately reported or had action taken to prevent re-occurrence. (Regulation13).

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 02 November 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 31 December 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Maternity and midwifery services	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The trust did not employ sufficient numbers of qualified, skilled and experienced midwives to meet the needs of women receiving care; and did not demonstrate that there were sufficient numbers of staff on duty for each day and night shift. Some of the skill mix was inappropriate for effective management.(Regulation 22).
We have served a warning notice to be met by 31 December 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Maternity and midwifery services	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met:

This section is primarily information for the provider

	The trust did not have suitable arrangements in place to ensure that staff employed in the maternity directorate were appropriately supported in relation to their responsibilities. (Regulation 23 (1)).
We have served a warning notice to be met by 31 December 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Maternity and midwifery services	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The trust did not have an effective system of operations to regularly assess and monitor the quality of the services provided in relation to maternity and midwifery services. There was a lack of clarity about accountability, and evidence of poor communication. The trust did not demonstrate that patients' and staff views were sufficiently considered to come to an informed decision about the care and treatment provided to service users. (Regulation 10 (1) (2e))

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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