

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

London Ambulance Service NHS Trust

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29 August 2013
28 August 2013

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

Care and welfare of people who use services	✓	Met this standard
Cooperating with other providers	✓	Met this standard
Cleanliness and infection control	✓	Met this standard
Safety, availability and suitability of equipment	✓	Met this standard
Staffing	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard

Details about this location

Registered Provider	London Ambulance Service NHS Trust
Overview of the service	The London Ambulance Service NHS Trust responds to emergency 999 telephone calls, providing medical care to children and adults across London, 24 hours a day, 365 days a year. The service also provides pre-arranged patient transport and finding hospital beds and deals with major incidents.
Type of service	Ambulance service
Regulated activities	Diagnostic and screening 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 announced 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 28 August 2013, 29 August 2013 and 30 August 2013, observed how people were being cared for and talked with carers and / or family members. We talked with staff, reviewed information given to us by the provider and reviewed information sent to us by commissioners of services.

We spoke with the London Ambulance Services Patients Forum.

What people told us and what we found

People we spoke with told us they received good care from the service. One relative we spoke with told us "the crew were very nice and kind, and quick and efficient. They did everything professionally and had done everything you expected them to." Another relative told us the ambulance crew had asked all about their relative's medication and any allergies, and had taken blood pressure.

There were effective systems in place to reduce the risk and spread of infection. There was a hand hygiene infection control policy in place. People we spoke with told us they felt the ambulances they used were clean and hygienic.

People we spoke with told us they felt the trust worked well with other services. One person told us "paramedics work well with nurses." Another person told us paramedics "had a good relationship with the police."

At the last inspection of 14 and 15 November 2012 we found ambulances were not all suitably equipped to meet the care needs of people using the service. During this inspection we found the trust had addressed this issue by issuing staff with personal equipment.

At the last inspection of 14 and 15 November 2012 we found the trust had failed to ensure there were a sufficient number of suitably qualified, skilled staff employed to meet the demands placed on the service. At this inspection we found there were enough qualified, skilled and experienced staff to meet people's needs.

The trust had a system in place to monitor and assess the quality of its service.

We found the trust had systems in place to ensure people's safety while they received care and treatment by ambulance crews. We found ambulances were responsive to

emergencies. We were told paramedics were caring and we observed this in practice. Overall we found the organisation was well-led with arrangements in place to monitor the quality of its service and effectiveness in the provision of care.

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People we spoke with told us they received good care from the service. One relative we spoke with told us "the crew were very nice and kind, and quick and efficient. They did everything professionally and had done everything you expected them to." Another relative told us the ambulance crew had asked all about their relative's medication and any allergies, and had taken blood pressure.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. People were initially assessed before they received care and treatment from the service. We observed telephone calls being processed by control room staff. Staff were given on screen prompts to identify and categorise people's conditions when they called the emergency number 999. This information ensured paramedics knew the condition people were suffering from before they arrived. Where patients needed additional clinical support the trust had a clinical support desk staffed by a minimum of two clinicians who would advise paramedics on site if they required it. This showed the trust had a system in place to provide additional support to paramedics to provide patient care and treatment.

There was a system in operation called 'hear and treat', where after an assessment by staff a patient whose condition was assessed as not life threatening or serious could be treated over the phone or referred to NHS 111 for further advice. The system allowed ambulances to respond to other emergencies.

Staff from the trust's specialist hazardous area response team (HART) told us they triaged patients before handing them over to the regular ambulance service. We were told by one paramedic "staff triage patients into category 1, 2 or 3 however it's very much assess, triage and treat if essential or life threatening." This process was called "smart triage" which prioritised categories based on: ability to walk, injury, breathing, pulse rate and breathing within set parameters.

There was a system in place for paramedics to assess patients when they responded to a

call. Paramedics we spoke with told us they assessed and recorded a patient's condition on the Patient Record Form (PRF). One paramedic told us "we do a full observation." We reviewed a sample of PRFs. We found the assessment included a check for vital signs, blood pressure, breathing and an electrocardiogram (ECG). This meant patients received a thorough assessment in order to provide treatment for their conditions.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Paramedics we spoke with told us they risk assessed all incidents they responded to. This ensured they and the patients were safe and risks to safety and welfare were taken into account.

People's care and treatment reflected relevant research and guidance. Information about the latest techniques and clinical updates was available to staff on the trust's intranet, the Pulse. Paramedics we spoke with told us they checked the Pulse to ensure they were up to date with trust wide guidance and reviewed booklets and newsletters. We found clinical update material was readily available. We reviewed two clinical update newsletters. We saw there was information about transient loss of consciousness or "blackouts", managing asthma - inhaler techniques and major trauma care.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. Staff told us they respected people's diverse culture, ethnic origin and condition. The treatment and care they provided took account of this. For example paramedic crews had access to 'language line' a translation service for people and patients where English was not their first language. The trust also assessed the prevalence of illnesses in the population leading to the development of alternative pathways-for example in mental health.

There were arrangements in place to deal with foreseeable emergencies. The trust had a major incident plan in place. Staff demonstrated the procedures followed in the event of a major incident. We saw the two 'Major Incident' rooms based at two different locations which allowed the trust to remain responsive in the event of an emergency. For example the HART team were specifically set up to deal with major incidents and hazardous situations requiring specialist paramedic staff. This showed the trust took appropriate steps to ensure the service and staff were prepared for emergency situations.

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 we spoke with told us they felt the trust worked well with other services. One person told us "paramedics work well with nurses." Another person told us paramedics "had a good relationship with the police."

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. Paramedics told us they regularly worked with hospital staff, the police, and the fire brigade and. We reviewed a memorandum of understanding between the police and the trust setting out the scope of their relationship during emergency situations.

We saw there was an electronic board in the accident and emergency (A&E) units we visited which gave the estimated time of arrival of ambulances. This allowed A&E staff to prepare for incoming emergencies and coordinate emergency procedures with ambulance crew.

We observed staff in A&E during a patient handover. We observed paramedics completing their Patient Record Forms (PRF) and handing these over to nursing staff. We were told by paramedics different A&Es had different systems. We found paramedics were aware of the systems in place and they would work with staff in different A&Es to ensure a safe and coordinated handover of patients to the care of hospital nurses by sharing the necessary information about a patient's condition. There was evidence paramedics worked with local authorities and referred vulnerable patients who were in need of more support at home. This meant patient care and support was coordinated and met their needs.

There was documentary evidence the trust worked with local mental health teams to provide an alternative care pathway for patients with a mental health illness. Where paramedics had assessed a patient was suffering from a mental health illness they could refer them to a community service where they could receive the appropriate care and treatment. Minutes we reviewed between the trust and a foundation trust showed there was an agreement and procedures in place to ensure patients were referred for further treatment for their condition. This showed the trust supported people to obtain appropriate

health and social care support where needed.

We reviewed information of the trust's relationship with their commissioner. Minutes from the 'Strategic stakeholder management' update from June to July 2013 showed there was a plan in place for the trust to work with their lead commissioner and stakeholders to ensure the services provided met the needs of patients. There was documentary evidence showing the trust worked with clinical commissioning groups (CCGs), consortiums of General Practitioners (GPs), to provide ambulance services in their local areas. This showed the trust was working with other providers to ensure patients care needs were being met.

The trust produced an 'enews' electronic bulletin which was sent to a variety of partner organisations and commissioners including NHS trusts, London Assembly members, clinical commissioning groups and overview and scrutiny committees. We reviewed the August 2013 edition. We found there was information about the NHS 111 service in London, ambulance staff involvement in the Notting Hill Carnival and the number of assaults on staff.

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

People we spoke with told us they felt the ambulances they used were clean and hygienic.

There were effective systems in place to reduce the risk and spread of infection. There was a hand hygiene infection control policy in operation. Staff we spoke with and documentary evidence showed appropriate measures were taken to reduce the risk of cross contamination between patients. For example hand washing and using wipes to clean equipment and surfaces.

The trust had an infection, prevention and control committee which met regularly to discuss safer procedures in patient care and ways to minimise cross contamination and infection. We saw from the minutes they discussed infection control audits, steering wheel removable covers and sharps incidents. The trust collated infection control data from ambulance stations across London to ensure there were effective systems in place to prevent, detect and control the spread of infection. This information was used by the trust's lead to monitor infection control procedures in place which included the cleaning of equipment and hand hygiene. This showed the trust took account and addressed the risk of infection and cross contamination to patients.

We saw staff had the appropriate personal protection equipment (PPE) needed to undertake their jobs. Staff told us they were issued with their uniforms which they washed at the highest temperature to prevent cross contamination. We were told by staff disposable gloves, wipes and sprays were always available for cleaning and disinfecting equipment between patients. There was a policy in place to ensure staff were appropriately equipped with PPE. We saw uniform audits were conducted by team leaders to ensure staff compliance with this procedure. Staff told us the trust provided influenza vaccinations to protect staff against the risk of catching influenza and reduce the spread of the virus. This meant the trust were taking appropriate steps to prevent the risk of cross contamination to patients.

The HART team had decontamination equipment and procedures in place for responding to hazardous or chemical emergencies. They were able to demonstrate what steps they would take to ensure patients and paramedics were safe from contamination on site.

Ambulances and cars had deep clean badges which had the date they were last deep cleaned and when they were scheduled to be cleaned next. The provider may find it useful to note that two out of five dates on deep clean badges we looked at had expired. It was noted in the minutes of the vehicle preparation contract meeting dated 1 August 2013 that vehicles should be scheduled to be cleaned the week before they are due rather than when they are overdue. We reviewed contract monitoring information dated June 2013. Overall we found the deep cleaning of vehicles was being undertaken. This meant the trust was taking appropriate steps to ensure patients were treated in clean and hygienic vehicles.

Equipment and reusable medical devices, for example splints, were cleaned or placed in a cage and scheduled to be cleaned for reuse. We reviewed information stating this was part of trust practice to prevent infection and cross contamination. This meant the trust had taken steps to prevent the risk of infection to patients in their care.

We saw there were two bins on an ambulance, one for general waste and another for clinical waste. These were identifiable by the black and orange bags in them. There was a sharps bin for needles. At the ambulance stations we visited there were large bins available for clinical and general waste and sharps. Staff we spoke with told us they disposed of all waste in the correct bins to prevent cross contamination. There was a separate bin for blankets which were kept sealed on ambulances.

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

At our last inspection of 14 and 15 November 2012 we found ambulances were not always suitably equipped to meet the care needs of people using the service.

The trust had an action plan in place to monitor the procurement of new personal equipment and ensure they were distributed to paramedics. There was documentary evidence the trust had undertaken a review of their non-compliance with this standard. We saw the trust had assessed the use and safety of personal equipment used by paramedics. Equipment included blood glucose monitoring kit (BM kit), a device used to monitor the glucose level in people's blood. We found the trust had taken appropriate steps to ensure they had sufficient supplies of equipment to meet the needs of patients in a safe and suitable way.

We saw the trust followed national guidelines for safety and patient care in the use of equipment. For example the National Institute for Health and Care Excellence (NICE) guidance on the treatment of feverish illness in children using tympanic thermometers, a device used to measure a patient's temperature. This showed the trust had taken appropriate steps to treat patients with the recommended equipment.

Some staff we spoke with said they had a BM kit. We reviewed minutes from one meeting held in February 2013 which showed the trust had a contractor in place and had trialled the use of BM kits before their roll out to all staff. We saw evidence the senior trust managers met regularly to discuss the availability of equipment. This ensured matters regarding equipment supply could be addressed appropriately for patient safety.

There was information available to staff about the safe and correct way to use equipment. At one ambulance station we visited guidance was placed on notice boards for staff attention. One supervisor we spoke with told us staff stay up to date with new techniques and using equipment. This meant equipment would be used correctly during patient care and treatment.

There was documentary evidence paramedics completed a checklist before their shift began to ensure they had the adequate equipment. We checked two red paramedic bags; these bags were carried by paramedics on shift and contained the necessary supplies of equipment needed to treat patients. We found they contained the appropriate equipment paramedics needed for their shift. There was a procedure in place to report damaged

equipment at stations. This ensured damaged equipment was highlighted and addressed for patient safety.

Ambulance vans and cars used by the trust were prepared overnight for their daily shifts. The system was called 'make ready' which was provided by a contractor to the trust. We reviewed documentary evidence which showed vehicles had been checked and signed off for use before ambulance crews and paramedics started their shift. This ensured paramedics had the correct equipment to meet patients' needs.

We checked the store room at one ambulance station. We saw there was sufficient quantities of equipment including, dressings and defibrillators for adults and children. There was also airway equipment which included laryngoscope blades and handles; this equipment was used to examine and diagnose problems inside the throat. All equipment was within their expiry dates. For example bags of fluid. There was a system to monitor which items were expired and to be disposed of to ensure patients were not at risk from out of date stock.

Portable equipment on ambulances, for example stretches and splints were in good working condition. One paramedic we spoke with was able to show us how these were to be used and how they were secured in the ambulance to ensure the patient was safe.

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

At our last inspection of 14 and 15 November 2012 we found the provider had failed to ensure that there were a sufficient number of suitably qualified, skilled and employed to meet the demands placed on the service.

There was evidence the trust was increasing the number of paramedics. The trust was undergoing a modernisation programme to improve the care provided to patients. The trust had a plan in place to proactively manage sickness to ensure staff could go to occupational health. This showed the trust were supporting staff to be fit and ready to work so that they could provide the essential care needed to meet operational demands and patients' needs.

The trust was reviewing its career structure. There was evidence the trust was supporting staff to progress in their clinical careers to meet the needs of patients. For example a plan was in place to create posts for 'advanced paramedics', paramedics trained in enhanced clinical techniques for patient care. These changes meant the trust could retain skilled and experienced staff and provide a better service to patients.

There was documentary evidence showing the trust had a recruitment plan in place to recruit more front line staff. The trust was reviewing the executive team roles to ensure they were set up to implement the changes underway in the service. There was evidence the trust had obtained funding to recruit 240 new paramedics to meet the demands of the service and ensure there were enough suitably qualified, skilled and experienced paramedics to meet people' needs. We reviewed data for July 2013 showing there were 1644 paramedics in post compared to an estimated 1765 which were still being recruited to in the trust's new structure. This showed the trust was taking appropriate steps to meet people's needs by recruiting sufficient numbers of paramedics.

We reviewed documentary information provided by the resources department which showed how paramedics were deployed on a daily basis to ensure the service was appropriately staffed. There were rotas in place that were continuously reviewed to ensure the operational needs of the service were met by having enough staff on shift to attend to patients. The trust used a relief rota of paramedics who could work across different stations to meet the service's needs and ensure there were enough staff on shift. We saw paramedics were sent to stations where there may be a shortage of staff to ensure there

was adequate cover, due to sickness or leave. This ensured the service maintained adequate staffing levels to provide a safe service to patients around London.

We saw staff using the electronic system called 'geotracker' to see the location and number of ambulances and cars on duty across London. Using the information from 'geotracker' paramedics could be deployed to areas of London with the least coverage of ambulances to ensure enough staff were able to meet patients' calls. The trust also used historical data to map where the highest demand of calls would come from. For example central London. This meant the trust could have enough crews of paramedics in areas where calls were most likely to be made. This showed paramedics were able to respond quickly to patient care and treatment.

Ambulance crews told us about the training that had been introduced to equip support staff to work with paramedics. Training took place over six weeks and staff then went out with a trained crew. There was documentary evidence showing 141 apprentice paramedics were currently in post, this figure exceeded the Trust's estimated number. This meant the trust was meeting their recruitment targets for apprentice paramedics. This ensured there were enough skilled staff available for patient care.

There was documentary evidence the trust was meeting its target for 'category A' response times which required a response within 19 minutes. 'Category A' are life-threatening conditions where speed of response may be critical in saving life or improving the outcome for the patient. This showed the trust were able to provide an appropriate and effective service for patients.

Assessing and monitoring the quality of service provision

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. People we spoke with told us they could feedback about the care they received through the London Ambulance Service's 'Patients' Forum'. We reviewed the 'Patients' Forum' annual report. We found the patients' forum were able to comment on the trust's performance and services in a constructive way which allowed the trust to improve its service. For example they were able to provide feedback on the trust's dementia care, care of vulnerable people and alternative care pathways.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. The trust had a system in place to ensure decisions regarding care and treatment were taken at an appropriate level. Paramedics we spoke with told us they were trained to respond to most situations however where further knowledge was required they had a clinical support desk that provided advice. There was a system in place to escalate strategic risks when they occurred and these would be assigned to the relevant committees to resolve.

There was a system in place for the trust to assess and monitor the quality of its service. Staff told us they completed a number of different audits to assess their work as part of their clinical performance indicators (CPI), which monitored the general documentation and the standard of care delivered by ambulance crews. We reviewed the Clinical Audit Annual Report 2012-13. We found the Trust had over a 95% completion rate of CPIs.

The provider took account of complaints and comments to improve the service. There was a system in place to manage complaints. The trust aimed to respond to complaints within 25 working days, more complex cases would be responded to in 35 working days. We reviewed a sample of complaints. We saw the trust used complaints as case studies to learn from. The trust produced a management report showing the trends and themes in the level of complaints. For example the main theme in the July 2013 report for complaints was staff attitude and behaviour. We saw there was a plan in place by the trust to give feedback to members of staff about their attitude and behaviour to ensure patients are treated appropriately.

We reviewed the 'Quarterly Patient Voice & Service Experience Report' from April - June 2013 which showed during the first quarter of the year the trust received 241 complaints. This was consistent with the average for 2012/13 which was 243. It was reported there was a slight increase from the last quarter in the number of cases where the complaint was about the delay in ambulance response at 105. It was stated seasonal impact may have contributed to this increase. We reviewed a sample of complaints received by the trust and a report about patient experience. Where complaints were made there were actions taken to resolve the matter and improve the service.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. We reviewed the 'Learning from Experiences' report which provided a number of case studies based upon patient feedback from complaints and investigations. Information was used to inform staff about safer working practices through the trust's intranet and clinical updates.

We found the number of reported clinical incidents were monitored. It was reported that they were lower in frequency than the previous year by 12%. The Trust also monitored the escalation of serious incidents. There was documentary evidence showing the Trust had reviewed 26 serious incidents during 2013-14; of this five were declared with NHS England. Overall we found the number of serious incidents was 10% lower than the previous year.

About CQC inspections

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

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

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

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

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

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

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

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

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

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

How we define our judgements

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

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

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

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

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

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

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

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

Meeting Nutritional Needs - Outcome 5 (Regulation 14)

Cooperating with other providers - Outcome 6 (Regulation 24)

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

Cleanliness and infection control - Outcome 8 (Regulation 12)

Management of medicines - Outcome 9 (Regulation 13)

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

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

Requirements relating to workers - Outcome 12 (Regulation 21)

Staffing - Outcome 13 (Regulation 22)

Supporting Staff - Outcome 14 (Regulation 23)

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

Complaints - Outcome 17 (Regulation 19)

Records - Outcome 21 (Regulation 20)

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

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