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

Kingston Hospital

Galsworthy Road, Kingston Upon Thames, KT2 7QB
Tel: 02089342814

Date of Inspection: 25 February 2014
Date of Publication: April 2014

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

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<th>Standard</th>
<th>Met this standard</th>
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<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
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<tr>
<td>Cooperating with other providers</td>
<td>✓</td>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓</td>
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**Details about this location**

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<tr>
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<th>Kingston Hospital NHS Foundation Trust</th>
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<td>Overview of the service</td>
<td>Kingston Hospital is part of Kingston Hospital NHS Foundation Trust. It offers all major medical, surgical maternity and diagnostic services to the people Kingston, Richmond, Roehampton and surrounding areas. The hospital has an accident and emergency department (A&amp;E). The areas we visited were A&amp;E and the medical wards.</td>
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<tr>
<td>Type of services</td>
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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 inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people’s experiences of moving between care homes and hospital.

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 25 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and received feedback from people using comment cards. We reviewed information given to us by the provider and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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

This inspection was mainly focussed upon the care and treatment people with dementia received when they came to the Trust for medical treatment. We spent three days speaking with 60 patients, their relatives, staff, observing care practice and checking records. We visited and collected evidence from six wards and the accident and emergency department. The wards we visited were 'general medical, the acute assessment unit and orthopaedics'.

People were generally positive about their patient experience. They told us "Very good, they do their best and very polite". "I have been visiting the hospital over a number of years and have seen it has radically improved over the last two years". "Attention in terms of user-friendly care is vital and this has improved, particularly in the way that meals are organised".

We saw that the trust had made efforts to increase the profile of people with dementia and improve their care by encouraging involvement of non-medical staff, relatives and volunteers from the local community. They visited patients on wards during mealtimes to help people to eat their meals and have a 'chat'. Open visiting times had also been introduced and this enabled more flexible and enhanced contact for people with dementia.
and other patients with relatives, friends and carers. Staff said that the dementia training had improved their understanding of how to support patients with dementia. Staff told us of the importance of having empathy with their patients and said they felt much more equipped to support patients with dementia.

We saw most staff were very attentive to patients needs and explained their treatment to them. They provided care in a compassionate, polite and thoughtful manner. We saw staff actively encouraging people to ask about their treatment and being supported to make choices.

The trust had also developed more in depth training for staff in dementia care. We saw that this was reflected in the care practices on the wards where staff had completed the training. On these wards there was more use of the eight things about me care planning document, forget me not symbols and blue bands identifying people with dementia and that they may need more explanation of their treatment and way it was delivered.

The quality and completeness of records of people with dementia and other patients we looked at varied from ward to ward. Most recorded the required information, although some documents were incomplete. The care plans incorporated input from a number of health care professionals to make the approach to dementia care and in general more holistic.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

How are the needs of people with dementia assessed?

The staff we spoke with confirmed that people who appeared confused or with a memory impairment would be assessed as part of the general nursing assessment. We saw a sample of nursing assessment documents that included sections covering general contact information, vital signs, mental health, nutritional risk, alcohol risk, falls risk assessments, Waterlow charts and discharge planning. The provider may wish to note that some of the discharge planning information was not completed. There were specific cognitive areas within the nursing assessment communication sections that included diagnosis of dementia, recent history of new forgetfulness, recognition of loved ones, repetitive behaviour, difficulty naming objects or people and orientation to time, place and person. There was also a section dedicated to social history that aided discharge planning. There were separate dementia and diagnostic assessments for all patients over 65 that was mandatory.

We saw that blue bracelets were used to identify people who were assessed as displaying difficulty with cognition to others within the hospital. There were posters displayed reminding staff that a person wearing a blue bracelet may be forgetful and need extra assistance.

Staff said that additional staff would be provided on a 1 to 1 basis if risks had been identified or the person was trying to walk around constantly. A & E staff told us that psychiatric liaison staff tended to be used for people with a mental health issue but not for people with dementia. Two staff said they would call the occupational therapy staff if they had a problem and that they were 'very helpful'. A sample of records we saw showed that some people staying on the medical wards had received an assessment from the liaison psychiatry service following a referral from the ward.

The Trust identified in its quarterly 'CQUIN' report in January 2013 that a target had been
set for 90% of patients over 75 to be screened, risk assessed and identified as at risk of having a new diagnosis for dementia. These targets were met in December 2013.

How is the care of people with dementia planned?

The care documentation we saw was initially based on the assessment information, involved a number of healthcare professionals including doctors, nurses, occupational therapists and physiotherapists and was required to be completed within specific time frames. It was then added to as treatment progressed. It varied in its level of completion and quality of information recorded depending on the ward although it generally met peoples' needs. On one ward there was a concern that a care plan had not been completed for one person with pressure sores recorded as present on two parts of their body. The daily notes seen stated that one sore had 'not been documented on a pressure bundle'. We saw evidence that this wound had been documented by staff in the notes five days previously and noted that a Tissue Viability Nurse had seen the patient twice but their advice had not been documented in the form of a care plan. It was documented by the Tissue Viability Nurse in the medical notes.

The Trust, staff and the dementia trainer told us that dementia care planning was based on current best practice and guidance from the National Institute of Clinical Excellence (NICE) guidelines and a number of other sources. Staff who had attended the dementia training said "It was incredibly useful in better understanding people and their needs" and "I understand much more now I've completed the training". Staff working on the medical wards told us that people living with dementia were identified by a forget me not symbol above their bed and an '8 things about me' care planning document was completed with them or carers and relatives to help staff meet their care needs. The use of this documentation varied from ward to ward and depended upon how many staff had completed the dementia training. On those wards where the training was completed, there was a higher usage of the dementia identification tools provided than on those where the training had not yet been completed. Bedside documentation examined for two people on a ward did not contain this documentation although it was seen to be contained in their medical notes that were kept at the nursing station. Only one of these documents was seen to be displayed above a person's bed on another ward and this was partially completed. On other wards the documentation was more prevalent and complete. We attended a ward round and saw that peoples' needs were identified and discussed on an individual basis including social as well as health care needs to ensure appropriate support was in place when they were ready for discharge. This included use of the dementia flower identification symbol that was used on the red, amber and green ward discharge boards.

Are people with dementia Involved in making decisions about their care?

Patients we spoke with told us that they had generally been involved in the decision-making about their care. One patient said "I've been included at each step of my treatment, know what is happening and why". Staff told us that the presence of a blue band or a 'forget me not' symbol reminded them to take extra time with the person and explain things to them. Staff comments included "I take that little bit extra time", "I try to involve their family or friends", "I try to orientate them" and "I give them constant reassurance".

On most wards the nursing records we saw showed that the assessment, care planning and treatment had been discussed with the patient with dementia, their relatives and care home staff if appropriate. The nursing records clearly set out the required information for
treatment but tended to be task focussed and did not reflect the preferences of people using the service in how they wanted their care and support to be delivered. On wards where staff had not completed the dementia training we found little evidence that people were involved in decisions about their care. Records showed that people's relatives signed one form at the start of the person's care at the hospital. Staff assured us that there were regular and routine meetings with relatives and people but we did not find records that verified this. On some wards patients health passports and other documentation if available was kept on medical files at the nursing stations rather than at bedsides. This meant that some staff were not made aware of this information even though it was in place. We saw one patient being offered a cup of tea by staff which they refused. Another staff member later offered them tea which they again refused. They were then offered a cup of coffee which they accepted and drank. We saw on the 'Eight things about me' information kept within their medical notes that they did not like tea but enjoyed coffee.

The provider may wish to note that nursing staff spoken with were aware of making decisions in the 'best interests' of people using the service but were not always knowledgeable about the Deprivation of Liberty Safeguards and their application.

Are people with dementia provided with information about their care?

We saw that patients were generally given information about their care although this varied depending upon the ward. Staff took time to explain things to people and repeat them as required although this was reduced during busy periods on the wards. One patient we spoke with said "They keep me informed about what is going on and I get the chance to ask questions". Another patient said "The staff are really good and kind, but sometimes they just don't have time". Relatives or friends spoken with said they were able to get information from the doctors when they needed it but were not aware of any named staff members to liaise with. Two members of a patient's family said; "We've been involved in everything from the start, and we can always find people to talk with if we're worried. We've never had a problem". There were leaflets that gave support information for patients with dementia, their family and friends. It contained a contact number, general overview about dementia, a description of the Trust's 'Forget me not' scheme, hospital tips for carers and where to go for advice and support on returning home. There were also dementia champions located within the Trust and information about how to contact them. An information board was displayed on each ward and in the accident and emergency unit.

We saw that staff on most wards took time to explain what was happening to people and warned them of what they were going to do when providing care. In the case of people with dementia the success with which they included people was reflected by the level of dementia training they had received. The provider may wish to note that we observed one instance when a bed was moved without the patient being warned causing them to cry out and another instance where staff started to take someone's blood pressure without informing them first.

How is care delivered to people with dementia?

Relatives and friends said "The care is excellent, very happy", "They treat my relative nicely" and "Excellent care overall". Staff told us that they thought the care delivered was "Fairly good", "Really good" and "Good care under difficult circumstances". Staff said that they were trying to make the care for people with dementia more 'family focused' and 'holistic'. The challenge voiced by the majority of staff spoken with was how this could be achieved with the current staffing levels.
We saw that the pivot for dementia care within the Trust was a 'Forget me not' scheme. This focussed on five specific elements, having staff who are skilled and have time to care, partnership working with carers specifically in discharge planning, assessment and early identification of dementia, care plans that are person centred and individualised and dementia friendly environments. We saw that the Trust aimed to meet these elements by setting up a comprehensive dementia training programme that staff attended together from all levels of seniority, forget me not symbols, blue identity bracelets, 8 important things about me, carers passport, information leaflet, carers survey and ‘This is me’ information sheet. The success of these initiatives varied within the wards as the training was being cascaded and were more successful on those where it had been completed.

The Trust had introduced a dining companion scheme that we saw in action. The purpose was to give staff who were not generally engaged directly with patients, family, friends and the public the opportunity to become involved in dementia care and increase their knowledge of dementia by visiting people with dementia during mealtimes and assisting with meals or having a chat. This enabled staff to better understand how their role and work contribution fitted into the patient experience and the patients, relatives and the public to get an improved perception of how care and treatment was delivered. This also gave front line nursing and care staff the opportunity to free up their time. We saw patients enjoying this approach to their care.

We sat in on a reminiscence session on one ward where people were encouraged to join in and share their experiences with others. These were facilitated by staff from a variety of roles within the hospital and patients we spoke with said they enjoyed them. There were also therapeutic activity kits available that contained items such as low vision playing cards, 1940s and 1950s reminiscence cards, large print song books and famous faces booklets that we saw staff using to stimulate participation and interest. We also saw staff improvising to stimulate particular areas of interests that people suggested and developed. The Trust was also piloting a software 'Life Story Book' that was created by people with dementia, their family, staff and carers, that could be accessed on a jumbo screen.

The provider may wish to note that we focussed upon fluid intake charts across medical wards and noted that although recorded, many were not totalled.

Is the privacy and dignity of people with dementia respected?

Patients told us "I'm very happy with the staff, they are all very nice". "I feel treated with respect and well looked after". "The care could be a lot more impersonal and sometimes I don't envy staff". The Trust had a policy and procedure regarding treating people with dignity and respect and staff confirmed they had received training regarding this. We saw that most staff followed the procedure in their care practices and patients were generally treated with dignity and respect during the inspection. Curtains around beds were closed when personal care or treatment was provided. The provider may wish to note that on one ward a ward sister came in and said across patients in their beds "Oh you're feeding that one are you". This was de-humanising.
Cooperating with other providers

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

How does the provider work with others when providing care to people with dementia?

Most records we saw demonstrated that information from other providers such as care homes and relatives was used in the initial assessment if available. We saw that staff in A & E received a handover from ambulance staff when they arrived at the department with written details of the person logged by an administrator. Ambulance staff spoken with said they did not always get a handover from the care homes and confirmed that good quality information such as a written health 'passport' was not consistently provided. Hospital staff said that a lack of supplied information about a person living with dementia made it difficult to establish a baseline assessment impacting on the care being provided to the individual. The department's manager told us that they were part of a working group establishing links with the local community and providing education to community staff to help prevent emergency admissions. Part of this work was also to try and improve the quality of information provided between care homes and the hospital. Staff on the A & E unit and medical wards told us they would contact local care homes to obtain further information about the person if required.

The Trust had a discharge policy that staff we spoke with confirmed had been made available to them and they understood and followed. There was also multi-professional training provided. We saw a sample of discharge summaries that were completed and gave information regarding follow up information, diagnosis, problems and procedures during the current visit and allergies identified, requests for further tests and medication information. There was also information regarding visit outcome and whether people were being discharged home or transferred elsewhere. Specific areas included clinical presentation, examination, significant investigations, clinical course, information given to the patient, GP actions and patient capability. The patient capability included self-caring, continence, mobility and social support arrangements made by the hospital. This encompassed meals on wheels, home help, home care and district nurse. They were signed by the sister/charge nurse electronically and stated that where patients were to be discharged a plan was in place for this. Staff told us that they contacted any services involved in the patient's care prior to discharge from the wards. Audits of discharge related
cause for concern were also carried out.

Staff acknowledged the importance of maintaining on-going contact with other care providers in the community to ensure the continuity of care once the patient was discharged. They told us that the Trust informed relatives, carers and care homes of the day of discharge but could not be specific on time, due to the effect of patient inflow and subsequent requirements for transport. They said sometimes delays occurred in discharge and they made sure that people received food and drink if they had to wait.

Are people with dementia able to obtain appropriate health and social care support?

A sample of records demonstrated that prior to discharge multidisciplinary meetings involving social workers, health professionals and care providers had been held and plans were drawn up to support the patient when they left the ward. Where patients needed support from other providers of care, appropriate referrals had been made. We noted during the ward RAG round we attended that a large part was devoted to identifying the support people would require on discharge and whose responsibility this would be to ensure the required services were in place. The RAG round was held at 9am each day and used to discuss all the people on the ward, looking at how close they were to discharge and what needed to happen to achieve this. A Health Needs Assessment (HNA) document was completed for people requiring further ongoing support and these were fast tracked for people with rapidly deteriorating conditions. Part of the HNA document was to obtain information from family and a ward co-ordinator explained the importance of 'involving and helping' the family.
Assessing and monitoring the quality of service provision

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 to regularly assess and monitor the quality of service that people receive. 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

How is the quality of dementia care monitored?

The Trust monitored quality of dementia care using the 'Friends and family' test and patients' and carers' surveys feedback. They identified a set of key performance indicators monitoring processes, quality and outcomes. The processes included targets ensuring that patients have cognitive assessments as required, the number of people with a suspected new diagnosis of dementia who are referred to a GP, memory clinic or local mental health team for older people, how many times patients are moved and how many staff have completed dementia training and are aware of the 'Forget-Me-Not' scheme. The quality level was identified through people led assessments of the care environment (PLACE) audits showing how user-friendly the Trust environments were, carer satisfaction, complaints and 'Friends and family' test scores. The outcomes were identified by changes in areas such as incidents of violence and aggression, length of stay, fall rates, increased nutritional intake, prescriptions for anti-psychotic medication for people with dementia and the number of patients reporting having disturbed sleep at night in the annual patient survey. The Clinical Quality Report was reviewed monthly by the Trust Board, contained key performance indicators and there were annual reports and quality accounts. There was also a procedure for monitoring the identification and management of serious risks. The ‘Supporting patients with dementia and their family and friends’ leaflet information also contained a carers feedback form asking about carers experience whilst people with dementia were in hospital.

How are the risks and benefits to people with dementia receiving care managed?

The Trust identified the Director of Nursing and Patient Experience as the executive lead for dementia care and a consultant in elderly care as the clinical lead. There was also a Dementia and Delirium Team established that held regular meetings to improve the care of patients and their carers. The team had endeavoured to strengthen relationships between staff and carers and the meetings were a sub-committee of the Clinical Quality Improvement Committee. A pilot in-patient psychiatric liaison service was running between
September 2013 and August 2014 with the purpose of establishing high quality psychiatric assessments, interventions, care and to deliver training for staff on wards. It also sought to liaise with community health and social care providers to provide support for patients and carers during the discharge planning and post discharge period.

Are the views of people with dementia taken into account?

The Trust had identified dementia champions whose role included pro-actively engaging with patients, their families and carers, acting as a role model of good practice for staff and to support and implement the 'Forget-me-not' scheme. They also fed back patient views to the Dementia and Delirium Team.

There was an advocacy service available that was contract managed by the Royal Borough of Kingston who took referrals. The service included access to an Independent Mental Capacity Advocate whose role included finding out as much as possible about the patient's wishes, feelings, beliefs and values. In addition patients and carers had access to the Patient Advice and Liaison Service team (PALS) who reported enquiries to the Patient Experience Committee monthly.

There was an 'Important Things about Me' document that outlined what people wished to be called, their former occupation, likes, dislikes and food and drinks preferences. The information requested was basic and its use from ward to ward was governed by the level of dementia training staff received, similar to the interaction between staff and patients on the wards. On most wards we saw that staff were very attentive, took time to listen to people and act on their wishes, whilst on others attention was paid in a more superficial, task driven way that was impersonal and purely functional. We saw staff on one ward taking time to explain what a patient had on their plate and repeating this, whilst on another ward a staff member assisting a patient to eat their lunch did not speak with them other than to encourage them to eat more. The member of staff said "Don't you like the food? No? But you chose it". This did not take into account that someone living with dementia may have forgotten the meal they had previously chosen.
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.
(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.