

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

Southampton General Hospital

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	University Hospital Southampton NHS Foundation Trust
Overview of the service	Southampton General Hospital provides a range of general and specialist medical and surgical services ranging from neuroscience and oncology to pathology and cardiology. Specialist intensive care units, operating theatres, acute medicine and emergency departments as well as an eye casualty are provided as are outpatient, day beds and longer stay wards for hundreds of patients are provided.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely 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'.

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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 carried out a visit on 2 October 2012 and 3 October 2012, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We assessed the regulated activities, diagnostic and screening procedures, surgical procedures and the treatment of disease, disorder or injury. We inspected acute medical and surgical wards, orthopaedic and medical care of older people wards. We also assessed the discharge lounge and medicines management. The inspection was carried out over two days, six inspectors, a pharmacist inspector and a clinical advisor were part of the inspection's team. We spoke with 64 patients and relatives, 53 staff including nurses, doctors, physiotherapists, occupational therapists and looked at 42 sets of records.

Patients and relatives were overwhelmingly positive about the staff and care that they had received. Patients said that staff were incredibly hard working. One person said staff were "always cheerful and friendly. Patients told us that they were provided with information about treatment options and consent obtained prior to procedures.

Although people were happy with the care they were receiving we identified some instances where inappropriate care had been provided such as the failure to always provide specialised stockings to reduce the risk of blood clots . We found that there were significant staffing vacancies especially for qualified nurses. People told us that "staff kept changing". Staff told us about and patients told us of delays to their medicines not being prescribed and available for discharge.

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

What we have told the provider to do

We have asked the provider to send us a report by 12 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

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

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

Our judgements for each standard inspected

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. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We found that specific consent forms had been signed by patients for all surgical, invasive and investigation procedures that would require them. One patient told us that they had been "given three options by their consultant and consent was sought at each stage of their admission to hospital". Another patient we spoke with had difficulty remembering if they had been consulted about their treatment. Staff told us that they had information and were able to understand, however the patient had been very ill at that time. We reviewed the patient's records and saw that consent forms had been signed by the patient for procedures and the records reflected what had happened. We observed a senior doctor seeking consent prior to carrying out an assessment. They had considered the persons level of understanding. This was carried out at a slow pace and allowing the person to respond and we observed very good interaction between the patient and the doctor.

Patients gave positive examples of consent being sought when procedures were undertaken. We spoke with staff who had an understanding of the need to ask permission prior to clinical interventions. Consent to care was apparent in the staff behaviour but was not specifically documented unless the patient refused. We observed how staff in one acute area supported a patient who required a particular procedure to be carried out. Staff and the patient discussed this and the patient then agreed to the procedure. We saw that staff recorded when patients had refused treatment such as medication. We spoke with patients who said that although they were not specifically asked before routine treatments they understood what was happening and why things were done. Most patients were aware of discharge plans. Staff told us that they involved people's relatives if people were too ill or unable to consent to care. Overall people were given information about treatment options and consent was obtained and recorded.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. Where staff had concerns that the person may not be able to make important decisions themselves additional assessments were undertaken to confirm this.

We saw that these specific assessments of people's abilities to make decisions were undertaken either by ward doctors or external specialist. The assessments viewed were in relation to specific decisions that needed to be made and were not aimed at removing all decision making from the person. We also met an external specialist who had been requested to undertake an assessment for a person who had a learning disability. There were therefore suitable arrangements in place to identify people who may not be able to make complex decisions and to ensure that these decisions could be made in their best interests.

Most staff confirmed that they had completed training in the Mental Capacity Act 2005 and were able to talk about their responsibilities in relation to this. The provider sent us training information that showed that the majority of direct patient care staff had completed mental capacity awareness training as part of their induction. We spoke with one staff member who said that they had not had training in mental capacity. However they were able to correctly identify that people had the right to refuse treatment and the action they would take if this occurred and gave examples to support their statements. Therefore staff, including those who had not completed training, were aware of their responsibilities to ensure that people were able to consent to care and treatment.

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

Our judgement

The provider was not meeting this standard.

The provider had failed to take proper steps to ensure that all people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. Care was not always planned in such a way that would ensure the welfare and safety of people.

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

Reasons for our judgement

We spoke with 64 patients. Most told us that they had received good care. We looked at 42 sets of records on 13 wards. In some areas they were using care pathways and on another unit we found that there were daily nursing care plans which were clear and comprehensive. However, on other wards we did not find that care planning was used. On these wards nursing and medical notes were completed together and recorded care and treatment provided. People did not raise concerns about their personal or medical care needs but the provider may like to note that not all areas were using care planning.

In all areas we found that risk assessments were in place to identify people who may require additional support in relation to pressure areas, venous Thromboembolism (VTE), falls and nutrition. Whilst many of these had been fully completed and action taken to mitigate the risks we found that risk assessments were not always being completed or action taken to reduce risks and ensure people's safety. An example was that a VTE risk assessment had identified a risk. The doctor had prescribed specialist compression stockings. One day later, when we inspected, the person did not have the necessary compression stockings. We found other concerns about the completion of VTE risk assessments and the management of identified VTE risks. Information provided by the Trust following the inspection showed that appropriately 10% of people did not have a risk assessment or preventative treatment for VTE.

We looked at how the hospital managed the risk of people falling. We were told that a falls risk assessment should be completed at the time of admission. In one ward we found that falls risk procedures were not being consistently followed. For two people this had been correctly followed, for the third the assessment had not been fully completed and there was no evidence that action had been taken to reduce the risk of the person's falling. In another ward we found similar inconsistencies with falls risk assessments not always fully completed and a falls management plan initiated. On one ward we considered a person who had been admitted as a result of a fall at home. They had suffered two falls since admission to hospital and were unsteady on their feet. Staff told us that they did not have equipment to alert them to the fact that the person was out of their chair and walking

around and relied on staff to notice this. There was a risk that if staff were occupied elsewhere this would not be immediately noted and they may fall. On another ward a person was identified as at high risk of falling from the bed and a special bed had been provided. Overall there were systems in place to identify the risk of people falling, however, these may not always be fully implemented and some people remained at risk.

We found that risk assessments had been completed for people and that pressure relieving equipment was widely used. We saw that other specialist healthcare professionals were consulted when necessary such as tissue viability nurse specialists. For example one patient had been seen by the Tissue Viability Nurse Specialist (TVN) and had been prescribed a specific wound care treatment. The wound care plans for this person showed that they were having their pressure ulcer dressing changed regularly. However for another person we could not find a wound care plan and saw that they were having different types of dressing applied to their pressure ulcers. The staff could not tell us why different dressings had been used. On some wards there were records to show that people were being supported to change their position on a regular basis. We spoke to one person who was at high risk and they confirmed that staff helped them to change position. There were systems in place to assess and manage the risks of pressure injuries. However, there was not always a consistent wound management plan when pressure injuries did occur.

We found some instances where we could not confirm that people were receiving the correct care. An example being a person who was receiving their fluids via a tube. Their records showed that at times they only received half of the amount of water prescribed. On the day prior to our inspection they received their insulin and subsequently concerns were raised about the positioning of the feeding tube. The feed was suspended whilst this was checked. However alternative fluids including glucose were not provided. We raised this with the Trust who have reviewed the care this person received. Other people were receiving fluids via an intravenous drip. We looked at the records for one person and it was unclear what they had received.

Another person was receiving their meals on a red tray. These alert staff to people who require assistance with meals and to catering staff that they should not remove the tray without consultation with nursing staff as these patients required their food intake to be monitored. We found that for three people, whose meals were on a red tray, that records of food and fluids were inadequate and saw one person was distressed and their mouth was dry. This person did not have any drinks nearby. For another person we were unable to confirm what meals they had received for the three days prior to our inspection.

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

Our judgement

The provider was meeting this standard.

People who use 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

People using the hospital 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. We spoke with staff who were aware of safeguarding and confirmed that they had undertaken safeguarding training as part of their induction. This was also stated in information provided by the Trust management team which showed that all staff undertook safeguarding training as part of their induction. Staff were aware of what might constitute abuse and most gave examples of when patients had been thought to be at risk from relatives or carers outside the hospital. Staff said that they would report any concerns to their ward manager. Staff were less clear about reporting safeguarding concerns to external professionals such as the local safeguarding team. We spoke to senior managers who explained their processes for investigating concerns relating to safeguarding. For instance, incidents of serious concerns were discussed at a joint critical incidents panel.

Staff were aware that there was a safeguarding matron. Following the inspection the provider sent us further information including their safeguarding action plan. This showed that the trust had identified concerns and that a clear plan was in place to address these. All areas of the action plan had been commenced and approximately half were completed at the time we were supplied with the action plan. This showed that the Trust had identified training and procedural concerns and taken action to address these. We spoke with the Southampton local authority safeguarding team. They told us that they had regular contact with the safeguarding matron and that incidents such as pressure injuries were reported at ward level, however, there was often a delay in these being reported onto the local safeguarding team. The local safeguarding team said they did not have any specific safeguarding concerns about the trust.

We had received notifications of a number of incidents when patients had been placed at risk due to their behaviour or the behaviour of other patients. We also saw an example in a record viewed which showed that a person was aggressive and hitting out when receiving personal care. There was no plan of action in place to show how this person's needs would be met and what action staff needed to take when the person displayed aggression. It was recorded that a behaviour chart should be completed and this was not done. The person's daily record showed that they needed three staff to assist them and that they had suffered multiple skin tears. We asked to see the incidents and accidents records for this

person and a senior staff could not locate them. It was therefore not possible to identify how or when the person's injuries had occurred or what action was being taken to reduce their risk of injury. This placed both the person and staff at risk. The completion of a behaviour chart may provide additional information to help staff determine the best way to support the person. The absence of incident records placed staff at risk of allegations that the person had been injured through inappropriate care and the provider may wish to note this.

We did not specifically discuss safeguarding with patients however people said that they felt safe and did not raise any issues that might indicate any safeguarding concerns. We saw within patients' records that valuables had been identified during admission and a note made of these.

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the prescribing, administering and dispensing of medicines for discharge in a reasonable time.

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

Reasons for our judgement

Our previous inspection in March 2012 we found that medication including fluids for intravenous infusion were not stored securely. The provider sent us an action plan telling us what they were going to do to ensure the security of medicines. Whilst action had been taken to address this we saw on one ward that the medicine trolley was left unlocked with the key in the lock. We also saw three people's medicines that had been signed for as administered and these were left on people's tables.

Medicines were stored in locked cupboards and the keys for these cupboards were kept in a key cupboard which was accessed by a code. We were told that there was a protocol to keep this code safe with the key pad codes being changed on a regular basis. In conclusion we saw examples where medicine security was compromised, which could put patients and visitors at risk.

Medicines were not prescribed and given to people appropriately. People who were unable to communicate their pain were at risk of not receiving adequate pain control. This was due to the pain assessment charts not being seen to be used and people's pain not being effectively assessed. On one ward we saw a person was distressed who told us that they were in pain. We noted from their records that they had not received any of their morning medicines at 11:30 that day. We also noted that they had not received any pain medicine since 21:30 the previous night. We brought this to the attention of staff and this person was given their medicines.

Another person said that the last pain relief they had received was given to them at 0900 that morning and at 14:30 (when we spoke with them) they were in pain. They told us that they had not informed the nursing staff or asked for any pain medicine as the staff were busy and they felt they would be discharged at any moment. The person's medication records were not complete when they were transferred to the discharge lounge and had remained on the in patient ward. Discharge paperwork including medication prescription had therefore not been completed when the person was transferred preventing them initially receiving pain relief when required. We were subsequently informed that the Trust

were aware of the issue of delayed discharge medicines and action had been initiated to make improvements. However delays were still occurring when we completed our inspection.

On another ward, we found that a person had been in hospital for 24 hours and had not received their medicines. A member of staff told us that they may have been given their medicine, but we found out that they had not been prescribed. Then we were told that this person may have self medicated. However the medicines were locked and the person could not access them without the staff's help. We looked at their daily records of care and this did not show that they had received their medicines.

In the discharge lounge people told us that they had been waiting for their medicines all day. One person was concerned when they were told in the afternoon that their discharge medicines had not been prescribed. This meant that they would have a long delay as they would have to wait for their medicines to be prescribed and dispensed. This person was later told that the ward's staff could give them their tablets from the stock. One person who was a patient in the hospital regularly told us that they would not wait for medicines as it would take a long time. They went home without their medicines and got them from their own doctor. Another person was tearful at the end of the day when their medicines were still not ready, having waited from around midday. When the medicines were ready, they were sent up to the ward and not the discharge lounge which further delayed them going home. Their family had been waiting with them for these 6 hours. Two people waiting for medicines had been told the night before that they would be discharged, but they experienced delays. The lack of clear processes caused people undue stress and delayed their discharge.

On all the wards we were told that there were concerns about the long delays in discharge as people waited for three to four hours for their medicines. The ward sisters told us that this was due to difficulties in getting people's medicines prescribed and the computer records being completed. One senior nurse told us that there were not enough computers for the doctors to log on and complete information to move the discharge along.

We spoke to the ward pharmacist who explained the level of service provided to ward clinical areas. They told us that although sometimes there are staff shortages they managed to support wards according to their needs. There was a 24 hour on call service and staff spoken with told us that they had good access pharmacy staff and medicine information. People we spoke to were very complimentary about the staff and confirmed that medicine information was given to them as needed.

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.
Regulation 22

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

Reasons for our judgement

There were not enough qualified, skilled and experienced staff to meet people's needs. People told us that the nurses and medical staff were "very good". We were told that staff responded as "quickly as could be expected" but that "response times were worse in the mornings when people needed help". Other comments included that staffing was "erratic" and that there were "not enough staff". Another person told us that staff had been "excellent, always very patient, and remaining calm despite being clearly extremely busy". On another ward we were told there were "not enough staff, not enough resources and that staff were run ragged". The person said the understaffing had resulted in staff not having enough time for patients and that they did not feel they had been properly involved in decisions about care and treatment. Other people told us that "staff kept changing". We were also told about an incident when people had received meals late, lunch at 15:00, due to shortages of staff. Another person told us that there were problems in the mornings which meant that they had to wait for help to go to the toilet and this meant they had been "desperate" by the time help was available.

A visitor told us that they helped a person with their meals as they were "slumped in bed" and could not manage their food and the nurses "were very busy". On a different ward another visitor told us that they spent all day on the ward until their daughter came in the evening to take over. This was because their relative had dementia and staff were too busy to provide the level of care and support they needed.

A senior doctor told us that the ward had employed a ward coordinator and that this was working well. They told us this person provided support on daily ward rounds and linked with the nurses. Feedback from the therapists showed that sometimes people did not get seen due to pressures in seeing people receiving rehabilitation first. People were therefore not getting the care they required. A doctor told us that due to a lack of specialist people to take blood samples they had had to do these themselves and had taken 10 samples so far that day. This removed them from other medical duties they should have been doing. Other doctors echoed these views.

At the time of our inspection we found that all wards were fully occupied with patients and

that the hospital was experiencing a period of high demand. We observed that staff were busy and medicines rounds, for example, were in progress at 11-11.30 am on one ward. We also observed that people were left for long periods unsupervised as nurses were busy in other bays. This increased the risk of some people falling. Another issue raised on several wards was the lack of equipment which meant borrowing frames and rotundas from other wards. This meant that staff were spending time going to other wards to find, borrow or return equipment. One staff told us that "there were times on the ward when they were understaffed to a degree", and felt they could not provide the "high quality of care they would like". On all wards we inspected we were told about high numbers of vacancies for nursing staff. Staff told us that the trust depended on high levels of agency staff especially at weekends. This in turn impacted on the care that people received due to the lack of continuity in their care. We were told that nursing staff shortages were a "regular occurrence" and impacted on their capacity to provide care and support. During the inspection we met some of the newly qualified nurses who were completing an induction period.

The trust provided us with information about staffing. This showed that the week prior to our inspection a total of 1670 shifts had been requested. During our inspection we were told that agency nurses had been requested but had not been available. On one ward we were told that an agency nurse was requested for a person who needed individual attention but not provided. To ensure this person's safety a nurse had been moved from another part of the ward and that another nurse now had to manage two areas of the ward on their own.

The trust provided us with information about the action they were taking to address this concern. We were told that they had recruited over 120 newly qualified nurses. Some had commenced working at the trust and others were due to start throughout October 2012. The trust was also recruiting to specified posts and providing a return to practise programme for qualified nurses who had not been working for a number of years. There were plans to recruit staff from overseas. From the analysis we found that the trust was well aware of the overall upward trend in vacancies across the trust from 177.4 in September 2011 to 240 in March-June 2012 culminating at 315.9 in September 2012. Some of these vacancies were due to an increase in the numbers of staff required by the Trust to provide additional services.

Although the trust was working to recruit nurses there remained a significant vacancy rate across the trust. The high use of agency nurses was placing considerable strain on staff and placing people at risk that they will not receive the care they require.

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

Our judgement

The provider was not meeting this standard.

The provider has failed to ensure that people are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Accurate records which included appropriate information and documents in relation to the care and treatment provided to each person were not maintained in all instances.

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

Reasons for our judgement

People's personal records including medical records were not always accurate and fit for purpose. We looked at a total of 42 people's medical and nursing records. We also looked at some computerised medication administration records. Overall we found that patients' records contained information that was required for the safe and effective care and treatment. In most cases we saw that notes were made of patient's care and treatment on a daily basis which ensured that there were effective records and communication about patients care and treatment. On most wards all staff, nurses, doctors and other health professionals recorded in one set of multi disciplinary notes. This provided a comprehensive record of care and treatment. However, there was a risk that important information could be missed or be harder to find in complex notes with many entries. We saw in one area that highlighter pens had been used to identify important information. This made finding key pieces of information easier and would help protect people.

In some instances we identified concerns with individual records. An example being a food chart where it was already recorded that a person had eaten their pudding when they were still seen to be eating it. We also found other examples where food and fluid charts had not been maintained. We spoke with the nurse in charge of a ward and were told that "sometimes nursing staff catch up with fluid recording later in the day, by asking what a person has had to eat or drink during that day". The failure to record care or fluids when people received them meant that it was not possible to ensure that accurate records were maintained. We found that on some records patients' names and details were not filled in on forms where they should have been.

Most records were kept securely and could be located promptly when needed. Most records were stored in the area next to the nurse's station where staff could locate them. We did find that notes were held on loose sheets of paper and these could be lost. We found pages missing in one set of notes viewed. Concerns were raised by one person who told us that their records were loose and when they had arrived on the ward several hours previously staff had noticed that their personal folder contained records of another person.

We looked at the records and found that these were now bound and maintained appropriately. In one area where there were a lot of admissions and discharges we saw piles of records stacked in areas accessible to people. We were told that it had been a busy weekend and the ward clerk was still dealing with these. We were told that it usually "takes till Wednesday to clear these". The matron in this area agreed that storage of records waiting to be processed was an issue.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010
Surgical procedures	Care and welfare of people who use services
Treatment of disease, disorder or injury	How the regulation was not being met: The provider has failed to take proper steps to ensure that all people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. Care was not always planned in such a way that would ensure the welfare and safety of people. Regulation 9 (1) (b)
Regulated activities	Regulation
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010
Surgical procedures	Management of medicines
Treatment of disease, disorder or injury	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the prescribing, administering and dispensing of medicines for discharge in a reasonable time. Regulation 13
Regulated activities	Regulation
Diagnostic and	Regulation 22 HSCA 2008 (Regulated Activities) Regulations

This section is primarily information for the provider

screening procedures	2010
Surgical procedures	Staffing
Treatment of disease, disorder or injury	How the regulation was not being met: There were not enough qualified, skilled and experienced staff to meet people's needs. Regulation 22
Regulated activities	Regulation
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010
Surgical procedures	Records
Treatment of disease, disorder or injury	How the regulation was not being met: The provider has failed to ensure that people are protected against the risk of unsafe or inappropriate care and treatment arising from a lack of proper information about them. Accurate records which included appropriate information and documents in relation to the care and treatment provided to each person were not maintained in all instances. Regulation 20 (1) (a) and (2) (a)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 12 December 2012.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

✓ Met this standard This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

✗ Action needed This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

✗ Enforcement action taken If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)

Consent to care and treatment - Outcome 2 (Regulation 18)

Care and welfare of people who use services - Outcome 4 (Regulation 9)

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

Safety and suitability of premises - Outcome 10 (Regulation 15)

Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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