# 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: 09 December 2014

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

**Care and welfare of people who use services** ✖ Action needed

## Details about this location

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| 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.<br>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<br>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<br>Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Termination of pregnancies<br>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 9 December 2014, 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 reviewed information given to us by the provider. We reviewed information sent to us by other regulators or the Department of Health, talked with other regulators or the Department of Health and were accompanied by a specialist advisor.

Theatre Specialist Advisor

### What people told us and what we found

On 31 December 2013 we carried out an unannounced inspection of the Emergency Department (ED) at Medway Maritime Hospital in response to information we had received from an anonymous source regarding the safety and effectiveness of the ED. We found that the service was failing to meet the national standards that people should expect to receive. As a result, we issued formal warning notices to Medway NHS Foundation Trust, telling them that they must improve in a number of areas within a specified period of time.

Medway Maritime Hospital was inspected again as part of a comprehensive inspection of Medway NHS Foundation Trust because Medway NHS Foundation Trust was rated as high risk in the CQC's intelligent monitoring system and the trust had been placed into 'special measures' in July 2013 following a Keogh review. This inspection took place between 23 and 25 April 2014 with an unannounced inspection visit on 1 May 2014.

As a result of the comprehensive inspection, overall, the hospital was rated as inadequate. We rated it good for being caring but improvement was required in providing effective care and being well-led. The safety of the hospital and being responsive to patients' needs were rated as inadequate. Whilst some core services were rated as good overall, for example critical care and services for children and young people, the emergency department and surgical services were both rated as inadequate.

We carried out further unannounced inspections of the ED on 27 and 28 July 2014 and again on 26 August 2014. In 28 July 2014 we also reviewed the surgery department to determine whether the trust had commenced making the necessary improvements to the service.

During our inspections of the ED in July and August 2014, we found that the ED lacked robust clinical leadership.

The ED had failed to review and optimally utilise its escalation policy within the ED to avoid the need to 'stack' or 'cohort' patients. Whilst patients were being stacked they were not undergoing regular nursing observations, and were not being seen in a timely manner by medical staff. We therefore took urgent action to impose additional conditions on the trusts legal registration with the Care Quality Commission. These conditions required the trust to operate an effective system which ensured that patients could expect to undergo an initial assessment by a skilled and qualified health care professional within 15 minutes of presentation to the Emergency Department. We also required the trust to report to us on a weekly basis, any patients who were not assessed within 15 minutes to determine whether those patients experienced sub-optimal care or had a poor experience upon initial presentation to the department.

Our reason for imposing these conditions was to ensure that staff working in the ED were acutely aware of all patients present in the department; this helped to enhance the safety of the department; we had previously found that patients who were acutely unwell could experience long delays before being initially assessed.

We carried out a further unannounced inspection of both the ED and the main theatre department on 9 December 2014. The inspection team included a general acute physician and a theatre specialist advisor.

Our key findings of the inspection were:

Emergency Department:

The department continued to experience significant issues with transferring patients to wards once a decision had been made to admit them. Delayed transfer of patients was resulting in patients experiencing delays in being treated once they had presented to the ED. However, the trust had implemented initiatives including undertaking an initial assessment of all patients within 15 minutes of their arrival to the ED. Improvements were required to ensure that patients arriving by ambulance received the same level of care as though who self-presented. This included ensuring that trust policies and procedures were consistently adhered to, including those relating to the management of "cohorted" or "stacked" patients.

Clinical leadership was starting to develop; staff were, however extremely candid with us regarding the current pressures of working within the department.

Theatres:

We found that there had been some improvements in the delivery of theatre services although we were concerned that the department was still not being well-led in some aspects; we have referred our concerns back to the trust executive team. Management of emergency theatres and trauma surgical lists was slowly starting to improve although it was difficult to measure the impact that this was to have on patient experience and the quality of care patients could expect to receive as the interventions remained in their infancy. Patients continued to experience delays in being transferred from the recovery department to a ward bed; this was attributed to the continued and significant capacity issues experienced across the hospital.

Medical Escalation Area - Sapphire Ward

We found that the environment of Sapphire Ward was not conducive to ensure that the

individual needs of patients could be met. Capacity issues across the hospital had resulted in excessive numbers of patients being placed on Sapphire ward. A lack of curtains impacted on the privacy and dignity of patients and a lack of piped oxygen and suction potentially placed patients at risk of harm.

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

## What we have told the provider to do

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

**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.

Whilst some improvements have been made since we last inspected in August 2014, care and treatment was still not being delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

### Reasons for our judgement

Current Trust Performance:

The performance of the emergency department during quarter 2 (6 July – 29 September 2014) was markedly worse than that of quarter 1 (6 April 2014 to 5 July 2014); this was despite there being fewer attendances during quarter 2. Data from NHS England indicated that between 6 April 2014 and 5 July 2014, 25,277 patients attended the emergency department at Medway Maritime Hospital. This was compared with 24,344 patients attending the ED between 6 July and 29 September 2014.

During quarter 1, 86% of patients were admitted, transferred or discharged within 4 hours of arrival; the national target of patients being admitted, transferred or discharged within 4 hours of arrival is 95%. During quarter 2, 84% of patients were admitted, transferred or discharged within 4 hours.

During the first 10 weeks of quarter 3 (29 September 2014 - 7 December 2014) the Medway Maritime Hospital treated 19,350 patients. Approximately 80% of patients were admitted, transferred or discharged with 4 hours during the same period.

In quarter 1, 515 patients experienced delays of between 4 and 12 hours before formally being admitted to hospital. This compared with 724 patients during quarter 2. Between 29 September and 7 December 2014, 1,162 patients experienced delays of between 4 and 12 hours before formally being admitted to hospital.

Furthermore, during quarter 2, 6 patients were reported as waiting for more than 12 hours from the time a decision to admit was made; this compared with 1 patient experiencing a delay during quarter 1. 2 patients experienced delays of more than 12 hours from the time a

decision to admit was made during the first 10 weeks of quarter 3 2014.

The Friends and Family Test (FFT) is a single question survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. 69% of patients using the A&E at Medway Maritime Hospital would recommend the department; 18% would not recommend the department. This is significantly worse than the national average of 87% and 6% respectively.

During October 2014, 77% of patients would recommend an inpatient ward at Medway Maritime Hospital. This compared with 14% of patients who would not recommend the same service. This was again worse than the national average of 94% of inpatients services recommended versus 2% not recommended. However, both Tennyson and Trafalgar ward attained a 100% recommendation rate during October 2014 (the response rates for these two wards were also higher than the national average which increases the accuracy of patient experience).

Between July and September 2014, the overall bed occupancy of the hospital was 89%. This was slightly worse than the national average of 86%. General and acute bed occupancy for the same period was 91% versus 88% nationally and 71% for maternity services versus 60% nationally.

National standards recommended that when a patient's elective operation is cancelled by the hospital at the last minute for non-clinical reasons, the hospital should offer the patient another binding date within a maximum of the next 28 days or fund the patient's treatment at the time and hospital of the patient's choice. Between July and September 2014, 81 patients had their elective operation cancelled at the last minute for non-clinical reasons. 2 patients were not treated within 28 days of their last minute elective cancellation. Overall, this was an improvement on the trust’s performance during quarter 1 of 2014 whereby 168 patients had their elective operation or procedure cancelled at the last minute for non-clinical reasons.

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Emergency Department

Initial assessment and management of patients:

During our inspection on 9 December 2014, we found that there had been some improvements in the initial assessment and management of patients who presented to the department. In response to the conditions we imposed on the trust (discussed on pages 4 and 5 of this report), the majority of patients who self-presented to the ED were initially assessed by a qualified nurse within 15 minutes. According to data provided to us by the trust, between 3 and 10 December 2014, 97% of patients who self-presented were initially assessed within 15 minutes. For the same time period, 94.5% of patients who were transported to the ED via ambulance were initially assessed within 15 minutes. The trust acknowledged that more work was required to ensure that this cohort of patients was assessed within 15 minutes.

A requirement of the trust's conditions imposed on them by the Care Quality Commission was that we required them to undertake a review of all patients who were not assessed within 15 minutes to ensure that those patients did not suffer harm as a result of the delays they experienced. We have raised concerns with the trust regarding the quality of their data with regards to this requirement and will follow this up formally with the trust.

We noted that the initial assessment of self-presenting patients was carried out by a

qualified nurse. However, due to the relatively short time scale in which we required the trust to meet the newly imposed conditions, there had not been sufficient time to redesign the reception area so that patients could be assessed in a private area. We observed initial assessments being undertaken at the main reception desk which afforded patients very little privacy. This again had been identified by the senior management team as an issue and a resolution was being sought.

We noted that changes to the layout of the ED reception area had taken place since our last inspection; the position of waiting room chairs had been changed so that patients were facing the assessment nurse. This allowed the assessment nurse to visibly monitor patients and to intervene where patients were observed to be deteriorating.

We had previously raised concerns with the senior management team regarding the management of patients who were 'stacked' or 'cohorted'. We had previously reported that the department was too small to accommodate the numbers of patients seen on a daily basis. On the day of the inspection we found that each major's cubicle was full and patients were being cohorted in communal spaces within majors. Cohorted patients were being managed by a team of South East Coast Ambulance Service (SECAmb) paramedics and technicians; SECAmb staff were observed to be performing basic interventions such as vital sign observations. We observed good communication between the SECAmb team and the clinical staff within the ED, with appropriate escalation of patients being reported where they had caused concern for the SECAmb crews. However, we found that there continued to remain some confusion regarding the governance arrangements for patients who were cohorted. During our discussion with staff from both SECAmb and Medway Maritime Hospital, we received mixed understandings of the roles that SECAmb had when managing cohorted patients. Some hospital staff believed that SECAmb could undertake a range of interventions including the administration of medications and intravenous fluids, as well as carry out diagnostic tests such as blood tests and electro-cardiograms (ECGs). Others considered that SECAmb were present to observe patients, to undertake routine observations of blood pressure, pulse and blood oxygen levels as examples, and that where patients were deteriorating, the SECAmb crews were required to escalate the patient to a relevant member of hospital staff. Whilst there was a cohorting protocol in place, we have judged that further work is required to ensure that all staff are aware of their roles and responsibilities to ensure that patients are kept safe whilst they are cohorted and awaiting treatment from hospital staff.

We found that there had been improved governance regarding the routine checking of emergency equipment such as resuscitation trolleys to ensure they were fully equipped and functioning. Data provided to us by the trust demonstrated that daily and weekly checks had been fully completed, without any gaps being noted for the three weeks leading up to the inspection (21 November – 5 December 2014). Emergency equipment was found to be plugged in and fully charged; resuscitation equipment was organised and accessible. The senior team acknowledged that further work was required to ensure that these governance arrangements were embedded into routine practice and that they could evidence sustained improvement in this area.

Clinical Leadership:

We had previously commented that the emergency department lacked strong clinical leadership. During our inspection we found that there was greater engagement of the senior medical team; a highly experienced and respected emergency physician had been sourced from outside the organisation to assist in improving the overall functionality and performance of the ED. A "Top 100" improvement plan had been introduced and senior clinical staff that

we spoke with were engaged in delivering the programme to help influence change in the department.

Two additional emergency medicine physicians had been appointed to the department since our last inspection in August 2014. As we previously mentioned, we found that on the day of the inspection, the department was extremely busy. We observed that the nurse-in-charge was hampered in their efforts to co-ordinate the department due to the high number of enquiries raised with them by visiting health professionals. Furthermore, we noted that the relationship between the nursing staff and duty consultant required improvement to ensure that the department could operate at its optimal performance. We observed some behaviour which we considered to be neither professional nor consistent with the values and behaviours of the trust. We fed our concerns back to the executive team on completion of the inspection; they acknowledged that their remained some “cultural and behavioural challenges” within the hospital and that these were not isolated to the emergency department.

Access and Flow:

The ability of the emergency department to fully function as intended was hampered by significant patient flow problems. Patients requiring admission to the hospital could expect to experience delays in being transferred from the ED to an inpatient bed. We were informed by the senior management team that an internal review of patient activity had been carried out on Friday 5 December. The outcome of this review was that there were a large number of patients who were medically fit to be discharged from hospital, remaining in hospital beds because there were delays in appropriate social care accommodation being found for them. A significant amount of work and engagement with local social services is required to ensure that patients are discharged in a timely manner, so that patient flow across the hospital can be improved.

The consequence of poor patient flow was noted to affect the majority of departments across the hospital. Because patients could not be transferred from the ED to ward beds in a timely and efficient manner, nursing staff in the ED were required to undertake additional duties to ensure holistic care was provided to patients; this impacted on the clinical effectiveness of the ED. Five nurses that we spoke with each explained that the type of care they were providing to patients was more commonly seen on medical wards and was not consistent with emergency nurse practice; we observed that this was impacting on the morale of the nursing staff working within the ED.

Issues with poor flow through the ED was compounded by the high volume of patients that were transported to the ED via ambulance services and by those who self-presented to the department with minor injuries or illnesses which could be resolved by primary care (GP) services. We noted that approximately 22% of all patients who presented to the ED were assessed as being suitable to be treated by the on-site General Practitioner service. We were reassured that, as a result of the high number of primary care patients presenting to the ED, on-site GP services had been extended to provide a 24 hour service.

Shortly prior to the inspection, we received information of concern regarding the number of nurses allocated to cover the 5 bed resuscitation bay. We found that on the day of inspection, 2 qualified nurses had been allocated to oversee the area. We noted that poor working processes, poor design and layout and a continued high turnover of patients impacted on the ability of the resuscitation area to function effectively. However, we observed nursing staff providing compassionate care to patients and their families. We

observed good examples of multi-disciplinary working with clinical nurse specialists and resuscitation officers providing additional nursing support to patients who were receiving care in the resuscitation area. We were told that a comprehensive review of staffing ratios was required within the emergency department to ensure that it was appropriately staffed at all times so that patients received appropriate care and support. Both nursing and medical establishment was listed as an area which required addressing as part of the “Top 100 Improvement Actions” for the ED.

During the inspection we received information of concern that patients were being nursed in an environment which was not fit for purpose; Sapphire Ward. As part of the inspection, we visited Sapphire Ward to corroborate the concerns that had been raised. Sapphire ward is routinely a day ambulatory unit, providing care and treatment to patients who require only short medical interventions such as blood transfusions and intravenous drug therapies. The senior management team advised that whilst Sapphire ward was not a suitable area to nurse patients overnight, the area was included as a step down area for low-dependency patients in the escalation policy and that 8 beds was the maximum number that should be opened.” We found that 10 patients were currently being cared for on Sapphire ward. Staff informed us that the majority of patients transferred to Sapphire ward were low-risk patients who required little intervention and were, most frequently awaiting to be discharged home or to a social care setting. Oxygen and suction was only available by way of portable units. We found that 2 patients were being cared for in a bay which contained no curtains and so this potentially compromised their privacy and dignity, although staff had made some effort to ensure that a dividing screen was available in order that the patients could be separated. One relative that we spoke with explained that they had been referred to the Sapphire unit the day before; they experienced a delay of 4 hours from arriving on the ward to being assessed and then was not transferred to a bed until 23:00 that evening, 13 hours after they first arrived. They reported that "communication was poor" amongst the speciality under which they had been admitted although we noted that the patient was being reviewed at the time of our visit to the ward.

The senior management team advised that whilst Sapphire ward was not a suitable area to nurse patients overnight, the area was included in the escalation policy and that 8 beds was the maximum number that should be opened. We were advised that the evening prior to our inspection, 12 patients were being nursed as inpatients on Sapphire ward. We were assured that patients would be relocated so that the number of patients was reduced to 8. Senior nursing staff reported that when numbers increased above 8, this could impact on the ability of the nursing staff to provide holistic care to patients which met their health and welfare needs. We received information of concern on 11 December that the number of patients remained at 10, with one patient requiring oxygen therapy and a further two patients being acutely unwell. We escalated these concerns back to the trust who responded in a timely manner, acknowledging the concerns and describing the remedial actions they had taken to resolve the capacity issues which had resulted on excessive numbers of patients being cared for on Sapphire Ward. We were further updated by the chief nurse on 16 December to advise that due to continued capacity issues, four patients remained on Sapphire ward but that the situation was being monitored to ensure patients were appropriately placed.

Theatres:

We found that the clinical team within the theatre department had accepted ownership of the issues which had been identified during the comprehensive inspection in April 2014. A new lead for trauma had been identified whose role it was to oversee the effective running of the trauma surgical list. A process of identifying a “Golden Patient” had been introduced. An

orthopaedic registrar would identify a patient who would be appropriate to be listed as the first surgical case on the trauma list for the following day. The golden patient was discussed with a junior anaesthetist during the previous evening to ensure that all necessary assessments and diagnostics such as blood results were available. The patient was then prepared by ward staff on the morning of the day of the operation, and the patient was then transferred to theatre for 08:30. A formal theatre list of trauma cases was planned at 08:00 and a finalised list was shared amongst the theatre team by 08:30. Whilst still early in its inception, theatre staff reported that there had been fewer delays during the trauma list and fewer patients had had their procedures cancelled. We were assured to find that the new process had been underpinned by a level of governance, with theatre staff auditing the process to ensure it was effective. At the time of the inspection, no audit data was available as the audit had only just commenced.

Two clinicians had been identified to lead on the development of the emergency (CEPOD) list. We had previously been critical of the effectiveness of the list; we had found that there were high numbers of cancelled procedures and poor, overall management of the CEPOD list. New processes have since been introduced to ensure the CEPOD list was more effective. Surgical representatives who had cases booked on the CEPOD theatre list met at 08:00 each morning to discuss their patient. There were clear expectations that the consultant responsible for each case was present for the 08:00 meeting however it was accepted that a senior registrar may represent the consultant in some cases. The CEPOD theatre meeting was attended by the surgical theatre matron, CEPOD co-ordinator and administration staff and a formalised CEPOD theatre list was generated and made available to the theatre team by 08:30.

It would appear that the changes made to the management of both the CEPOD and trauma lists was making a difference. Having dedicated leads ensured that staff remained focused. We reviewed the list of patients cancelled within the theatre diary dating from 1 July 2014 to 8 December 2014; we identified an average of one trauma and one CEPOD patient being cancelled each week. This was a considerable improvement on the information that was reviewed during the inspection in April 2014. However, a review of an electronic report provided to us by the theatre department identified that 83 patients were cancelled from the theatre 8 list in the 5 month period; we noted that theatre 8 was used as the trauma theatre. The data identified that 150 patients were cancelled from the theatre 6 list which was used as the emergency theatre.

Work was being undertaken to review the capacity and optimisation of theatres. Capacity planning processes had been introduced and was referred to as the “421” process. Staff were now reviewing any unused theatre lists four weeks prior to the date and staff were contacted to advise whether they wished to utilise the additional theatre capacity. At 2 weeks, patients were identified and surgical teams were informed. At 1 week, the theatre list was “locked” and patients were confirmed. The “421” concept has demonstrated that the theatre department is now considering how it functions in order that it can meet the needs of patients. It remains too early to determine whether this initiative will be sustained and to determine any impact it has on patient experience. However, we will continue to monitor this and will follow-up with further inspection’s in the future.

We had previously reported that due to poor patient flow, post-operative patients were experiencing delays of more than one hour in some cases before being transferred from the recovery department to a ward. We followed this up during our inspection on 9 December. Recovery staff reported that more staff members were now engaged in trying to resolve the flow issues through the recovery department. We found that an escalation policy was now in place, and this was reported to be used. A recovery register had been compiled; this allowed

recovery staff to record the duration of time that patients spent in the recovery department. We found that staff had historically been reporting all patients who had experienced delays of one hour or more into a single daily Datix entry. Delayed patient incidents were now being reported on a monthly basis. A review of the recovery register and incidents suggested that approximately 40% of all patients undergoing surgery could expect to experience a delay of one hour or more from being transferred from recovery to a ward bed. Therefore, whilst there has been increased emphasis on improving the flow of patients through the recovery department, continued capacity issues within the hospital has resulted in little progress being made.

As a consequence of the findings of our previous two reviews of the theatre department, we considered it important to consider the clinical oversight and clinical management of the theatre department. Concerns were raised that the nursing component of theatre management was not well-led. Staff raised concerns with us that nursing leadership had adopted a “hands-off” approach to the management of main theatres. Staff reported that it had not engaged with addressing the issues which we had reported in both April and July 2014. The conclusion from our specialist advisor was that, considering their observations of the management of theatre department during the previous three inspections, the general consensus amongst staff was that the nursing leadership in theatres did not manage, provide direction or support theatre staff. We have fed our concerns back to the trust executive team as we considered that this was critical in ensuring sufficient changes were made to the theatre department so as to ensure the department met its optimal level of long-term effectiveness and sustainability.

## 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.

| | |
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| ✓ **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.<br>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.<br>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:

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| 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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