Care Quality Commission

Inspection Report

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

Macclesfield District General Hospital

Victoria Road, Macclesfield, SK10 3JF

Tel: 01625661501

Date of Inspection: 13 August 2013

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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	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ 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	East Cheshire NHS Trust
Overview of the service	Macclesfield District General Hospital is a small district general hospital located in the town of Macclesfield. It is the management base for East Cheshire NHS Trust who are a provider of acute hospital and community healthcare services.
Type of services	Acute services with overnight beds Community healthcare service Long term conditions services Rehabilitation services Urgent care services
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Nursing care Personal care Surgical procedures Termination of pregnancies Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

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 13 August 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and were accompanied by a pharmacist. We were accompanied by a specialist advisor.

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

When we carried out our inspection we spoke to patients on the surgical and children's wards.

On Ward 2 one patient expressed satisfaction with the ward saying their experience was "all positive, nothing negative" and that they "rate this hospital highly". Another said "It is 200% in here -absolutely amazing. You hear all this about how awful things are in hospitals but I have no complaints." A third said "Cracking experience. These girls turn themselves inside out to make sure you get the care - they are so patient I could never possibly be as patient as they are and what is unusual is that it is all of them not just one or two".

The relative of a patient with dementia told us; "Considering this is a surgical ward he has had an exceptional level of care – better than a lot of wards where you would have expected more of them in terms of understanding his dementia and meeting (his) needs".

On the Children's Ward when asked if they wished to comment one parent said, "just how good they have been".

Patients also commented on staffing levels. One said "There is nearly always someone around and if not I ring and they come almost straight away usually". Another patient commented "I have been surprised at how many staff there are".

Another said "They seem to have plenty of staff and they take time to talk to you one to one when they have time. There is some nice banter but they're respectful with it."

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

Care and welfare of people who use services ✓ Met this standard

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

Our previous inspection in February 2013 found moderate concerns with this outcome because of gaps in risk assessments and care plans. The Trust provided us with an action plan to address these issues which is now complete and part of this inspection is to check that problems have been resolved.

Many of the concerns that we had were about systems of care not being addressed on surgical Ward 2 and this was linked to that ward being understaffed. As Ward 2 was now a day case unit we also visited the adjacent Ward 1 which looked after surgical patients and carried out the role previously done on Ward 2.

One both these wards patients expressed satisfaction with their treatment and care. We looked at a sample of four patient's notes and found that in all cases they were completed properly. We also observed during our visit that staff were making appropriate use of them.

We noted that as they went about their duties, staff were pro-active in checking with individual patients that everything was alright. This was done in an appropriate and discreet manner, and staff used people's preferred names. Patients and relatives reported staff members treated them with respect and afforded them dignity at all times.

Staff were friendly and smiled as they went about their tasks but were professional in manner. We saw they took an interest in people as individuals discussing their interests and backgrounds as well as clinical matters.

We heard evidence that patients and where appropriate relatives were involved in the planning of their care and that their views were taken into account.

We discussed the systems in place at a ward level to ensure patient's received safe and effective care. We were told of and shown how patients agreed to risk assessments taking place and that these were carried out at least weekly. A sample was audited each day by

the ward sister to ensure that they were carried out to a sufficient standard. We also saw that "comfort rounds" took place every two hours where a check was made on each patient's comfort and safety. There was also a "safety brief" system where particular issues arising from risk assessments that affected the ward that day were briefed. As well as speaking to managers we spoke to staff nurses and healthcare assistants who confirmed this.

On the surgical wards we discussed how the ward identified patients at risk of pressure sores and how these were then prevented. There were systems in place to assess patients on admission and to develop care plans for those who were identified as being at risk. We spoke to junior staff about this and they were confident when describing what they did; one member of staff was particularly knowledgeable. Staff described how they got help from specialists to manage tissue viability when needed and we were told about a recent pressure sore and how it had been reported as an adverse incident. This demonstrated that problems were picked up and that staff were making proper use of incident reporting systems.

The Children's Ward has 21 beds but on the day we carried out our visit there were 8 patients. Part of the ward is an observation unit which is open during weekdays from 8am until 8pm. If children need to stay they would be admitted to the main ward.

When we visited the Children's Ward we noted that staff interacted well with parents and were pleasant and helpful. In terms of decoration and facilities the ward had good artwork and a bright playroom. However the environment was ill suited to older children and when we spoke to staff about this they were aware of the issue and told us they were considering how to address this.

We spoke to the parents of two children and both said they were happy with the care given and that they were kept fully informed. They said staff were kind and responsive to their needs and they were aware of plans for their children's treatment and what might happen when they went home. One parent said the information they had been given was "brilliant".

When we asked them if they wanted to comment on anything they said, "Just how good they have been". They said that when their child was admitted at the weekend the consultant on call came in straight away. They commented that he was dressed informally and that really made her feel comfortable and that she could relate to him more easily.

One parent told us that they had stayed with their child overnight sitting in a chair next to the bed where they had been cold and uncomfortable. It was only the next day they found that there was a camp bed with bedclothes for their use that had not been drawn to their attention. This was fed back to The Trust for them to highlight at staff meetings.

We looked at the quality of care plans by tracking a patient from their admission through the accident and emergency department. We saw that the admission checklist had been completed, that general observations were made and that a plan for the management of the patient was set out in their notes.

We looked at the provision of emergency equipment on the ward and spoke to staff about its use. We were satisfied that it was appropriate and that staff knew how to use it in an emergency.

The provider may wish to note that staff raised concerns with us that some children with mental health problems who were admitted to the ward as a place of safety stayed too

long before being transferred into the care of the Children and Adolescent Mental Health Service (CAMHS). This was because staff from CAMHS which was provided by another NHS Trust only visited on Mondays, Wednesdays and Fridays. We were told of delays of several days that happened if admissions took place just before a weekend or over a bank holiday. This was confirmed to us by a relative of a child who had used this service on previous occasions and told us they felt the ward was simply "babysitting" their child until the CAMHS service could take responsibility.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

During this visit we spoke with members of staff working on the two hospital wards (four nurses and a ward pharmacist) and with the Chief Pharmacist about The Trust's arrangements for handling medicines. We looked at the prescription and medication records in detail for five patients on two wards.

We looked at how medicines were handled and saw appropriate arrangements were in place for confirming and reviewing people's medicines on first admission to hospital. When patients were admitted to the hospital doctors recorded and prescribed their medicines following a standard procedure. This was checked by the pharmacy team to make sure all the information was correct.

We found that appropriate arrangements were in place in relation to medicines administration. We spoke with three relatives of patients and three patients themselves. No-one we spoke with expressed any concerns about their medicines. One patient told us, "They got me stabilised, I was in a lot of pain …, they gave me a new tablet, it's very good." The medicines records we checked were usually completed correctly and medicines were obtained promptly when patients were admitted to the hospital. However, as identified in the Trusts own audit we found occasional gaps in the prescription chart where doses were missed, but the reason was not recorded. Appropriate arrangements were in place in relation to the safe self-administration of medicines but the provider might wish to note that these were not consistently followed. Not all nurses we spoke with were familiar with the hospitals self-administration policy.

All the staff we spoke with were aware of how to report any medicines incidents and the Chief Pharmacist explained how these were monitored and assessed. We saw how learning from a medicine safety incident had been shared with prescribers and nursing staff using a bulletin, to heighten awareness and reduce the risk of reoccurrence. Nurses on the children's ward also explained how they had received information about two recent national alerts about medicines use in children. However, the provider may wish to note that as identified by The Trust in a recent pharmacy audit, we found that posters detailing critical medicines, which should never be missed, were not on display. Two nurses we spoke with were unaware of this information about these critical medicines.

We looked at medicines storage. We saw that medicines were kept safely locked away and the ward emergency drug packs were in date and regularly checked to ensure they were available when needed. However, we found checks of a tamper evident case of medicines kept on the children's ward were not recorded. Additionally, we saw two examples where medicines remained on the ward's medicines trolley after the patients had been discharged.

Records of medicines given to people on discharge were clear. Most patient's take home medicines were checked and labelled on the ward, helping to reduce waiting times. However, take home medicines needed for patients being discharged from the children's ward often had to be prepared in the hospital pharmacy. Nurses on this ward told us waiting times could "vary widely". This was acknowledged by the Chief Pharmacist, who explained plans to increase pharmacy resource to help improve the "take home" service for discharges that come to pharmacy.

We asked the Chief Pharmacist about the arrangements for auditing medicines handling and recording at the hospital. A programme of audit was in place and there were clear procedures for reporting and acting upon information from medicines audit.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

During our previous inspection we had moderate concerns in respect of this outcome. On Ward 2 we noted a significant problem with understaffing and this was having an effect on the quality of patient care. We understood that the background to this was an overall problem in recruiting and retaining staff across the hospital.

The Trust provided us with an action plan that addressed this issue in a number of ways including a full review of the staff needed at the hospital which identified additional recruitment was needed. We understood that these staffing targets had now been achieved partly through recruitment of qualified nurses from Spain.

During this visit we looked at the staffing levels on Wards 1 and ward 2 and found them to be at an appropriate level. Senior staff were able to carry out their management and supervisory responsibilities rather than having to help out on the ward. Our observations of the wards found that staff were coping well and there was no sense of only doing the essentials which had been the case in our previous inspection.

On the surgical wards we observed that call bells were accessible to all patients and they were answered in a timely manner. No one complained of having to wait a long time for assistance. We were told by one patient that "staff responded very quickly" and by another that, "there is nearly always someone around and if not I ring and they come almost straight away usually". Another patient commented, "I have been surprised at how many staff there are".

One patient told us that the situation was similar if not better at night; "Generally speaking they come reasonably quickly if you buzz but sometimes it is a bit long. They tend to be quicker at night ".

Another said "They seem to have plenty of staff and they take time to talk to you one to one when they have time. There is some nice banter but they're respectful with it".

Relatives also gave us information that told us that there were enough staff on duty to meet the needs of patients. One said, "They talk to him properly and respect him and even when very busy take time to be patient and try to understand him as he has speech problems and poor eyesight", another told us, "The young doctors in particular have taken

time to explain things to us both" and a third commented, "They are so patient and never complain no matter how many times they have to change his bed".

Senior staff on the surgical ward told us that they had a full staffing complement and that all vacancies were covered. This was a significant contrast to our previous visit to the surgical ward where managers were struggling to get the minimum number of staff for each shift. The manager told us they rarely used agency staff although some had been use on nights a few months previously. When extra staff were needed they were either "pulled in" from other wards or were the Trust's own "bank" staff. This meant that they were inducted and trained to the Trust's standards.

We found a similar situation on the day case unit where they had an appropriate number of staff with the correct skills.

On both the surgical wards the minimal use of bank and agency staff was confirmed by the junior staff to whom we spoke and through staffing records on the wards. We asked nursing staff on Ward 1 if the ward was always staffed to an appropriate level. We were told that it was usually fine and that when there were patients with a higher than usual dependency they were given extra staff to support them.

The Children's Ward had 21 beds and on the day we visited there were 8 patients. We discussed the staffing establishment with the ward manager and understood that during the day there were three registered nurses, two healthcare assistants, a ward clerk and two play therapists. At night there were two registered nurses and a healthcare assistant. Specialist paediatric nurses had their base on the ward, reviewing and assessing children as out patients and conducting home visits as required, as well as working on the ward from time to time during very busy periods.

However staff told us of a circumstance where a regular patient needed one to one care and that left only two registered nurses for the rest of the ward. When this happened night staffing was increased but not during the day which meant that if there was a theatre list it would leave only one qualified staff on the ward to deal with admissions. We were told by staff this was safe but hard work. Senior staff on the ward said that they could obtain staff out of other areas as necessary should the number, or dependency of patients increase during the day.

Recently there had been a high use of agency staff because of maternity leave and there had been recognition by the new manager in December 2012 that they were understaffed. They were recruiting to cover this with two temporary and two part time staff. We spoke with a recently recruited member of staff who confirmed that this was the case.

We asked about the provision of doctors on the Children's Ward and were told that there was consultant cover during the weekday supported by two specialist registrars one to cover the children's ward, A&E and admissions and another for the special care baby unit, maternity and theatres. Out of hours this was reduced to one doctor covering. We were told that this was usually safe but that it was possible to become too busy and that consultant help was not always immediately available if they were busy elsewhere.

When we spoke to hospital managers about staffing levels on the Children's Ward they told us that there was a need to carry out a full establishment review to identify the correct staffing levels for paediatric services. This was part of the South Sector Review of the provision of paediatric services across other hospitals as well as Macclesfield meaning that they did not yet know which services would be provided.

Supporting workers ✓ Met this standard

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

Following our previous visit we had minor concerns about this outcome because staff were not receiving appropriate supervision. The Trust sent an action plan that showed how they were to remedy this and part of this inspection was to follow up on that.

On Ward 1 we spoke to a manager about the new staff. They told us that they had all received a five day induction programme over five weeks and their progress was monitored and signed off by a preceptor. We looked at training records for these staff which confirmed this.

We were told that staff had an annual appraisal and we looked at four staff records that confirmed this for those members of staff. However the paperwork was inconsistent and not always signed by both the appraisee and appraiser. We noted that the documentation and planning around the Knowledge and Skills Framework which outlined the core competencies for staff was accurate.

We understood that ward nursing staff did not have regular one to one meetings with their manager outside of the appraisal process but that there were regular team meetings and discussions around the daily safety briefings. This meant that staff did receive support and had the opportunity to discuss concerns. We saw that notices advertising team meetings were on the noticeboard of Ward 1 and when we spoke to staff they knew about them. The provider may wish to note that staff told us they had difficulty attending team meetings which took place outside of their shift pattern and some staff were unsure whether they would be paid for attending some upcoming meetings.

On Ward 2 we found that new staff had been inducted to the Trust requirements. On this ward we were told that supervision took place because the manager saw each member of staff on shift each day and that the open door policy resulted in good support of staff which enabled them able to bring issues to their manager. We were also told that on this Ward staff had a one to one with their manager each month as well as their yearly appraisal.

When we spoke to staff on the surgical wards they told us of training opportunities that they were offered as part of their personal development plans and we saw that various courses were advertised on noticeboards.

Whilst on the wards we saw a central database of compliance with mandatory training and this was accurate for the staff on that ward.

We asked ward staff about induction to the Children's Ward and they told us that there was a specific programme in addition to the core nursing induction as it was "very different to adults". In addition to the trust induction there was the opportunity to meet specialist nurses and specialist training covered topics such as paediatric life support and the safeguarding of children.

We asked about how competencies were assessed and we were told basic life support was signed off by the training officer. For extended skills such as venepuncture or cannulation, staff were supervised to carry out the procedures and were assessed as competent before they were authorised to carry out the procedures independently.

We asked about mandatory training and updates. We understood much training was now done on-line but that there was also an "Essential Paediatrics" study day. This covered, amongst others, the resuscitation trolley and the use of infusion devices and staff's understanding was checked. We were told staff could access any training available in The Trust, which was paid for but that staff were generally expected to do it in their own time.

We asked staff about individual learning plans and were told that they were in place and that and staff were personally accountable for them. All staff did core elements and then had individual learning records according to their identified needs at appraisal.

Staff had appraisals that resulted in yearly updates of their personal development plans. We asked for copies of these and they demonstrated they took place in an effective manner. We asked about regular supervision and understood that this was done through monthly ward meetings. We were told that it was difficult to get all staff to attend and that the ward was looking at having them at different times and at overlap of shifts so more staff could attend. We saw minutes of one and it covered appropriate topics. We were also told of a monthly email newsletter and we saw copies of this too.

We asked for and were provided with notes of team meetings across other wards of the hospital and these demonstrated that these staff had effectively received group based supervision.

Medical staff told us that they received peer group clinical supervision each week and that annual appraisal and revalidation took place. They said they had confidence in the systems that assured competence of medical staff.

We spoke to senior hospital managers about the Trust's progress on supervision and appraisal of staff. We were shown how this was monitored through The Trust's governance mechanisms and that there was a monitored improvement plan in place.

We asked for the figures for this and we were told that the organisation was slightly below the required performance for both mandatory training and staff appraisals. We looked at the actual data and saw that while the shortfall was currently small, approximately 2% for mandatory training and 5% for appraisal if progress continued at the same rate the gap would worsen and be significant by the end of the financial year. The Trust provided additional information that showed it understood that this performance differed across business groups.

We asked how the Trust was addressing this issue and were told of a recovery plan and

shown evidence of how this was being implemented and resourced through various documents that addressed the differing performance and issues across business groups. This process included robust reporting and regular scrutiny of and challenge to the managers responsible for its delivery.

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

During our visit we spoke to with senior managers including the Chief Executive, Medical Director, Director of Nursing and the Director of Corporate Affairs and Governance about how they were assured that risks were managed to assure the health, welfare and safety of patients.

We were told of the integrated governance arrangements that were in place to enable the above and the explanations of this were consistent amongst the people we spoke to at all levels of the organisation as well as with the evidence we were given and what we observed.

We saw that this was achieved through means of committees with reporting mechanisms and accountabilities. This is described in The Trust's Corporate Governance Manual which defines how The Trust is run including for the standing committees clear description of their terms of reference. We identified three key standing committees, the Safety Quality and Standards Committee (SQS), the Audit Committee and the Clinical Management Board.

The Clinical Management Board is a mechanism by which the Chief Executive gains personal assurance from clinical and business directors that objectives are being achieved and risks managed. Terms of Reference include oversight of The Trust's Cost Improvement Plan and Quality Improvement Productivity and Prevention programmes which are closely linked to both risk, quality improvement and safety. We saw evidence from board papers that this group ran effectively with oversight from the Trust Board.

The Audit Committee ensures that processes operate effectively including those applicable to integrated governance, the management of risk and clinical management. We saw from notes of this committee, board papers and other reports that it ran effectively and with appropriate oversight from the Trust Board.

The SQS assures the Trust Board that key safety and quality standards are being met. There are many sub-committees and groups whose role and accountabilities are defined within the Corporate Governance Manual including those at business group level. We

asked for and were provided with representative notes of this committee and these together with Trust Board papers and other documents demonstrated it to be operating effectively.

We looked in more detail at how some aspects of the safety and quality systems operated including dealing with adverse incidents and how The Trust monitored and responded to mortality data.

We saw through policies and procedures that The Trust had systems in place for staff to report adverse incidents, carrying out investigation at a level appropriate to the incident's seriousness and when necessary implementing measures to prevent reoccurrence. We were given a demonstration of The Trust's computerised incident management system and saw how it was integrated into the risk registers that The Trust held at various levels across the organisation, by for example, using the same risk grading process as for financial and other risks. We also noted that the system was aligned with the complaints process so incidents brought to light by patients were properly dealt with.

We asked ward staff about untoward incident reporting and they were familiar with how to report them and how the Trust had a system to identify root causes and plan preventative measures in the case of serious events. Staff discussed recent issues with us and described what measures had been put in place locally to prevent reoccurrence. We asked for example incidents and were assured that these had been investigated and dealt with properly. We noted that The Trust had carried out work in preparation for any introduction of a "duty of candour". We saw that this was being introduced into relevant systems and when we spoke to senior ward staff they knew of this and told us how it was changing the way they communicated with patients about any mistakes.

One of the means that CQC and other agencies use to provide information on NHS Trusts is to look at mortality outlier figures provided by government and other organisations such as Dr Foster. A mortality outlier is when there are a higher number of deaths for a particular group of patients than might be expected. A higher number is not itself a cause for concern but should prompt the hospital and others to ask further questions.

We noted that the Trust had a sub-committee responsible for the review of mortality data and we asked the Medical Director who was the lead director for the group to explain its role. We understood that The Trust made use of a commercial package to monitor and measure mortality as well as taking note of statistics provided by outside organisations. We were told how this group used the data to identify trends and concerns as well as to audit areas of potential concern such as admissions that took place at the weekend. We looked at notes of the sub-committee and this corroborated what we were told.

CQC is told of mortality outliers and we ask trusts to investigate and provide us with a report. At the time of our visit one such study was nearing completion and we spoke to the Medical Director about it receiving assurance that this work was integrated with that of the Mortality Review Sub-committee.

One aspect of governance that we noted was oversight each day of the hospital's status through review of a "daily dashboard" by an executive director. This dashboard tracked, amongst other things, the activity, workforce and productivity status of the hospital. We saw that the daily trust situation report noted bed states as well as A&E four hour breaches and discharge problems. We also saw an example weekend plan which identified potential issues and gave a strong narrative as to how they should be approached including the opening of additional beds and drafting in of agency and locum staff.

This meant that the Trust Board knew daily of the issues affecting The Trust each day and could be held accountable for them.

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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk