

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

Thornbury Hospital - Henderson Ward

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21 October 2013

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

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	North Bristol NHS Trust
Overview of the service	Henderson Ward at Thornbury Hospital accommodates up to 20 patients who need rehabilitation treatment (occupational therapy, physiotherapy and nursing Care) following an acute hospital stay. Also provides care for patients needing palliative care and to prevent an admission to an acute hospital. Medical cover is provided by Thornbury Health Centre, St Mary's surgery, Bradley Stoke and Almondsbury surgeries. Brisdoc provide out of hours services.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Treatment of disease, disorder or injury

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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 21 October 2013 and 23 October 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 reviewed information given to us by the provider.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

Patients were generally satisfied with the care they received. Comments included: "I am being very well looked after and could not ask for better care", "they are kind and very caring. I am treated with respect" and "I have been very impressed with the care I have received here". We spoke with visitors. One said "Things are so calm here. The staff are very attentive". There were effective procedures in place to manage the admission and discharge of patients to and from the ward.

Medical care was provided by the local GPs or the out-of-hours doctors. Some patients said they were disappointed that the doctor did not visit them every day. Patients also raised concerns regarding their physiotherapy treatment as they had expected to receive intensive rehabilitation services on the ward.

On the whole we observed positive experiences for patients, but did note that some patients were not responded to appropriately. We heard a staff member express impatience when a patient asked for help, and heard another make an unkind remark to a patient. We also observed that some patients were unable to access drinks or call bells.

All ward staff we spoke with said they had received mandatory safeguarding training and knew what to do if abuse was suspected. Nursing staff spoke kindly about the patients they were looking after, were well trained and supported to do their jobs effectively. There were robust measures in place to assess and monitor the quality of care provided.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Some of the patients we spoke with during our visit were elderly and frail, had varying degrees of confusion or a diagnosis of dementia. Not all patients were able to tell us about how they were treated and whether they were involved in making decisions about their care. Others made the following comments, "I am being very well looked after and could not ask for better care", "The food here is very good. It is nice to have a choice", "I have been an inpatient on the ward. This is for rehabilitation, when I come here I know I am one step closer to home, I am about one month from home" and "I am hoping to be discharged home soon. The social worker is arranging my package of care which needs to be increased now". This patient told us they felt involved and informed of the process.

Henderson ward used a symbol known as the 'forget me not' symbol by patients beds to identify those with dementia. Staff told us that the ward also used the Alzheimer's Society 'This is me' form for their patients with memory impairment. We saw one that had been completed for a patient with dementia and was kept with their nursing notes. Nurses and healthcare assistants told us "We ask all our patients if they have problems with their memory. If they do we refer them to the doctor as this might be an opportunity for them to get the help they need."

We spoke with visiting friends and families of some of the patients. The relative of one patient commented "Things are so much calmer here than in Frenchay Hospital. The staff are very attentive". Another visitor said "the staff are all local so my friend feels very at home here and amongst friends". We were able to speak with the family of one patient who had expressed their dissatisfaction about the way they were looked after. They told us "They are being very difficult at the moment and complain about everything. There is good communication between the ward staff and the family and we know they are getting the care and support they need".

Patients were provided with information about the services available at Thornbury

Hospital. Information leaflets were set out on the desk in the corridor leading into the ward. There was a supply of the Care Quality Commission's 'What standards you have a right to expect from the regulation of your hospital' leaflets. Patients admitted onto the ward were provided with a ward information booklet. This listed arrangements for discharge planning, mealtimes and refreshments, visiting times, details about the nursing staff and the therapy staff and the facilities available. Along the corridors and in the day room there were supplies of other leaflets in respect of infection control measures, weight loss, flu vaccination, advocacy services, community transport and carer support, to name a few. All leaflets were produced in English but could be made available in other languages and formats.

Patients' privacy and dignity were respected. The ward provided in-patient care for both male and female patients. They did not share bathroom or toilet facilities. There was clear segregation between the sections of the ward designated 'male' or 'female'. There were two male and two female bays, plus three single side rooms. One side room had en-suite facilities, but two were for females only because of proximity to bathroom facilities. Signs were in place to promote awareness of male and female facilities.

We spoke with from the occupational therapy and physiotherapy team. They told us they consulted with patients about the care and support and treatment plans they were to provide. Multi-disciplinary meetings were held on a weekly basis and were attended by the therapists, the discharge liaison nurse from North Bristol NHS Trust (NBT), nurses from the ward and a social worker.

Patients said they were treated with dignity. On the whole we observed the nursing staff interacting with the patients in a respectful manner and addressing them using their preferred names. HCAs told us that one person preferred to be called by their title and not by their first name. During the lunchtime meal we saw a member of staff ask a patient if they would like salt and pepper and if they would like help to sprinkle the salt on the meal. We heard staff ask patients if they had enjoyed their meals and ask if they had finished eating before removing their plates. However, the Trust may also like to note that our observations included two occasions where ward staff did not respond appropriately to patients. One expressed impatience when a patient told them they had been incontinent and another made an unfeeling comment to a patient who had expressed the wish to die. We also observed that a few patients had been left drinks and call bells which were out of reach.

We noted that patients were dressed in day clothes and when personal care was being provided the curtains were pulled around the beds. The day room was not used by patients in the morning but as visitors arrived in the afternoon, some patients moved to the day room for greater privacy and more space. Patients told us they preferred to remain by their beds during the day.

A patient-led assessment of the care environment (PLACE) gathered by the Health and Social Care Information Centre, found that the ward had scored 75.56% in respect of privacy, dignity and wellbeing (national average was 88.87%) . The assessment took place in April and was published in September 2013. The assessment looked at the provision of outdoor space, changing and waiting facilities, access to television, radio and telephones. It looked at practical aspects such as appropriate separation of sleeping and bathroom/toilet facilities for single sex use, the bedside curtains being sufficient in size and ensured patients were appropriately dressed to protect their dignity. Patients on the ward did not have televisions by their bedside; there was a television in the day room.

Consent to care and treatment

✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

The Mental Capacity Act 2005 (MCA) provides a legal framework which safeguards people who lack capacity to make certain or all decisions about their care and treatment. The MCA states that every adult must be assumed to have capacity to make decisions unless proved otherwise. It also states that an assessment of capacity should be undertaken prior to any decisions being made about care or treatment. Any decisions made on behalf of a person who lacks capacity must be done in their 'best interests'.

We looked at the Trust's 'Consent Policy'. This had last been reviewed in August 2012 and was next due for review in September 2015. The policy made reference to the Trust's 'Photography Policy', which outlined the requirements in respect of patients' photographs and to the Mental Capacity Act 2005 and assessment of capacity. All Trust policies were kept electronically and all ward staff we spoke with told us they were able to access the policies if they needed to.

We looked at the care records for four patients. We saw that one patient had signed to give their consent to the taking of medical photographs. Some patients had bed rails in place to prevent them falling out of bed. Risk assessment forms evidenced that there had been a discussion with the patient about the use of bed rails; however the Trust may like to note that no written agreement had been made regarding their use. Nursing and healthcare assistants (HCAs) were clear with us that bed rails were only used to safeguard a patient whilst they were in bed.

Nursing staff and HCAs completed basic Mental Capacity Act 2005 (MCA) awareness training as part of their mandatory training programme. This was included as part of safeguarding vulnerable adults and child protection training. All nurses and HCAs we spoke with confirmed that they had received the training. One of the ward sisters had also completed more in depth MCA training and was able to talk confidently about how the Act was applied on a day to day basis.

Patients were often not directly admitted into Henderson ward but would have been transferred from wards in either of the other North Bristol NHS Trust hospitals, or other local hospitals. When patients were admitted a nursing admission assessment was

completed. This included a section where the mental capacity of the patient was assessed. In three out of four of the records we looked at this had been completed appropriately. An assessment for the fourth person had not been completed however the GP was on the ward to consult with this patient. We spoke with the doctor regarding this patient. The patient had capacity but was non-compliant with care, support and treatment plans. The patient, who had very complex physical and emotional healthcare needs, had previously been assessed by other relevant parties as having. A multi-disciplinary meeting was to be planned in order to make best interest decisions regarding their on-going care. Where patients did not have the capacity to consent, the Trust ensured appropriate assessments were completed.

Before patients received any support with personal and nursing care, or therapy tasks, they were asked for their consent. Nurses, healthcare assistants and therapists we spoke with said they always gained patients' verbal consent when assisting with personal care or supporting people with moving and handling techniques. They said they explained the process and only proceeded when the patient indicated they were happy for them to proceed. Patients we spoke with confirmed this to us and we saw staff assisting patients in this manner.

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

On the whole patients and their visitors told us they were satisfied with the care and support they received on the ward. One patient said "I came to Thornbury Hospital with no mobility and within a week I could walk again. They are very good at helping and encouraging me." Other comments included: "They are marvellous, gentle; they look after me very well", "They are kind and very caring. I am treated with respect. They are looking after me very well", "I am getting better and very keen to get home now" and "I have been very impressed with the care I have received here".

However the trust may like to note that some patients' expectations had not been met. Some patients told us they were disappointed that the doctor did not visit them every day to check how they were doing. Nurses told us that GPs from Thornbury health centre were funded to provide medical care for the majority of patients (three other local surgeries provided cover). The GP was contacted each day and nurses prepared a list of patients who needed to be seen. From 24 October 2013 the majority of patients would be seen by Thornbury health centre GP's and their medical care reviewed.

Patients also raised concerns with us regarding their expectations about on-going physiotherapy treatment. One patient said "I was told I was coming here for intensive physio but this hasn't happened". Another said "I have only had an hour's therapy a week and I was led to believe there would be more". We were told that there had been a vacancy for a physiotherapist for some time but one had now been recruited.

Nurses and healthcare assistants (HCAs) were knowledgeable about the patients they were looking after. Occupational therapy staff and physiotherapists told us how they supported people to regain the life skills they would need to return home after a fall, a bone injury, a stroke or a prolonged period of ill health.

Nurses and HCAs knew what support each patient needed because they received a handover report at the start of their shift and were provided with a care profile for each patient on the ward. These were updated daily to reflect patients' needs. It was the responsibility of the night staff to update the care profiles for the day staff.

We looked at the medical records and nursing care records for four patients. One patient was ready to be discharged and one patient was newly admitted. The medical notes provided a detailed account of the treatment and support the patient had received in another acute hospital, an account of the GP's review of the patient whilst on the ward and detailed accounts of treatment plans and progress notes by physiotherapists and occupational therapists.

On admission to hospital, patient information was recorded on a nursing admission assessment form. Three of the four assessments we looked at had been fully completed, the fourth was partly completed. All four patients had been transferred from acute wards in one of the North Bristol NHS Trust hospitals. We asked nurses whose responsibility it was to complete this documentation and were told it was the admitting staff however, if it had not been completed it was their responsibility.

We looked at information that was kept at the bedside of patients. Bedside information included intentional rounding charts. These enabled the nurses and HCAs to record assessments of falls risk, skin condition and prevention of pressure damage measures and pain, personal care needs, position and possessions. Each chart identified whether the patient needed one, two or four hourly interventions. Other charts kept at the bedside included fluid charts and food record charts. Patient in-patient prescription charts were kept at the bedside.

Risk screening tools to assess the likelihood of developing a venous thromboembolism (VTE) and pressure ulcers, falls and nutrition were completed. Where patients needed support with their mobility a patient handling assessment was completed and a safe handling plan was devised. All assessments had been reviewed regularly. Nurses and HCAs had a good awareness of the individual patients who were at risk and could tell us about the measures in place to reduce that risk.

Core care plans were used to record patients' care needs. We saw plans in respect of wound care, urinary catheter care, mobility and personal hygiene. On the forms there was a reminder for staff to individualise the care plans as appropriate. The Trust may like to note that these plans were not individualised, for example the mobility plan for one patient who had casts on both legs, made no reference to the specific support they needed. Personal hygiene plans made no reference to whether the person was bed-bound or able to have a wash in the bathroom with assistance. All staff we spoke with talked confidently about patients' care needs.

Three patients told us the ward was cold and they had had to ask for extra blankets. Nurses told us that the controls for the heating system were in an unused part of the building and at times it was difficult to get the ward temperature correct, particularly when there had been a marked change in the outside temperature. As part of the intentional rounding process, each patient was asked regularly if they were comfortable and warm enough. Nurses and HCA's checked on patients' comfort regularly. We received mixed comments about the length of times calls bells took to be answered. Some patients said that there could be a delay in call bells being answered or assistance being provided "at certain times of the day" whilst others said that staff were always available to help them. One patient said "I expect to wait, the staff are very busy but they come as soon as they can". They also said the night staff were very attentive and commented "It is a different atmosphere here at night, nothing is ever a problem and they come to me very quickly."

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

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We spoke with patients during our inspection but their feedback did not directly relate to this outcome. They told us "I am waiting for my home care package to be set up", "the nurses will be coming in to see me when I go home. The staff here are arranging everything for me" and "I was in hospital in Southmead and have been transferred here for on-going treatment".

Admission of patients to Henderson Ward I was managed by the Joint Community Access Point (JCAP) team. Patients would have been referred to this team by nurses on the acute wards in the other North Bristol NHS Trust Hospitals (Southmead and Frenchay), or surrounding acute Trusts. Community admissions also had to be arranged via the JCAP team. We were told that the ward was usually fully occupied with only ever one or two empty beds. The average length of stay for patients was 26 days but most patients would have been receiving hospital in-patient care in other acute hospitals. We saw the referral forms from the JCAP team in the patients' notes we looked at.

Nursing staff told us that they were able to refuse to accept a patient referred by the JCAP team if they felt they were unable to meet the patient's needs. They were also able to send patients back to the acute Trust if the patient's health needs deteriorated and they needed greater medical input.

The occupational therapist (OT) told us that they supported people to return to their homes and liaised with equipment providers where necessary. Multidisciplinary planning meetings were held each week between OT's, physiotherapists, nursing staff and a social worker, to share information about patients' progress and to plan their discharge home, or on to another care provider. There was an OT area adjacent to the ward, which had a kitchen where the OTs worked with patients to assess and practise kitchen skills. Occupational therapists also accompanied patients on home visits to assess the feasibility of discharge plans and assess any equipment needs. The physiotherapists had an area where they could assess patients' mobility.

Nursing staff told us that preparation for a patient's discharge home began before they

were admitted to Henderson Ward. The nursing staff and multi-disciplinary team would have a discharge transfer plan that they working towards. This included the planned destination on discharge from hospital and social services notifications. Nursing staff told us that domiciliary care agencies would visit the ward to discuss patients' community arrangements and that there had been occasions when the agencies had worked alongside ward staff in more complex cases. We found that the ward staff worked together with community-based care services in order to facilitate timely discharges from hospital.

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients we spoke with said "I am very well looked after", "the nurses are very good and kind to me", "the nurses have so much to do and sometimes don't know which way to turn" and "I get very good care". Visitors we spoke with said they were satisfied with the way their relative was being looked after. They told us "They can be a very difficult person, but the nurses and other staff are so patient" and "I have no concerns about the safety of my relative".

Information about how to safeguard adults from abuse and neglect (produced by South Gloucestershire Council) was displayed on the ward, along with other leaflets. This informed patients and their relatives/visitors about the process for reporting any concerns they may have. The information included the contact telephone numbers for the adult care duty desk (South Gloucestershire Council) and the Care Quality Commission.

We looked at the Trust's 'safeguarding adults' policy. This was stored on the Trust's intranet document management system and was accessible to ward staff.. The policy referred to the different types of abuse, informed staff what to do if abuse was suspected and stressed the importance of clear, accurate record keeping.

We observed the nurses, the HCAs and therapy staff interacting with patients in the hospital in a respectful manner. In general, patients were referred to by their first name and those patients we asked about this, said they were happy to be addressed by their first name. Staff spoke kindly about the patients they were looking after.

All ward staff we spoke with during our inspection visit said that they had received the mandatory safeguarding training. The training covered vulnerable adults and child protection and also provided an overview of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLs) procedures. They told us that this was included as part of the 'training passport' they had to complete. Training records were held electronically by the Trust and the matron was sent notifications if individual members of staff were overdue in their safeguarding training.

We spoke with four HCAs, two nurses, two ward sisters and the ward matron. Each staff member demonstrated good awareness of safeguarding adult issues and abuse awareness. They each told us they would have no hesitation to report any concerns they had about patient safety. Staff had access to the Trust's electronic safeguarding policy.

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We did not speak with patients about this outcome. We spoke with nursing staff, HCAs, the matron, one of the ward domestics and the receptionist.

We were told that newly employed staff would undertake full induction training prior to commencing their role on the ward. The programme included attendance at corporate induction training sessions, orientation to the ward environment and specific health and safety and clinical training. Clinical skills' training was arranged for those who required it. These measures ensured that staff were fully informed and equipped to carry out the role for which they were employed.

Nursing staff and HCAs we spoke with during our visit reported that they were well supported in their work and had access to training appropriate to their needs. All staff had a 'training passport' and were expected to complete their training at designated intervals. They told us it was their responsibility to make sure they attended training, but their training needs were discussed at their annual appraisal meeting. The trust's staff learning and development department held staff training records for each member of staff.

HCAs and nurses told us that mandatory training included basic life support, manual handling, infection control, waste management, dementia care, fire awareness and safeguarding vulnerable adults. This training took place in the learning centre at Southmead Hospital. Other examples of training included venepuncture (the taking of blood for analysis), cannulation (the siting of intravenous infusions), syringe drivers, male catheterisation and the administration of intravenous antibiotics. Specific wound care management training had been scheduled for later in the week because of the needs of one patient on the ward.

Support tended to be provided on an informal basis between members of the team at ward level. The two ward sisters each had responsibility for a team of HCAs, but informal support was provided by both amongst the whole team. The ward sisters told us there were formal processes in place which would be used if they needed to manage an individual staff member's poor performance. The nurses received regular clinical supervision from a senior nurse manager.

The Trust did not have a specific staff supervision policy but there was an expectation that all managers met regularly with their staff to talk about their work. The Trust had a learning and development strategy for supporting and developing the role of the HCA and supervision was a key part of this. We discussed this with the ward sisters, who confirmed that this support was provided. The Trust may like to note that no notes were kept of these meetings, which made it difficult to review the progress of their strategy. The aim of the strategy was 'to support workforce planning to shape our workforce so that it meets the future needs of the organisation'.

Assessing and monitoring the quality of service provision

✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

Patients we spoke with told us that they had been asked to comment about their stay in an acute hospital prior to being transferred to Thornbury Hospital Henderson Ward, but had not been asked to make comment about this hospital.

Nursing staff told us that patients would be asked to complete a survey form prior to their discharge and this would include the 'Friends and Family Test'. Results that were reported on in September 2013 showed that the ward had been the highest scorer for patient satisfaction in the North Bristol NHS Trust. Patients were either 'extremely likely' or 'likely' to recommend Henderson Ward to friends and family members.

A range of different audits were undertaken on Henderson ward. Information was monitored in respect of staff sickness, ward acquired infections (MRSA- methicillin-resistant staphylococcus aureus, often called the 'hospital superbug' and C-diff – Clostridium difficile), pressure ulcer development and incidence of falls.

A Nursing and Quality Assessment (NQAT) had been last completed in October 2012 and provided a 'snapshot' of quality at that time. The assessment incorporated a total of 173 quality measures and consisted of a real time patient survey, documentation audits and a clinical observation, all conducted on the ward within a 3 hour period. Results were combined to provide a standard measure for the quality of nursing care. In October 2012 the ward achieved an overall score of 92.6% - a 'gold' score. The Trust told us that the NQAT was due to be repeated within the next month.

NHS 'Safety Thermometer' audits were completed each month and enabled nursing staff to check basic levels of care, identify where things had gone wrong and take action. The audit enabled nurses to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, venous thromboembolisms and falls.

Bedside documentation included patient handling assessments, bed rail assessments and skin bundle assessments. . An assessment of a patient's skin condition was undertaken on admission to hospital and repeated as determined by their risk score or if the patient's

condition/needs changed. Patients who were at high risk or deemed to be at risk and should be put on a group of interventions called the "Skin bundle".

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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