Inspection Report

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

University Hospital Lewisham

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Date of Inspections: 11 February 2013
08 February 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cooperating with other providers	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Lewisham Healthcare NHS Trust
Overview of the service	University Hospital Lewisham is the main hospital location of the Lewisham Healthcare NHS Trust, a medium-sized integrated acute and community trust which is the primary provider of a broad range of acute and community healthcare services for approximately 265,000 people living in the London Borough of Lewisham. University Hospital Lewisham has a 24-hour emergency department, inpatient beds, outpatient clinics, operating theatres and an integrated critical care unit.
Type of services	Acute services with overnight beds Diagnostic and/or screening service Urgent care services
Regulated activities	Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Termination of pregnancies 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'.

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 8 February 2013 and 11 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We reviewed information sent to us by other regulators or the Department of Health, reviewed information sent to us by other authorities, talked with other authorities and were accompanied by a specialist advisor. We used information from local Healthwatch to inform our inspection.

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.

Our inspection team included specialist elderly care and learning disability associate inspectors.

What people told us and what we found

The main focus of our inspection was on the care and treatment provided to more vulnerable patients, for example older people, people receiving end of life care and people with dementia or learning disabilities.

The trust worked in co-operation with other partners, and was part of an innovative "developing integrated pathways across health and social care" project.

There were clear pathways and tools which were aimed at meeting the needs of vulnerable patients; however, some of the measures and tools within the pathways were not yet fully implemented or had not been audited to assess whether they were meeting patients' needs.

Some of the care records and assessments we saw did not reflect people's needs, or were incomplete or inaccurate, which meant there was a risk that not all patients experienced care, treatment and support that met their needs.

Overall, patients' views and experiences were taken into account and staff respected and promoted their privacy. However, patients' personal dignity was not always taken into account. Some patients were complimentary about the service they had received, and told

us, "staff are busy but they do have time to talk to me and they listen to me. They do a great service", "the nurses work really hard, they have lots to do" and "staff have been marvellous". However, during our inspection we saw examples of poor communication, and some patients told us that staff did not listen to them or their views.

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 20 April 2013, 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

Respecting and involving people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Overall, patients' views and experiences were taken into account and staff respected and promoted patient privacy. However, people's dignity was not always respected.

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

Most patients we spoke with during our inspection understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.

Patients knew why they were in hospital and what treatments they were receiving, although about 80% of them did not know that they had a written care plan. An inpatient with communication issues said that they were well-looked after and staff explained their care and treatment when they didn't understand.

In 2012, the Parliamentary and Health Service Ombudsman had found that a patient "was not given relevant and accurate information" about their condition on discharge. At our inspection we saw that the trust had developed a range of patient information leaflets for patients to take home, including on the risks and benefits of elective surgery and on post-natal infections, to promote patient understanding about their care and treatment.

Reasonable adjustments were offered to patients with communication difficulties. For example, people with learning disabilities (PWLD) or with dementia were encouraged to bring a supporter with them to hospital appointments. Staff we spoke with were not aware of leaflets in easy read formats, but said they could ask for these to be provided reactively. A communications passport was available for PWLD, with large print and pictures to illustrate questions. A similar passport was in development for people with dementia but was not yet available for staff use. Information could be provided in Braille, and interpreters for second language speakers or people with hearing impairments could be made available. The hospital used a symbol to indicate when a patient had specialist communication needs, such as dementia or a learning disability, to remind staff to provide extra communication support. A specific symbol indicating LD had been piloted, but was not yet in use on all hospital wards.

Signage throughout the hospital was poor, including temporary, handwritten signage and signs that did not provide good directions. Some signs were high-up and not appropriate for people with dementia or with limited mobility. We saw many people having to ask staff for directions. Staff told us that poor signage was often raised by visitors. A project to improve signage at the hospital had been completed, but due to ongoing discussions about the future use of the hospital the project recommendations were on hold.

The results of patient surveys and some information of concern we received showed that some patients or their visitors had experienced issues relating to attitude of staff and poor communication.
The trust gave us evidence which showed there were measures in place to monitor, learn from and improve the patient experience. There were specific action plans to improve patient experiences, and close working relationships with the Local Involvement Network. Recent patient feedback reports showed some improvements. We saw the results of a recent survey where 90% of patients who were asked, "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?" responded that they were "likely or "very likely" to recommend the hospital.

During our inspection, most patients told us they felt well-looked after. The majority of patients, family members and visitors were complimentary about the hospital and its staff. Some people told us, "the nurses are fantastic", "I am treated really well" and "I can't fault most of the staff". However, one person said, "there were two rude nurses… but I ignored them". A family member told us, "on this ward the staff have been great but they were horrible" on another ward. An inpatient said that night nursing staff had ignored their requests for help with personal care, but that their daytime nurses were "great".

Some patients told us that they did not feel that staff listened to them or involved them in making decisions about their care. For example, a patient with learning disabilities (PWLD) said they felt well-looked after but had not been offered any choices about their care. However, most patients told us that some of their individual preferences, for example what they wanted to eat, were taken into account.

Most staff we observed provided patients with appropriate personal care and attention, spoke with patients politely and treated them with respect. Measures were in place to protect people's dignity and privacy, for example soft music was played at outpatient reception areas to mask conversations. Staff used privacy curtains when personal care was provided and during examinations and there were separate male and female bed areas. Most patients said that staff responded to call bells promptly, although some said that it was the only way they could get any attention. A patient told us, "staff are so busy I don't like to bug them…"

However, on some wards where care was provided to elderly patients we saw examples of poor or no communication. We observed that staff entered a bay, spoke to no-one and went out again. We also saw two staff having a conversation about a patient's care in front of them, without involving them in the discussion. One person told us, "I want to go home. It is so lonely here, no-one ever comes in."

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients' care records and assessments did not always fully reflect their needs, or were inaccurate or incomplete, and not all measures to provide appropriate and personalised care for vulnerable patients with specific needs had been implemented. This meant that there was insufficient evidence that all patients experienced care, treatment and support that met their needs.

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

Most care we observed was given in a professional and timely way. The majority of patients we spoke with said their care was good and appropriate and understood their treatment. We saw examples of flexible and personalised care, such as an outpatient clinic which offered weekend appointments to ensure that people's needs were met.

However, we found there was insufficient evidence that all patients experienced care, treatment and support that met their needs. Some assessments and care records were incomplete or inaccurate, which meant care and treatment was not always planned and delivered in line with individual care plans or patient needs. The trust's nursing audits in January 2013 evidenced poor completion rates for some care documents, including that on two wards only 40% of individualised care plans for each issue identified by nursing assessments were in place.

During our inspection we observed a patient, admitted after unintentional weight loss, who waited an hour for food, having been nil by mouth all day after a cancelled procedure. Their nutritional screening was incorrectly completed, and did not document their weight loss or require staff to monitor food and fluid intakes to ensure the risk of further weight loss and poor nutrition was minimised. The trust had a system of two-hourly nursing basic checks that include positioning and pain relief for all patients. Two out of three sets of care records we looked at on one ward showed no evidence that two-hourly nursing basic checks had been done. On a third ward, there was a vulnerable patient with no appropriate plan of care.

In 2012, the trust identified a risk that it might fail to meet the national target for 98% of patients to be diagnosed, treated, discharged or admitted within four hours; it had implemented a recovery initiative and by February 2013 this risk was significantly reduced. Specialist pathways and plans, such as an overnight community palliative care nursing care service, had helped reduce hospital admissions and length of stays.

Staff carried out assessments to ensure that people's safety and welfare needs were met. For example, skin viability assessments were completed as soon as possible after admission. Staff were trained in pressure ulcer management and prevention. There were quarterly audits of pressure ulcer documentation. The audit results showed a reduced incidence of hospital acquired pressure ulcers in 2012. Pressure ulcers were reported and investigated as incidents and lessons from investigations were communicated to staff and incorporated into a monitored pressure ulcer prevention action plan.

Data collection and reporting arrangements were in place to ensure that elderly emergency patients at risk of or with dementia were identified, treated and referred to appropriate specialist services. Completion rates for ward cognition assessments had improved significantly throughout 2012.

The trust had a dementia care pathway and guidelines, elderly care specialist clinicians, and a senior clinician who led on quality improvements in dementia to ensure that people with dementia (PWD) received appropriate and personalised care. The effectiveness of care and treatments for PWD was monitored. For example, learning from an audit of prescribing for PWD was communicated to clinicians to improve future prescribing practices.

There was a named dementia champion on each elderly care ward, and staff were trained to recognise signs of dementia. However, the total number of staff who had attended dementia care training was not available, and three ward staff we spoke with were unaware of the dementia pathway. This meant there was a risk that some care and treatment for PWD might not always be planned and delivered so as to meet their specific needs.

The trust had an action plan and a clear pathway to improve access to healthcare for PWLD. Measures which had been introduced were commended by local partners as examples of good practice. Specific tools had been developed for PWLD, including a communications book, to help staff and PWLD to communicate effectively. There was a hospital passport to be completed by clinicians with the PWLD at initial medical appointments to ensure that further treatment took their needs and preferences into account. However, the tools were not yet fully implemented; some staff were not aware of the tools and had not yet attended health and wellbeing for PWLD training, and no evidence of how many passports had been completed. The trust had not yet implemented specific audits or satisfaction surveys to check that the services it provided met the needs of PWLDs.

Palliative care consultants and a local palliative care team were responsible for overall care management and pain control for people receiving EoLC. Ward staff providing the day-to-day nursing told us they were provided with EoLC training. We saw appropriate care being provided to an EoLC patient; an EoLC plan was in place and support from a palliative care link nurse. Patients with capacity were supported to make advance decisions to refuse treatment and a tool had been introduced to evaluate the wishes and needs of EoLC patients who were discharged to care in nursing homes. These EoLC tools were monitored to ensure they were used appropriately.

The trust followed national adult palliative care guidance but its EoLC strategy was still in draft form, and was not, therefore, fully implemented. A plan to replace all syringe drivers, in line with national recommendations, had been delayed as the equipment supplier was unable to provide all the required staff training until June 2013.

Cooperating with other providers ✓ Met this standard

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

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, because the provider worked in co-operation with others.

We were aware of some instances where patients were discharged with a lack of information or the wrong information, or where family or home situations were not taken into account. We had received information from some local care homes that discharge information was not always provided in a timely way when patients were transferred, to ensure people's safety and continuity of care. Some care home staff told us they had identified pressure ulcers which were not noted in discharge information. Our review of complaints in 2012 found that on one occasion a patient was discharged without appropriate arrangements for pain relief and with no discharge summary, and, on another occasion, the hospital acknowledged that the discharge information sent to a GP "could have been more detailed".

The trust worked with local care providers and patient representatives to improve the quality of its services. For example, there were quarterly joint providers meetings, attended by staff from care homes, inpatient and community services and local authority teams, where joint learning events and discussions about shared issues and potential solutions took place.

We saw evidence that the trust had improved the provision of information to patients, carers and GPs. Systems had been improved to ensure that sufficiently detailed information was provided to GPs. The outpatients we spoke with told us their GPs always knew about their hospital appointments and received information and test results from the hospital in a timely way.

The trust was part of the local EoLC and palliative care network. A Proactive Elderly Advance CarE (PEACE) plan had been introduced for patients at the end of their lives who were being discharged to care homes, which provided clinical advice for future medical care to support GPs and care homes to provide care in the home setting. The trust's elderly care team were responsible for completing PEACE plans and communicating them to GPs on discharge. An evaluation on PEACE plans in 2012 found that 88% of patients

with a plan were discharged for continuing healthcare. Most GPs who received the plan had found it useful in supporting the EoLC. However, 14 out of 23 discharge notes had not noted that a plan was in place, and not all GPs were aware of the plan or of its purpose. The trust had responded by improving the quality of PEACE plan completion and providing more information for GPs. A monitoring system was in place to make sure that discharge information noted that a PEACE plan was in place, to ensure that the plan of care was implemented after patients were discharged.

There were systems in place to ensure that, whenever possible, patients were discharged in a timely and appropriate way. The trust and its partners had a well-advanced "developing integrated pathways across health and social care" project, to promote people's health and wellbeing through prompt and effective interventions. During our inspection we spoke to several of the project partners and saw evidence of close working, good co-operation and communication.

A CQC review of NHS Hospital Discharges in 2012 identified no significant differences between the trust and other comparable trusts in relation to delayed discharges, delayed transfers of care or emergency readmissions. The trust's most recent monitoring of delayed discharges/transfers of care showed that most delayed discharges and transfers of care were due to shortages in non-acute NHS care. The trust and its partners had worked together to identify solutions to the delays, and a specialist team had been developed to focus on placing patients who needed high levels of nursing care. The provider may find it useful to note that while delayed discharges due to social care partners not completing assessments or putting suitable care packages in place in a timely way reduced throughout March to December 2012, these delays rose again significantly in January and February 2013.

Measures, for example daily ward rounds and meetings where discharges were discussed, and faster access for community-based care, had resulted in better than estimated dates of discharge for many planned admissions.

Most inpatients were aware of their estimated discharge dates or why their discharge was delayed. We saw evidence that patients and families were involved in discharge decisions and planning, including one-to-one meetings with hospital social workers to discuss their discharge needs and plans.

Ward staff were clear about what they needed to do in relation to making referrals for continuing health or social care, and ensuring that discharge documents and medications were in place. Each ward had either a named staff nurse or ward-based social worker who was in charge of ensuring safe and co-ordinated discharges.

Systems were in place to ensure that more complex and high-risk individuals were identified, so that coordinated responses to their care needs were developed with community partners. We saw evidence of appropriate referrals and communication between the ED and community nursing, for example referrals to tissue viability nurses where pressure sores were identified, or to dementia care specialists if patients were assessed as being at risk of dementia. The local authority's specialist LD team were involved at admission or as soon as a PWLD was identified. An A&E social worker worked alongside ED staff until 10pm, and could identify patients with specialist LD needs, alert social services and the trust's safeguarding lead, and ensure that PWLDs specific needs were identified and met.

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

Our previous inspection in 2011 highlighted that staff shortages were potentially impacting on the provision of good quality care. After our inspection the trust told us that it had implemented a staffing review to ensure that there were enough qualified, skilled and experienced staff to meet people's needs.

In the 12 months before this inspection, we had received some information of concern about potential low levels of staffing and examples of poor care in outpatients and inpatients, including elderly care, assistance with eating, timely assessment, pain relief and poor communication by staff. A recent staff survey also indicated that many staff were working extra hours.

At our inspection, we found that there were enough qualified, skilled and experienced staff to meet people's needs.

During our inspection, a patient we spoke with told us, "staff are busy but they do have time to talk to me and they listen to me. They do a great service." Other comments were, "the nurses are fantastic" and "the nurses work really hard, they have lots to do". Another inpatient told us, "staff have been marvellous".

On some wards we visited there were staff vacancies and we observed that staff sometimes found it difficult to meet all patient needs. For example, one ward we visited had two nurses and a healthcare assistant (HCA) providing care for 20 patients. We saw a patient continuously ringing their call bell for five minutes before someone went to them. All three staff were providing care with other patients, and told us two agency staff had not arrived for their shift.

During our visits to the fully-occupied medical admission unit, we did not observe any patients waiting a long time for care or support. Most patients spoke well of the staff caring for them. However, out of the 60 Band 6 and Band 5 nursing staff budgeted for the unit, 10 Band 6 posts were vacant at the time of our inspection. Interviews for all 10 posts were being held during our visit, which demonstrated that the trust was attempting to fill the vacancies with permanent staff. Staff we spoke with told us that these vacancies were mainly due to high staff turnover, as the unit was demanding and busy and nurses tended to move to other wards when the opportunity arose. This meant that many of the

permanent staff were working additional hours, and that bank and agency use on the unit was high.

The provider may find it useful to note that, on both days we visited, the hospital's discharge lounge was staffed by one discharge nurse, with no other staff available in the lounge. The nurse had to collect patients' take home medications from the pharmacy, which meant the lounge was not staffed at all times.

We also visited wards where there were no staff vacancies, and the same, regular staff cared for patients. Inpatient ward staff told us that they could request additional staff if people required higher levels of care or had more challenging needs, for example if end of life care was required or a patient had a learning disability.

In outpatient clinics and A&E we observed that there were sufficient staff and a calm atmosphere. The trust had increased nursing staff in the rapid assessment and treatment unit to ensure that appropriate care was provided.

The trust risk register report dated 5 February 2013 identified two key staffing risks at the hospital, primarily related to proposed changes in the way services were delivered at the trust. We saw evidence that the trust had recruitment and retention strategies in place and was providing ongoing support and clear communications for staff to try to mitigate the risk that it would fail to recruit and retain staff.

Senior staff told us there were no frozen nursing posts, but that it was sometimes not possible to recruit suitably qualified and experienced staff.

The trust Board received quarterly reports on issues relating to staffing. The report dated 5 February 2013 showed that although overall vacancy rates at the trust had remained stable from April to December 2012, the use of bank and agency staff had increased; the trust was analysing the reasons for this in order to reduce the use of agency staff.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately. People's complaints were fully investigated and resolved, where possible, to their satisfaction.

Reasons for our judgement

People were made aware of the complaints system, which was provided in a format that met their needs. There was a written complaint policy and process, which was available on request or on the trust's website and intranet. The complaints information was available in Braille and easy-read formats on request.

An integrated complaints and patient advice and liaison service (PALs) system was in place. There were leaflets about the complaint process and PALs displayed on most inpatient ward noticeboards. However, the provider may find it useful to note that the leaflets were not visible in outpatient departments we visited. There were also electronic feedback kiosks, and we saw evidence that patients used these to comment on the services provided.

Most people we spoke with during our inspection had no complaints, but some said they were not aware of how they could comment or make a complaint. Following our visit, the trust told us it had ordered banners for display in the hospital, to help raise the awareness of patients, members of public and staff on how to make a complaint.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately, and people were given support to make a comment or complaint where they needed assistance.

Staff confirmed that if someone wanted to raise an issue or make a complaint they would direct them to PALs. We saw evidence that the PALs team supported people to make complaints, if they needed assistance. PALs could also arrange for interpreters or direct people to independent advocacy, if this was required. Patients and family members we spoke with who had accessed the PALs service said they had found it responsive and helpful.

Statistically, the trust received about the same number of complaints compared to other similar trusts. We asked for and received a summary of complaints people had made. At our inspection, the trust provided us with information which showed that it had received a total of 355 written and verbal complaints about University Hospital Lewisham between 1 April 2012 and 31 December 2012.

There was an effective complaints system available. The comments and complaints people made were generally responded to appropriately, and their complaints were fully investigated and resolved, where possible, to their satisfaction. In 2011/12, 527 written complaints were made by (or on behalf of) patients about the trust, with 52.8% of written complaints upheld.

There were systems to monitor complaints, including an electronic complaints logging system which helped to identify any trends or themes. The most frequent complaint was communication and the trust had introduced changes to address this complaint. For example they ensured all directorates and member of the public was part of the complaints committee.

Each directorate had a named senior staff member 'complaints leads', responsible for overseeing the investigation and response for each individual complaint. Action plans were in place to ensure that actions after complaints investigations were completed, with ongoing monitoring by the steering group.
The minutes of the monthly complaints steering committee (November and December 2012 and January 2013) showed that complaints leads, representatives from patient forums and PALs and other senior managers, including the Chief Executive, had attended, and discussed new and open complaints, learning and Ombudsman complaint reviews.

The minutes also showed that the trust was failing to meet its target complaints response rate of 95% of complaints responded to within 25 days. In November 2012, 69% complaints were responded to within the agreed timescale. The trust introduced measures to improve the response rates, including that one directorate had introduced a dedicated complaints co-ordinator. By December 2012 monthly complaints performance had improved, with the response rate going up from 69% to 89% responses within the agreed time.

Senior staff told us that the learning from complaints and investigations was fed back to frontline staff. However, the provider may find it useful to note that some staff we spoke said they did not get formal feedback about complaints from their managers.

We saw evidence that the trust learned from the outcomes of investigations into complaints, and implemented changes to improve the quality of the services it provided. For example, information leaflets were being provided for surgery patients after it was found that a patient had not been given appropriate and sufficient information about their surgery and aftercare.

In some cases where local resolution did not satisfy complainants, they had requested an independent review by the Parliamentary Health Service Ombudsman (PHSO). Two complaints about the trust were accepted by the Parliamentary Health Service Ombudsman (PHSO) for investigation in 2010-11; neither was upheld. In 2011/12, the PHSO received 40 complaints about the trust; one was accepted for review and was fully upheld. At this inspection, we saw action plans which provided evidence that the trust took into account learning and implemented change even when issues were still under PHSO review.

A public interest disclosure 'whistleblowing' policy was available to staff. Staff we spoke with said that if they felt their concerns were not listened to by the trust they would use the whistleblowing system. We saw evidence that one whistleblowing concern had been raised in the past 12 months and was being investigated.

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 activity	Regulation
Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Patients were not always treated with courtesy and respect or encouraged to express their views about what was important to them in relation to their care. (Regulation 17 (2)(a) & (c)(ii))
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Some patients were not protected against the risks of receiving inappropriate or unsafe care. Accurate needs assessments were not always in place, which meant that care and treatment was not always planned and delivered so as to meet patients' individual needs. (Regulation 9 (1)(a) & (b)(i))

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

This section is primarily information for the provider

The provider's report should be sent to us by 20 April 2013.

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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