Inspection Report

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

Slade House

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Tel: 01865747455

Date of Inspections: 23 September 2013
17 September 2013
16 September 2013

Date of Publication: November 2013

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
Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Enforcement action taken
Safeguarding people who use services from abuse	✖ Action needed
Cleanliness and infection control	✖ Enforcement action taken
Management of medicines	✖ Action needed
Safety and suitability of premises	✖ Enforcement action taken
Safety, availability and suitability of equipment	✖ Enforcement action taken
Assessing and monitoring the quality of service provision	✖ Enforcement action taken
Records	✖ Enforcement action taken

Details about this location

Registered Provider	Southern Health NHS Foundation Trust
Overview of the service	Slade House comprises of two separate units on the Slade site in Headington, Oxford. John Sharich House is an eight bedded assessment and treatment unit for adults over the age of 18 years who require treatment for a period longer than six months. The Short Term Treatment and Assessment Team Unit (STATT) is a seven bedded facility for people requiring treatment for less than six months. Patients can be admitted both formally and informally.
Type of services	Community healthcare service Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 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 16 September 2013, 17 September 2013 and 23 September 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 given to us by the provider. We were accompanied by a pharmacist and were accompanied by a specialist advisor.

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

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

On arrival on the Short Term Assessment and Treatment Team Unit, we were taken on a tour of the service. It was apparent there were several areas of concern that required urgent action. We asked senior managers to attend, so that we could discuss our immediate concerns with them.

We were unable to speak with people on John Sharich House as they did not wish to do so. On the STATT unit, we spoke with three of five people there. We asked them about the assessment, treatment, care and support they received. One person told us they felt unsafe and uncared for, another told us they "hated it" there. The third person said "It is okay."

We spent some time observing the interactions between people and staff. There was a marked difference between the two units. JSH staff interacted positively and therapeutically on many occasions. We did not see this on STATT. Whilst we were there, up to four staff mainly worked on administrative tasks within their office, with one member of staff out on the unit. Over the course of two days, we saw few social or therapeutic nursing interactions with people who stayed there. There appeared to be an impoverished environment with little therapeutic intervention or meaningful activities to do.

After our visit, we spoke with relatives by telephone, and heard mixed responses about their experience of having a family member stay on either STATT or JSH.

We spoke to staff about their understanding and practice of safeguarding vulnerable adults. Staff could describe many types of abuse but did not mention neglect or institutional abuse.

We toured the building and noted that the environment was not suitably clean for the people who stayed there. We asked the Trust to quickly address this.

The pharmacist found that medicines were not always safely administered. Expiry date checking was not carried out adequately, the emergency oxygen was significantly out of date, and appropriate arrangements were not in place for the storage of medicines. We inspected the emergency equipment, and found some of it was not working. We asked the Trust to immediately address these issues of concern.

We saw that the building was not suitably safe for the people who stayed there, or for people who may visit.

We looked at the quality monitoring checks that took place. These are to enable senior managers to be assured the units are functioning well and safely, and taking people's preferences into account. We found quality monitoring to be inadequate. Whilst much audit work was undertaken, there was little that impacted positively and directly on the care of the people that were being looked after on the STATT unit. There was substantial evidence of ineffective monitoring regarding the health, safety and welfare of people who used the service, and people who worked or visited the STATT unit.

We examined records of people, of staff and of equipment. We found that these were sometimes inaccurate. We asked the Trust to take immediate action on this practice.

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 17 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Slade House to protect the health, safety and welfare of people using this service.

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.

People's privacy, dignity and independence were not always respected. People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.

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

People who used the service did not always understand the care and treatment choices available to them. We spoke with people who used the service, and a relative of one person on STATT unit about this. They told us that they did not know what activities their family member could attend. The relative also told us they had been given no clear idea of progress, or what the next treatment steps would be, and the relative was worried about this. This meant that little meaningful involvement had taken place with the family, or with the individual.

A person's diversity, values and human rights were not always respected. There was one person on JSH who belonged to an ethnic minority. They were unable to access any specialist food via the in-house food preparation. Staff told us "It is easier to buy ready made meals." This meant that this individual's access to a culturally-appropriate diet was restricted to main meal times. This was not appropriate to the religious and cultural requirements of this person.

We noted that the two downstairs bathrooms on STATT had missing shower curtains. The nurse in charge told us that the torn shower curtain had been removed at the end of August and new ones ordered. A different member of staff told us they had been removed for cleaning, but they were not in the unit laundry. Meanwhile, people who stayed there had been showering with no curtain in place. The bathroom was overlooked by a window with frosted glass but no curtain. This meant that the staff had neglected to protect the privacy, modesty and dignity of people using the service.

We were aware there was a meeting taking place in the staff office between medical staff, nursing staff and someone who had decided to go home. The office was frequently

accessed by other people coming in and out, and there were constant interruptions by phone. This meant that the person who was leaving had little privacy in which to discuss their concerns.

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However, during treatment the provider did not always act in accordance with people's wishes and consent. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

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

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. On 16 September we were accompanied on our inspection by a Mental Health Act Commissioner. They reviewed the processes around obtaining consent for people receiving care and treatment. From a review of the record on the electronic patient notes it was possible to locate records of discussions and the recording of capacity and consent for all of the patients. These included assessments for; consent to informal admission, consent for medication and consent for physical examination. Where people did not have the capacity to consent, there were identified interventions. These included formal admission under sections of the Mental Health Act (MHA), and compulsory treatment under the MHA.These assessments included the individual's understanding and involvement in this process.

One patient undergoing treatment on the service articulated they did not feel safe on the ward and that they wanted to go home. On the second day of the inspection, they packed their bags and clearly stated their intention to leave the service. This patient was eventually able to leave the service. However, there was considerable delay in responding to this request and a doctor was called to attend to make the final decision. The individual was not able to leave at any time, despite their informal status. This meant that the person was not able to exercise their free will, and had their use of consent removed from them. The Mental Health Act Operations Manager accompanying CQC on this inspection had to remind the nursing staff of their responsibilities in this area.

A relative told us their son, who was a voluntary patient, had frequently requested to leave. He had been told he may not do so unless he attended specific workshops at STATT which he did not wish to do. This meant that he was illegally deprived of his liberty and had his use of consent withdrawn.

Care and welfare of people who use services

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not consistently planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People did not always experience assessment, care, treatment and support that met their needs and protected their rights. We spoke with three people who stayed on STATT. One person said "I think it is okay here, but I wish my Dad came more often. I am going shopping to buy a jacket, but I have been waiting a long time." Another person said "I am going home. I don't feel safe here. No one asks me what I want, or if they do, they ignore what I tell them. I have told them I want to go home. I can't eat, can't sleep, my medications have been given to me wrong, and that man (another person staying there) terrifies me. He is marching up and down outside my room and he frightens me. He is not allowed there, but no-one has stopped him. I will be safer at home. There is nothing, nothing for me here. I'm going home to tell my GP." The third person spoke to us briefly. He was agitated. He told us he hated being on the unit. He said he wanted to be at home with his family, where he could "do things." He said he had not seen his family "for days." He said he wanted to go outside and wasn't allowed to. He said no-one told him why this was. These comments showed that there was little evidence that staff were assisting people to understand why they were there.

None of the people we spoke with had a copy of their care plan. We asked why this was. Nursing staff told us the electronic care records did not neatly print into a useable document, and was not available in an easy read format. This meant that people were not aware of their care plan as a working document, and it could not then reflect the day to realities of their lives.

Over a two day period, we noted that nursing staff stayed in the staff room for most of the time. They were accessing documents on the computer, and speaking to people on the phone. Over the course of the inspection, we saw very few social or therapeutic nursing interactions with people who stayed there. We did observe one support worker speaking in a kind and respectful manner to someone as they left to support a person with their shopping.

On the days of our inspection, the unit appeared to be process-led rather than patient focused. There was little interaction with people who used the service. We were told by a nurse that they were unable to build therapeutic relationships they knew should be in place because of other non care tasks they had been asked to do. This was corroborated by the length of time the nursing staff spent in their office undertaking non clinical tasks. For example, they had been asked to undertake some audit procedures, but had not been given extra time to do them. When they discussed this in supervision, they were told to "prioritise their work". They told us this had been discussed in supervision, as they wanted to spend more time with patients and constantly felt that they were unhappy about this. Another member of nursing staff told us they felt as if there was too much to do. "The phone rings and it is someone I have never heard of telling me to do some "Corporate stuff." I told them I do not even know who they are, and they got annoyed."

We used a tool called the Short Observational Framework for Inspection (SOFI) to record all interactions. In a 35 minute period, we had not recorded a single interaction between a nurse and the person they were looking after. When the person left their room, the nurse followed behind with no eye contact, no physical contact and no therapeutic intervention. This demonstrated a lack of meaningful support. We were told by the staff nurse that this nurse was from an agency and had less knowledge of the patients than the other staff. They had been asked to look after the person with the highest needs that day. This meant that the people on the unit were not afforded the expertise they could reasonably expect on a specialist unit.

There appeared to be an activity-impoverished environment with little therapeutic nursing intervention or meaningful activities to do. We asked two people how they spent their time during the day. One person told us "There is nothing to do. I was meant to go to a meeting today, and they forgot to tell me about it. I just found out." They also said "There is a man here who just lies in his bed all day. All day, every day. Sometimes there are dvd's to watch." Another person told us they were bored. They were waiting to be taken shopping but said "I have been waiting a long time. I was going this morning, but nothing happened."

We spoke with three nursing staff on STATT to try to understand how they assessed people, provided their care, and monitored progress towards a pre-determined goal. They were unable to describe how they assessed people's individual needs within a structured framework. We asked what model of care they used and were given a variety of answers; there did not appear to be a cohesive understanding of what a nursing model was. One nurse told us "I don't use a model, I know what questions to use." Non ward based senior staff were clearly aware of the process used to develop a care pathway and how this was being used across the services. However, the staff on the ward were not able to describe the process, or how needs were identified. We were told the following; "We do what the doctors tell us." "We don't have a model of care." "We use the Activities of Daily Living." "We did use the Roper, Logan Activities of Daily Living but we have been told not to use this anymore." When we asked how they would measure if a person was getting better, or how effective therapeutic interventions were, they were not able to tell us.

There appeared to be little evidence of the role of family and friends. There was also little evidence of imagination, planned purposeful activity or nursing support with a specific end point in sight. There was a lack of engagement and empathy with the people who used the service, as "Care Planning" seemed to have become a process to be followed, rather than a tool to extract pertinent, useful and personalised information. This meant that the initial assessment of individual needs was unlikely to reflect an accurate understanding of what interventions and risk assessments were required.

People were not always given appropriate treatment and therapy by the nursing staff as the staff could not measure how best to deliver this care. For example, one person had a risk assessment in place to safely walk up the stairs because of a physical disease they had. However, this person was able to safely walk up the stairs, and partake in a variety of social and sporting activities at home, such as swimming. We spoke with nursing staff about this risk assessment. They told us "It seemed entirely inappropriate to have this risk assessment in place. It did not fit in with the normality of the life we were trying to deliver, and did not reduce his risk of falling". The risk assessments in place did not accurately reflect people's requirements to enable them to lead a productive life within a therapeutic placement.

We asked the nursing staff what benefit they thought the STATT gave people who were being treated there. One person said that behaviour modification therapy was used. Another told us that medication regimes were started. We discussed this further with staff and asked them to describe any appropriate social interactions or interventions, or productive or appropriate activities for the people living there. They told us " If they don't want to do something, we might just leave them as we do not want to challenge them." We asked what would happen if someone chose to stay in bed all day. We did not get a reply.

Care and treatment was not planned and delivered in a way intended to ensure people's safety and welfare. We asked the nursing staff about their knowledge of physical illness. One person told us that if a person had, for example, epilepsy, there was a regional nurse expert who helped them draw up their care plans. We looked at the care plan of a person with epilepsy but were unable to find any documentation relating specifically to the needs and requirements to effectively manage this disease. This meant that we could not be sure that people with specific physical diseases would be looked after by nursing staff with the necessary knowledge and competence level.

We asked about bathing and observation routines of those who may have an epileptic fit on the unit. We heard from two nurses that these had recently changed. The senior nurse in charge of the unit described that people with epilepsy were now "routinely observed discreetly" whilst bathing. This had been an organisational response put into place after a death on the unit this summer. We noted an absence of call bells within the units. This meant that people may be unable to access help quickly if they required it.

We discussed emergency life support training with nursing staff. They told us they had had training in the last year. We viewed their training records and found that one third of them had not attended this basic training. They told us they felt confident to deal with emergency situations. However, one of the nursing staff we spoke with was not fully able to demonstrate emergency procedures. We informed the Senior Manager of this incident.

We checked the Resuscitation Policy for the Trust. It stated that qualified nursing staff of an inpatient area with a defibrillator and oxygen would have been expected to attend an Intermediate Life Support Course. The training records for the unit stated that only Basic Life support was required, but this was not compliant with the Trust's Resuscitation policy. 67% of staff had attended this course. The Senior Manager of the unit was not able to explain why all the staff had not attended. The training records noted ""No local course." This meant that, in the event of an emergency, there was a risk that some nursing staff may not have been able to deliver the level of care required or expected of healthcare professionals.

We spoke with case managers and other healthcare professionals about their experiences of the STATT and JSH units. Some of the comments we heard were positive, although most of the comments about positive interactions related to the Occupational Therapy staff and the unit psychologist. We heard little about the interventions of the nursing staff. We read an email from another healthcare professional about the nursing staff. This described the "excellent and compassionate care" given to someone who had recently been treated on the STATT unit.

We spoke with relatives whose family members had recently stayed in STATT and JSH. Some people told us this had been a good experience. They had felt welcome, and had visited regularly. They described the care given as "Okay" and "Quite good." Others told us they had had little to do with their relatives' care, had not been asked to be involved in any care planning, and had not felt welcome on the unit. They felt they had been seen as being "obstructive". They told us they had not been allowed easy access to their relative, and had not been enabled to play a part in any recovery plan. They said this was not what they had hoped for. They also said that comments from the nursing staff were "conversational pleasantries", but this provided little information in relation to any care, therapy or intervention with their family member. They told us they did not know what positive actions or activities had taken place to aid their relative's recovery. During their relative's stay on STATT, they were not given a copy of the care plan. We read some meeting notes about this person, and the family had told the staff their family member spent "a minute proportion . . of time spent engaging in actual activities." They had expressed concern that "there were not enough activities."

We noted that information regarding advocacy services was on the noticeboard, but was out of date and therefore not appropriate or accessible to those who may have required it. Two people who used the service told us they had had no access to an advocate; they also told us it had not been discussed. Neither of them had a South of England Advocacy Project (SEAP) leaflet when asked.This meant that a level of expertise and comfort was not accessible to those who may have wanted it or benefitted from it.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

People were not protected from the risk of abuse because the provider had not taken reasonable steps to ensure that people were safeguarded against the risk of abuse.

We spoke with four members of staff on the STATT unit. They told us they had been given safeguarding training in the past year. They were able to describe a wide variety of types of abuse including financial, emotional, psychological, sexual, elder and physical. We reviewed the training records available on the ward. Records showed that two thirds of the staff had attended adult safeguarding training, and none of them had attended safeguarding of children. We asked the unit manager why one third had not attended this adult training. He said that "other staff were scheduled to do this in the near future" and was able to show us this had been booked.

At the beginning of our inspection, we saw that a reminder to make a safeguarding referral had been entered on the communication board in the staff office. At the end of our first inspection day, we asked if the safeguarding referral had been made. It had not. The reason given was that the member of staff making it was on a day off. No-one else had made the referral. On the second day of our inspection, the safeguarding referral was still outstanding at lunchtime. This meant that the safeguarding referral system was not sufficiently robust to quickly address safeguarding concerns on the STATT unit.

We spoke with people who used the service. One person on the STATT unit told us they felt "very unsafe here." They told us the staff were not able to protect them from another person who stayed there. They described a situation the previous weekend where they had been frightened by the behaviour of this person. During our inspection, we saw that this person was allowed to roam unchallenged through the female part of the house. We asked why the nurse did not prevent this from happening. The nurse told us the person may get very agitated, so they just followed him to ensure he was not physically aggressive. We observed no verbal interaction between this person and the nurse. This meant that the person in the female part of the house was not kept safe from fear or harm.

The staff failed to protect her psychological welfare. This person decided to leave STATT and return home in order to feel safe.

We heard that relatives were not always able to visit their family members when they came to the unit. A staff nurse told us that one person had not been able to have his family visit him because a more senior nurse had made the decision that it may not be "good" for that person. This senior nurse had told the other staff to always ask the person if they wanted visitors. The nurse said that the person was "given the choice" to say yes or no when relatives arrived, but the nurse could not confirm if the person had understood the implications of this choice as sometimes he had said no, then later asked where they were.This meant that we could not be sure that people on the unit were not emotionally harmed by this type of ad hoc decision, as it potentially removed the comfort of a visit from their family and friends.

Whilst safeguarding processes (such as staff training and knowledge) were in place, there was a clear dis-connect between policy and practice. This meant that abuse and neglect was not prevented from taking place.

Cleanliness and infection control ✖ Enforcement action taken

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.

People were not protected from the risk of infection because appropriate guidance had not been followed. They were not cared for in a clean, hygienic environment

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People were not protected from the risk of infection because appropriate guidance had not been followed. Systems were not in place to prevent and control the spread of infection.

The systems in place to reduce the risk and spread of infection were ineffective. A lead person had been identified for the monitoring and auditing of infection control. This person showed us the infection control audits, hand hygiene audits and ward cleaning audits for the previous three months. Whilst these audits gave highly positive scores, they were not an accurate reflection of the conditions we found. For example, the recent cleaning audit showed a compliance of 96%. However, the unit had had no cleaner since the beginning of September, and the cleaning had been allocated to the nursing and care staff. We asked them what cleaning schedule they had used to ensure everything was done. Staff were not able to describe the checks in place to monitor the cleaning process.

In the bathrooms, there was a cleaning chart affixed to the wall. The correct procedure was to record three times daily that the area was cleaned. This had not been completed since 14 August 2013 and had not been used regularly, as the chart had been in place since March 2013.

The upstairs shower room in STATT was currently being used by one patient; the high ledges in this area were dusty. The toilet roll holder was broken. The sink and the toilet were also both soiled. The room was malodorous with an overflowing waste bin.

In JSH ,there were two bathrooms downstairs. Both had showers but neither was working on the day of our visit. The second bathroom was out of order as there was a problem with the shower and the seal around the bath. Water had lifted the floor which was very wet and smelled of damp. In an en suite bathroom, we noted that the shower cubicle was dirty and covered in soap scum. We asked when the last deep clean had taken place and were informed that the cleaner had left three weeks ago and had not been replaced (as on

STATT).

Staff told us that the cleaning process was in place. However, the actions carried out by staff were not checked against a cleaning list, as some areas were plainly dirty. This meant that there was a lack of cross referencing of appropriate safeguards to ensure that cleanliness was maintained.

In the laundry room, we saw that the cleaning mops were stored inappropriately, with both "Clean" and "Dirty" area mops touching. This meant that people who used the service were at considerable risk of cross infection.

We looked in five bedrooms. Two were substantially unclean with dirty floors and dirty furniture. In one bedroom we saw a substance that appeared to be dried faeces on a soft chair. We were told that this room had been already prepared for someone to use it. This meant that the cleaning checks were wholly inadequate.

We spoke with the infection control lead about the training available to staff, and reviewed these records. The unit records stated that only 13% of healthcare staff and 33% of non healthcare staff had undertaken infection prevention and control. However, the records released by the Trust, in response to a query about this, showed that the range of compliance was from 43% to 75%. The discrepancy was clarified by the Trust following the visit. The figures shown to CQC on the day were at least a month out of date. The Trust told us that more staff had attended training.

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

Medicines were not safely administered. During the initial visit we observed single use disposable medicine pots being used for multiple medicines and patients. This meant that there was a risk of cross contamination between patients. A number of medicines were provided as liquids. When we enquired about the use of oral syringes significant prompting was required before we were told by the staff that they were different to those used to inject medicines.

Appropriate arrangements were in place in relation to the recording of medicines. During our second visit we reviewed all the drug charts for the patients (three and seven patients in the respective units). These records were complete and clear, allergies or "No Known Drug Allergies" were documented for all the patients. Where more than one drug chart was in use this was clearly indicated. Where a medication was prescribed "when required" the reason to administer the medication was documented along with the maximum dose. We were advised by the staff that a Pharmacist visited each week on a Wednesday and the drug charts that were on the units the previous Wednesday had been annotated by the pharmacist. Therefore, we were assured that patients were receiving their regular and as required medicines.

Appropriate arrangements were in place for the ordering and supply of medication. However, expiry date checking was not carried out adequately. We were advised by the nursing staff that when the pharmacy staff visited they also checked the medicines and ordered additional medicines when needed. If medication was required urgently between these visits they could fax orders though in working hours to be delivered according to the local delivery schedule and outside of normal working hours they had access to an on-call service. During our initial visit we identified that the emergency oxygen was significantly out of date: this had been replaced by the second visit. At the second visit, whilst the medicines were in date, we were not assured that this would remain the case. This meant that there was a risk that patients may be administered out of date medicines.

Appropriate arrangements were not in place for the storage of medicines. Medicines were

stored at one location within each unit. In one unit the cupboards were suitable; however stock medication was being stored in the Controlled Drugs (CDs) cupboard. Therefore, if CDs were to be held as stock the cupboards would be of inadequate size. At the other unit there was a similar lack of capacity, however the area that would be used to store CDs was not compliant with the legislation. We observed that the medicines commonly used in an emergency were within the CD cupboard. This meant that there was a risk that access to emergency medicines could be delayed due to the level of security leading to delays in the treatment of severely ill patients.

We looked at the CD registers for both units; at the time of the inspection CDs were not held. Neither register contained any records showing that the staff on the unit had undertaken any stock checks whilst they held stock. There were records to indicate that the Pharmacist has undertaken a stock check twice over the period of one year. Medical gases were used on a regular basis in one unit. Spare medical gas cylinders were stored in an external store with compressed gas warnings. This store was not compliant with legislation on the storage of compressed gases. This meant that there was a risk the cylinders may not be immediately available for the patients when required, due to the location of the external store.

Both units had a refrigerator for the storage of medicines. Temperature records indicated that the current temperatures were being recorded either once or twice a day. The minimum and maximum temperatures were not being recorded or reset. One thermometer indicated a maximum temperature of 22 degrees C during our visit. This refrigerator was empty at the time of the inspection. The room temperatures where medicines were stored were not currently monitored. We were advised by staff that one of the rooms was consistently over 25 degrees C. Therefore, there was a risk that patients may be administered medicines that had deteriorated due to incorrect storage temperatures.

Arrangements were not in place to ensure the most up to date information on medicines was used. The staff told us that the majority of information they need relating to medicines could be found via the organisation's intranet. We observed a number of reference books in one treatment room were not the current edition and a few were up to 10 years old. We found stuck to one medicines cupboard clinical guidelines published in 2005. This meant that there was a risk that patients may not receive current information concerning the medicines they were taking.

Safety and suitability of premises

✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People who used the service, staff and visitors were not protected against the risk of unsafe or unsuitable surroundings. On arrival on STATT, we were taken on a tour of the service. Very soon into this tour, it became apparent there were several areas of concern that required urgent action. We asked senior managers to attend, so that we could discuss our immediate concerns with them.

The first floor corridor was accessed from staircases at either end of the unit. The corridor had four large roof windows. Two of these were able to be fully opened, as the restrictors were either not attached or missing. This meant that there was a risk to the health and welfare of people who lived there, as this afforded direct access to the external roof.

There were two fire points for extinguishers at the head of each staircase: this equipment and signage had been removed, and the only fire fighting equipment was locked behind a door at one end of the corridor at the opposite end of the corridor to the occupied bedroom. This meant that, in the event of a fire, other than a fire door there was little immediate protection for the person using the bedroom on that floor. This upstairs corridor also contained a training room and an office. This meant that people working there may have been at risk also.

There were several cupboards along the length of the first floor corridor. One of these was broken and unlocked. The lintel inside was damaged. A piece of wood was sticking out, attached to the wall very loosely with long nails. This meant that there was a risk to the safety of people living there as it could be used either to self harm, or to injure others.

We asked the managers to immediately rectify these deficits. By the end of the first day, the windows had been made safe, the fire extinguishers replaced, and the cupboard mended.

The clinical room on the ground floor of STATT was chaotic and cluttered. There was no clinical sink and no clinical waste bin. The room was being used both for the storage and dispensing of medication and the physical health checks and examinations of people using the service. The room also contained the emergency resuscitation equipment.

The room had a clear window in the door affording a view to the corridor. One-way film had been fixed to the window. This had not been fitted correctly, and did not prevent people from seeing into the room from the corridor. The examination couch, and any people within the room could clearly be seen from the corridor

There was a storage area in the male bathroom that contained a large amount of combustible materials (toilet rolls). This space did not contain a smoke detector, and was thus a potential danger of an unseen fire. The provider had not taken steps to provide care in an environment that was unsuitably designed and inadequately maintained.

Safety, availability and suitability of equipment ✖ Enforcement action taken

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were not protected from unsafe or unsuitable equipment.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We had not planned to inspect this outcome. However, some of the things we saw gave rise to considerable and immediate concern. We found that some of the emergency equipment was either unusable or out of date. This was of such importance that we asked the senior managers of the unit to accompany us, so that they could view our findings.

The defibrillator on JSH had no battery inside it. This meant that, in the event of a cardiac arrest, this defibrillator would not be able to be used for emergency treatment.

We checked the oxygen cylinder in the clinical room. It had expired in June 2012. This meant that, in the event of an emergency requiring the administration of oxygen, no oxygen would be immediately available.

People were not protected from unsafe or unsuitable equipment because the provider had not ensured it was available in a safe and suitable manner. There was not enough equipment to promote the independence and comfort of people who use the service.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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 not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service, and others. During our inspection, we identified concerns in the quality monitoring within the service. Specifically, we found that where the service had identified concerns internally, these had not been acted upon and followed through to completion. Examples included a lack of actions to address identified issues related to ligature risks, windows lacking restrictors and daily cleaning of the unit. There were other substantial areas of lack of governance identified, within the areas of non robust checks of equipment, especially emergency equipment. This meant that the provider could not be assured, at any level, that checks made were an accurate reflection of the actual situation.

In many instances, there seemed to be appropriate mechanisms in place to address potential areas of concern. However, the areas being measured failed to identify the specific concerns they purported to measure. The underpinning data was not robust, and there was a systemic failure of process to follow through to completion. For example, the Matron walk-around on the 15 September signed off bathrooms as clean, although the records were incomplete, and the bathrooms were clearly not clean on the 16 September when we inspected the unit. There was a lack of assessment and management of risks relating to the health, welfare and safety of service users. We found that there were processes in place to identify potentially dangerous parts of the building. However, after these assessments had been carried out, nothing was done to resolve the identified problem. The risks posed by ligature points, and by lack of window restrictors, had been noted in June 2013 by the Unit Manager, and referred to a Senior Manager, but no action on these points had been noted since. We were shown a document with the date the referral to the senior manager had been made. We were told there had been no response to this. We read a copy of recent Board Minutes which referred to the Trust undergoing a

comprehensive internal safety alert audit of window restrictors. We were told by the ward manager that had not yet happened on STATT.

Staff described a culture of restrictive supervision practices and lack of support from one senior staff nurse who was "never on the ward, always at meetings somewhere." We were told of lack of effective communication and engagement with staff, thus not enabling them to make effective contributions to the delivery of good care. For example, with regard to the unit cleaning, there had been no discussion with the staff of what they should not do to enable them to free up the time to do this. No cleaning schedule had been provided, just an expectation that "it would happen." There was no clear directive of how this could or would impact upon the service delivery to people who needed and expected to have quality interventions, assessment and treatment.

People who used the service, their representatives and staff were not always asked for their views about their care and treatment. We spoke with nursing and care staff, service users and relatives of service users. Some relatives did comment positively on the care they had seen given on the unit, but they also noted that their opinion had not been asked for when the initial care plan was drawn up. One person said they had felt unwelcome on the unit. They told us that family and friends seemed to play little part in an environment described as "non-therapeutic" and "non-beneficial" to the people who may have benefitted from this structure.

We discussed quality assurance procedures with the Unit Manager. This is a means of using information to check on the quality of the service, and should include feedback or input from people who use the service and staff who work there. There was little evidence of clear input from patients or family. One relative we spoke with told us they had not been asked for any feedback on the unit, the care or the treatment their relative had received.

Another person verbalised her discontent with the service she had received on the two days we inspected. She told us the staff had not listened to her views about one of the other service users on the unit. We observed this incident, where she attempted to tell staff of her distress. We noted that staff did not show an appropriate level of concern, and that this person had repeatedly been put at risk by the actions of another service user. This demonstrated a careless disregard for her welfare and meant that her views and concerns had not been appropriately dealt with.

We looked at audit records, Matron's Walk around records, infection control and cleaning records, staff rotas, service users care plans, training records, policies and procedures. We found that there was a lack of regular assessment and monitoring in place that impacted upon the care being able to be effectively delivered to service users. For example, a service user with a physical illness had no care plan assessment specific to this. His keyworker nurse told us this should have been done by a local specialist nurse, but did not know why it had not been done. It was not known why this lack of professional help had not been sought when the lack of input was noted.

The risk posed by a lack of fire extinguishers on an upper floor where a patient was situated had not been noted, thereby putting this service user, and others, at risk of non-containment of fire. There was no effective system or process in place to assess that there were no adequate fire safety mechanisms. The audit procedure that was in place to check emergency equipment had failed to demonstrate that this equipment was missing.

The checks of the emergency equipment, such as the cardiac defibrillators and the fire

extinguishers, were serially signed as being correct. Our inspection found that the battery was missing from the defibrillator on JSH, the oxygen was out of date on STATT unit, and the upstairs fire extinguishers on STATT were not in their correct place. There were not effective operations of systems.

There was a failure to regularly seek the views of staff to improve the service they provided to people. Nursing staff told us they were not able to deliver the care they wished, due to being asked to undertake many non clinical duties. Nursing staff told us they felt "inadequately supported" and "overly-challenged" by one of the more senior nursing staff, and by senior managers in the Trust. They told us the unit manager was pleasant and helpful to them. One person said "We worked brilliantly when we were a smaller unit, but now we are part of a much bigger organisation and no one even knows us."

Records

✖ Enforcement action taken

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 were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

People were not protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not consistently maintained or stored. This meant that people had been placed at risk of harm, because inaccurate or missing records gave false assurance to staff and the Trust.

People's personal records including medical records were not accurate and fit for purpose. We read care records and risk assessments of people who used the service. We saw there was missing information that was required. For example, we noted there was a lack of record for clothes worn on section 17 leave: this meant that the person was placed at risk. If they had gone missing, the staff did not have up to date and accurate information to help find this person in a timely manner. The Mental Health Act Commissioner noted that one patient on JSH did not have current detention papers on file. This meant that an inconsistent approach to maintaining master legal and copy legal Mental Health files was in place.

Records relevant to the management of the services were not accurate and fit for purpose. We read bathroom cleaning records. These stated that they should be filled in three times a day. They had last been filled in on August the 14th. This audit trail of record keeping was inaccurate and out of date, so no-one could be sure when the bathrooms were last cleaned or checked.

We reviewed the quality assurance and clinical governance records for the unit. We saw that many audits and measurement activities were recorded regularly, but these records did not accurately reflect the true state of the activity being surveyed. For example, a Matron's Walk-around had been conducted the day before our inspection. The Senior Nurse for STATT and JSH told us this was a whole-day activity, recording the outcome of many detailed activities undertaken throughout the previous month. This check was meant to assure the senior managers that the unit was compliant in all areas being measured.

However, there were multiple areas where the response of "Yes" proved to be inaccurate when scrutinised, for example, "furniture and upholstery were clean" "Medical emergency equipment is in order". Similarly, cleaning audits displayed high scores, but this was not reflected in the standard of cleanliness we saw during the inspection.

We read the emergency equipment checking records. The records stated "Complete AED checks". These had been checked and signed the night before our inspection, by a qualified member of nursing staff. We checked the equipment and found that one of them was not working, because there was no battery in it. The records were therefore not an accurate reflection of the true state of the equipment.

We read signed records stating that that all fire extinguishers were in place. The fire extinguishers and fire notices had not been replaced on the first floor corridor after recent refurbishment two months previously. This meant that the record was inaccurate, and that the safety and quality of the equipment was unknown. The impact of this was that people who stayed on the unit, or worked there, were not as safe as they should have been.

These "false positives" and inaccurate records resulted in an comprehensively-inadequate assurance regarding the quality and safety of this unit. The resultant risk to people was therefore serious.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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: People were not consistently provided with appropriate information or support related to their care or treatment. Regulation 17 (2) (b). People were not always provided with opportunities or encouragement to promote their autonomy, independence and involvement with the service provided. Regulation 17 (2) (g).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Suitable arrangements were not in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18.

This section is primarily information for the provider

Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People were not consistently protected from the risk of abuse due to the lack of identifying and preventing abuse before it occurred. Regulation 11 (1) (a). Acts of neglect or omissions in care potentially put people at harm or the risk of harm. Regulation 11 (3) (d).
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not safely administered. Regulation 13.

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 17 December 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 01 December 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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: Due to the lack of consistent or updated assessments of the needs of people using the service, people were not always protected from the risks of receiving inappropriate or unsafe care. Regulation 9 (1) (a). Care was not consistently planned to meet peole's individual needs, their welfare and safety, or reflect published research evidence and guidance. Regulation 9 (1) (b) (i) (ii) (iii).
We have served a warning notice to be met by 01 December 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Assessment or medical treatment for persons detained	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**

This section is primarily information for the provider

under the Mental Health Act 1983 Treatment of disease, disorder or injury	**How the regulation was not being met:** People were not protected from the risk of infection because appropriate guidance had not been followed. They were not cared for in a clean, hygienic environment. Regulation 12 (1) (b) (c) There was not an effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection Regulation 12 (2) (a) There was a lack of maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity, and materials to be used in the treatment of service users where such materials are at risk of being contaminated with a healthcare associated infection. Regulation 12 (c) (i) (iii)
We have served a warning notice to be met by 01 December 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People were not protected from risks associated with unsuitable premises due to the layout and design of the unit. Regulation 15 (1) (a). Appropriate measures to ensure the premises were secure and adequately maintained were not managed in a timely manner once risks had been identified. Regulation 15 (1) (b) (c).
We have served a warning notice to be met by 01 December 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act

This section is primarily information for the provider

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: The equipment had failed to be maintained and was unsuitable for purpose. Regulation 16 (1) (a) (b) There was insufficient availability of equipment reuired to maintain the service. Regulation 16 (2).
We have served a warning notice to be met by 01 December 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: There was a significant failure to regularly assess and monitor the quality of the services provided to the people who used the service. Effective systems were not in place to identify, assess and manage risks relating to the health, welfare and safety of people using the service. Regualtion 10 (1) (b). Effective analysis of incidents that resulted in harm, or potential harm, did not routinely take place to inform treatment or care provided to people. Regulation 10 (2) (c) (i).
We have served a warning notice to be met by 01 November 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act

This section is primarily information for the provider

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Service users had not been protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of such other records as are appropriate in relation to the regulated activity.Regulation 20 (1) (b) (ii).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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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