Inspection Report

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

Widbrook Medical Practice

Widbrook Surgery, 72 Wingfield Road, Trowbridge , BA14 9EN

Tel: 01225757120

Date of Inspection: 29 August 2013

Date of Publication: October 2013

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

Respecting and involving people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Safety and suitability of premises	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Widbrook Medical Practice
Registered Manager	Dr. Carolyn Foggett
Overview of the service	Widbrook Medical Practice is a GP practice located in the Wiltshire town of Trowbridge. The practice supports just under 6,000 patients. The surgery offers a range of services including minor surgery, health screening, childhood and pneumococcal immunisations, some contraceptive services, asthma and diabetes advice, and extended hours access.
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures 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 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 29 August 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information sent to us by other regulators or the Department of Health.

What people told us and what we found

Most of the people we met at Widbrook Medical Practice were happy with their medical care. Some people were critical of the appointments system and the attitude of a small number of staff. The practice had taken steps to improve the appointments system and access to a GP and a new doctor was starting at the practice shortly.

We found the practice respected the dignity and independence of people they looked after. People were able to make decisions about their treatment. They were treated with consideration and respect. People were encouraged to express their views and given opportunities to be involved in how the practice was run.

Staff at the practice had been trained in recognising and reporting signs of abuse in vulnerable people. Staff who worked for the practice were employed safely and checks were made about them. The medical staff made sure people were referred safely into the care of other health and social care professionals.

What the practice was not doing well related to cleanliness and the prevention and control of infections, and the confidentiality and security of people's records. There were some concerns also around preventative maintenance of the premises.

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 25 October 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 ✓ Met this standard

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 meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

The clinical staff at the practice treated people with consideration and respect. People we met and talked with said they were listened to and given time and staff were patient with them. We were told the doctors and nurses gave people time to explain why they had come, and describe things in their own words. They said the clinical staff asked questions and, as one person told us, "don't rush you and they don't miss things either. My doctor has picked things up that I hadn't even thought about." People confirmed they were encouraged to ask questions and go over anything they did not fully understand.

There were some concerns from people, although not all, about the appointments system. A GP Patient Survey was carried out in 2012/13 at the practice. This survey assessed people's experiences of the access and quality of care they received from their GP. The survey reported a high number of those people who completed it found it either "not very easy" or "not at all easy" to get through to someone to make an appointment. Two people at the surgery told us they needed to arrive at the practice about half an hour before it opened just to be sure of getting an appointment that or the next day. Otherwise, two patients we met confirmed they could always get an appointment when it was convenient for them, and often at short notice. We talked with one of the partner GPs about this concern. The practice was aware of this and had extended the provision of locum doctor appointments. The practice had also engaged a new GP who would start in October 2013. This would enable the surgery to offer extra appointments to people.

There were some concerns from people we met and also from the GP Patient Survey 2012/13 about the attitude or helpfulness of the reception staff. Four of the six people we met on our visit said they had experienced what they all described as either "rudeness" or "sharpness" from "one or two" of the reception staff in the past. They said the staff on duty when we visited were polite and professional. We observed the staff greeting patients while we were at the practice and found them to be polite and discrete. People were greeted with a smile and staff were friendly when speaking with them on the telephone. A patient we met at the surgery said they had no hesitation in recommending the practice

and had frequently done so with friends and relatives. We brought the concerns of people we had met to the practice manager who was already aware of some concerns and we were told positive action had already been taken. There had been staff changes and some training delivered.

We talked with the GPs and practice nurses about maintaining people's independence and were told people were able to make their own mind up about any proposed treatment. People we asked said the doctors or nurses told them advantages and disadvantages of any choices they were presented with. People did not feel pressurised to follow any course of action other than the one they felt most comfortable with. One of the GPs we spoke with said the doctors or nurses understood if a person wanted to take a risk which did not include the course of action recommended to them. People we spoke with confirmed they were free to make their own decisions.

The practice knew how to respond to people who could not make valid decisions for themselves. The GPs and the practice nurses knew about the provisions of the Mental Capacity Act 2005 and acting in the best interests of people. If a patient came for a consultation or treatment and did not have the mental capacity at that time to make a valid informed decision, the doctor or nurse involved others who spoke for the person. In that way, any decision taken to move forward with treatment, or to avoid treatment, would be made by people who supported the person and in the best interests of the person concerned. The practice had involved independent mental capacity advocates before when there were no close relatives or friends available to speak for the person.

The practice worked with people to seek the views and ideas of the local community. We met with a member of the Patient Reference Group (PRG) and the GP who led this group. The PRG is a direct enhanced service. This is a service put in place by the practice following direction from the national NHS Commissioning Board. It comprises a group of patients who meet from time to time to provide the practice with feedback and on the range and quality of services provided. The group at Widbrook Medical Practice had been running for around eight years. We were told the group met once or twice a year and discussed a range of topics and looked at issues affecting the practice and the community. The group were also contacted by email or phone at times. The group listened to and were said to understand the pressures on the practice. As a result of the consultation with the group, the practice had extended appointment times, so there were regular longer appointments available to people who needed them. Also, the practice now offered more appointments which could be booked online, and had introduced online ordering for prescriptions. Both the GP and the member of the group we spoke with said it was a challenge for the practice getting younger members of the community involved with the group. It was also difficult to persuade an independent person to chair the group. The practice was looking at ways to develop this further.

People were able to get information about the practice and health and wellbeing matters in different formats. The practice website provided information and allowed people to give feedback, order repeat medicines online, and see what services were offered. There was a wide range of leaflets in the practice and a number of different notice boards with patient information. The practice website told people the opening times and explained what to do if the practice was closed.

People with needs relating to equality and diversity were considered. The practice had access to translator services, and would accommodate chaperones, family or friends who could provide translation. One of the GPs told us the practice had patients who were profoundly deaf or had impaired hearing. The practice arranged longer appointments for

people with hearing impairment if they were bringing a person to translate with them. This meant other health and wellbeing matters could be included in the consultation if this suited the patient. The surgery premises were accessible for people who used wheelchairs or needed support to walk. One of the GPs were spoke with gave us examples of different cultural and religious values the practice would take account of. We were told people were not treated all the same, "but according to their needs."

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

We found the practice was knowledgeable and experienced at referring patients into secondary care such as hospital consultants or specialist services. People we met said when they had been referred the transfer of care was made effectively. People said they were referred to the right person or department. People told us the hospital, consultant, nurse or clinic had accurate information passed on by the practice. We were told information passed to a third party included the patient's medical history, medication (both current and relevant history), and the GP's and/or patient's description of the reason for the referral.

The surgery used computerised template referral letters for patients to ease referrals and ensure all the information was automatically provided. The templates had been produced with standard information for certain conditions. The practice's computer system was designed to download the required information from a patient's records. This included standard information like the person's name, address and contact details (including those to use in an emergency). It went on to include the person's medication, records of care, and relevant medical history. The GP's notes were then added directly.

Staff told us about the system for organising referrals to other health and social care providers. The GPs told us the practice used the NHS Choose and Book system and the patient referral network, operated by the local Clinical Commissioning Group. The practice nurses said they referred people to clinics and screening services. This system was usually managed through email requests and people being contacted directly. We met a patient who was using the diabetic retinopathy service hosted at the GP practice. They confirmed they were given regular appointments and all the information about them had been shared between the practice and screening service.

The practice made sure care was coordinated when the practice was closed. The practice manager told us the administration staff ensured the out-of-hours service was aware of any patients in palliative or end-of-life care.

The GPs worked with people living in the community in the care of other providers. GPs carried out regular 'ward rounds' with a local nursing home. The GP we met who was

primarily responsible for this work said they worked closely with the staff at the nursing home to ensure care was effectively coordinated. This included getting involved with the home and any other agencies providing care. For example, some people had been referred to mental health services or district nurses when needed. The GP also audited and reviewed the management of medicines for the patients living at the home to ensure this was safely managed. The GPs also worked with services supporting people with learning disabilities living in shared homes in the local area. People had annual health checks and the chance to get to know their GP. The practice also worked closely with their named district nurse and the health visitor, who was based at the surgery.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Staff working at the surgery were able to demonstrate they understood their roles and responsibilities relating to safeguarding children and vulnerable adults. The practice had a GP who led on safeguarding children and another GP who led on vulnerable adults. This meant these GPs were able to focus on these different groups of people, where there were different arrangements for reporting concerns.

The GP who led on vulnerable adults and one of the other GP partners were able to tell us clearly the signs of abuse they might encounter in any vulnerable person in their care. This included physical injuries, but also the person acting out-of-character, being withdrawn or agitated. They told us some of the types of abuse. This included neglect, and physical and sexual abuse, which could be both mental and physical.

All staff at the practice had received safeguarding training in 2013 for both children and vulnerable adults. This had been delivered at a practice 'away day' by the lead GPs. The practice nurses were able to confirm the training had been provided and could give us examples of what they and other staff had learned.

The staff knew how and when to report concerns. The GPs told us they would hold discussions among staff at the practice when any concerns arose. They would then develop a plan of action which would include informing, as required, the local authority vulnerable adult or child safeguarding team.

The provider may find it useful to note one of the GPs we spoke with was not familiar with the Deprivation of Liberty Safeguards (DOLS). This is a licence that may be granted by the local authority, to temporarily deprive a person of their liberty for their own health or safety or that or others. This may have meant the GP, on an external visit or at the surgery, might have been confronted with a patient who was subject to a DOLS licence. They may then not have been aware of the circumstances of this situation and how it might affect their care of this person.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

In some parts of the surgery, people were not entering a clean, hygienic environment.

This is a breach of Regulation 12(1)(a)(b)(c) and (2)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Reasons for our judgement

We found some parts of the practice fixtures and fittings were not cleaned or maintained satisfactorily to prevent or control the spread of infections. The male toilet and female toilet provided for patients at the entrance to the surgery were in a poor state of repair. The handle of the toilet brush in the female toilet was dirty and the practice manager could not say how long it had been there. The toilet brush in the male toilet was standing on the side of the toilet without a holder. The string of the light pulls in both toilets was dirty and turned from white to dark brown. The wall coverings were old and marked. The flooring was not effectively sealed. There was, however, soap, hot water and hand towels available for patients. But there was no foot-operated waste bin so patients could avoid touching the waste bin with clean hands.

There were other areas of concern. The practice carpets were stained in places and showing signs of age and being difficult to keep clean. Some of the walls had small amounts of plaster missing due to general wear and tear and a lack of maintenance. This made these areas difficult to keep clean. We found one of the GPs consultation rooms had significant levels of dust on many surfaces. The surfaces were cluttered with books, toys, and paperwork. This made them hard to clean. The shelves, books and other objects were covered with dust which we judged had not been addressed for a long time. This consulting room also had a number of soft toys on the shelf above the patient couch. We showed the practice manager how they were covered in a layer of dust and had not been washed either recently or at all. The other GP consultations rooms were free of dust and the shelves had limited items placed upon them.

Personal protection and other equipment was available for use. Patient examination couches in consultation rooms has disposable curtains which had recently been hung. The practice manager was unsure about how long they should remain in place before being replaced. GPs and nurses had gloves, and nurses had uniforms. There were a number of rooms for staff to use.

Equipment used for cleaning was generally satisfactory. The cleaner kept colour-coded mops in a loft space adjacent to the upstairs staff toilet. One of the mops was wet and placed in the bucket. This meant the mop had not dried effectively in fresh air to prevent the growth of bacteria. Another dry mop in a bucket was dirty and appeared old.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were mostly protected against the risks of unsafe or unsuitable premises, although some maintenance and safety problems had not been adequately addressed.

Reasons for our judgement

The surgery had good access at the front door. People entered through double doors which were wide enough to accommodate people using wheelchairs and could be electronically opened. There were patient toilets immediately adjacent to the entrance doors. A toilet for people who had disabilities was located through the practice waiting room and near the nurses' treatment rooms. There was relatively easy access to this toilet.

We found the waiting area to be adequate in design and layout and allowed for confidentiality to be reasonably maintained at the reception desk. However, some people we talked with at the practice thought the waiting area was "soul destroying for a doctor's surgery", "not somewhere you would be proud of", and "awful."

We found the surgery had taken precautions against fire. This included recently tested fire extinguishers and fire exits. The fire exits were marked with the recognisable green signs. The provider may find it useful to note one of the fire exits at the rear of the premises had a set of steps to reach ground level. The bushes alongside the walkway were also becoming overgrown. This might have prevented someone with vision impairment, or who used a wheelchair to be unable to safely exit the building if required. One of the other fire doors was difficult to open.

The provider may find it useful to note some of the problems with maintenance and safety of the premises had not been addressed. A patient we met and a number of staff told us there was a problem at the front of the surgery when there had been heavy rain. The drainage at the bottom of the slope leading to the surgery was said to be inadequate. We were told this had caused some large puddles and one person had slipped in the winter and sustained a minor injury.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

The recruitment of staff was carried out to ensure staff were able to perform their roles effectively. The practice manager described the recruitment process. Advertisements for administrative staff or practice nurses were placed locally. This included the practice website and local media. Applicants were assessed and once short-listed were invited for interview. Interviews were conducted with two members of staff who were either to manage the person or already carried out a similar role. Interview questions were decided in advance and notes of the candidates' responses were kept. This would enable the practice to demonstrate the process had been fair and why one person had been selected over another.

Candidates who were successful at interview were required to provide evidence of their identity, relevant qualifications, and references. Identity included a photographic document such as a passport or driving licence with a photograph. The person's address was checked generally with copies of utility bills. Certificates of relevant qualifications were provided and placed on file. References were then obtained from the candidate's most recent employer and someone who knew them personally.

Staff were required to provide evidence of their registration with any professional body or regulator. The GPs were required to provide evidence of their medical insurance and registration with the General Medical Council. The nurses were required to provide evidence of their registration with the Nursing and Midwifery Council and their ongoing membership status.

Checks were made of staff with external agencies. This included all staff having enhanced Disclosure and Barring Service checks (DBS - formerly CRB). The provider may find it useful to note the practice did not have a policy deciding which staff, if not all, would be required to have DBS checks. The practice had not determined whether, for example, reception staff should be DBS checked. This may have meant people or their records were being supervised by staff who had not been adequately checked.

We found from a recent employee file and information held on the computer system, the practice had secured all the information the practice manager had described. This included a job description and contract of employment.

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. The access to the system and organisations overseeing the practice were not, however, as easy as they should have been.

Reasons for our judgement

The practice had a complaints procedure to tell people what they could expect from the surgery if they made a complaint. People we spoke with said they were aware of the process. One person told us: "I have never had to complain in over 40 years with this practice, but if I did need to raise an issue I have every confidence the practice manager would deal with it promptly and efficiently." Another person said: "any issues I have raised were always sorted out by the staff, and so I never felt the need to complain".

The provider kept a log of complaints and concerns which people had raised. The log captured the details of the complaint or issue; date and venue at which the matter was discussed; actions that had been taken; and comments on the outcome. An example of a complaint we saw demonstrated complaints were appropriately managed. Another issue we read about concerned the lack of appointments for routine medical examinations which were required for insurance purposes. We saw the practice had discussed the matter at a practice meeting. Changes were made and allocated appointments made available each week to deal with these cases. This had been monitored by the practice manager who was able to report the new system had resolved the matter.

The provider may find it useful to note the complaint process was not as accessible to people as it should have been. People were required to request a complaint form from reception and it had not been made available for them to freely take. This may have meant people could not make a complaint anonymously if they wanted to. The leaflet given to people did not have the correct details of other bodies to contact if they were unhappy with the local resolution of any complaint. This may have meant people were not able to take the matter further with bodies that commissioned or regulated services if they wished to.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People's records were not adequately protected to ensure their confidentiality and security.

This is a breach of Regulation 20(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Reasons for our judgement

During our visit we found the practice was not keeping people's records as securely as they should have been. Information about people was also not kept as confidential as it should have been. In the large administration room at the rear of the reception, confidential patient information was placed on surfaces where it might be viewed by unauthorised people coming into that area. Although this area was not open to the public, it was accessible and unlocked when the practice was open. It was also accessible to contracted cleaning staff.

Confidential information was visible to unauthorised people. This was due to information recorded on wipeable boards on the walls of the administration office. These boards had information showing when a patient had died, the names of people who would not be permitted to register at the practice, and other general information about patients. This information was visible to the general public through a glass door leading out into the car park at the side of the premises.

Other records were not held securely. There were large stacks of confidential patient records held in an attic room at the surgery. This was information that had been scanned into patient notes and was therefore due for confidential disposal. Of the small sample of paper we looked at we could see the information was of a highly confidential nature. This attic room was accessible from the adjacent loft where the cleaning equipment was stored, which was not locked. There were also shelves of old patient records in their beige envelopes being stored there. The practice manager agreed that specific information would not be easily found if it was needed.

The information was not secured from unauthorised access. Although this area was also not a public area, it would be easy to get access to this attic space without being challenged by staff.

Patient information was not being securely destroyed when it should have been. Neither the practice manager nor one of the partner GPs were aware of the legal requirements on how long patient information should be retained. They were also unsure whether information that had been scanned to a computerised record could be destroyed as confidential waste. They did not have a contractor to carry out this work or a shredder at the surgery which would be able to handle this amount of paperwork.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Some parts of the surgery were not cleaned or maintained well enough to provide a hygienic clean environment. This included the patient toilets and one of the GPs consultation rooms.
Regulated activities	Regulation
Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: There was confidential information stored in the attic of the surgery which was not locked. Any relevant information in these records would not be able to found as they were not filed. There was confidential information about people written on wipeable boards which was visible from the outside of the premises. There was confidential information left in an area which was accessible to unauthorised personnel.

This section is primarily information for the provider

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

The provider's report should be sent to us by 25 October 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 other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

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

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

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

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

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

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

How we define our judgements

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

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

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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