

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

## Avalon Harrogate Services

6 Grove Park Court, Harrogate, HG1 4DP

Tel: 01423530053

Date of Inspection: 24 July 2013

Date of Publication: August 2013

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

<b>Consent to care and treatment</b>	✓ Met this standard
<b>Care and welfare of people who use services</b>	✓ Met this standard
<b>Management of medicines</b>	✗ Action needed
<b>Requirements relating to workers</b>	✓ Met this standard
<b>Staffing</b>	✓ Met this standard
<b>Assessing and monitoring the quality of service provision</b>	✓ Met this standard

## Details about this location

Registered Provider	Adult Placement Services
Registered Managers	Ms. Denise Castle Mrs. Karen Oddy
Overview of the service	Avalon provides supported living support, or community based support in people's own homes, and a 'Shared Lives' service where people stay for long term or short break stays with 'carers' in the carers homes. The service supports people from a few hours a week, to 24 hour support and management of the support is delivered through an office in Harrogate.
Type of services	Domiciliary care service Supported living service
Regulated activity	Personal care

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*When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.*

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## Summary of this inspection

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### Why we carried out this inspection

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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.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 24 July 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

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### What people told us and what we found

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We visited the service and spoke with two support workers, two managers and two people who used the service. We also visited two 'carers' home and met both the carers and the people who used the shared lives service. We also looked at files and documentation.

We found that people were happy with the support they received. One person we spoke with told us "I am absolutely happy with my support. They have brought me such a long way and it's like having an extended family". Another person told us "It makes my life better and it makes me happy".

We saw that people were asked for consent and given choices and chances to make their own decisions about their support. Staff were appropriately recruited and underwent a detailed induction at the start of their employment. Staffing levels were well managed and closely monitored.

We identified some issues with the way that medication administration was recorded and issues with the way that medication audits were carried out. This meant that it was not possible to ascertain whether medication was being correctly administered.

There were various opportunities for people to give feedback and the quality of the support was monitored in different ways to ensure that it met with the satisfaction of all those using the service. Where areas for improvements were identified, action was taken that involved everyone and this was well managed.

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

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### What we have told the provider to do

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We have asked the provider to send us a report by 07 September 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.

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### **More information about the provider**

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Please see our website [www.cqc.org.uk](http://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

### Consent to care and treatment

✓ Met this standard

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

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### Our judgement

The provider was 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.

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### 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.

We looked at the ways in which the provider made sure that people were happy with the support they were receiving and were able to make choices and decisions where appropriate. We saw that there were consent forms within people's files regarding photographs and videos and the sharing of information within and externally to the organisation. The consent forms noted the detail of what the person was consenting to and how the support would be managed for each individual.

We spoke with people who used the supported living service about the ways in which they were supported by staff. One person told us "They ask me what I want to do and the control is 50/50". Another person told us "They tell me what they are there to do and check that I am happy with it". We also spoke with people who received support from 'carers' in the shared lives part of the service. One person told us "It's great for me as I can be independent and tell them what support I would like". Another person told us "I am listened to and I make my own choices".

We spoke with support workers about the ways that they ensured people understood their choices and gave consent. The staff gave us examples such as asking questions like "Is that okay?" before carrying out support, explaining things in simple terms, giving choices, respecting people's choices and double checking with people if they seemed unsure. They also told us that they would raise any concerns with management about potential changes in people's capacity and this might result in a review of people's plans or risk assessments.

We spoke with 'carers' who provided support to people through the shared lives part of the service. They explained that in most cases the person would be able to communicate their wishes and they could also gather information from support plans, discussions with the person's families and by building knowledge of the person over time. This ensured that they could tailor the support accordingly. One carer told us "We would take time to explain

and help the person to understand". Another carer told us "If there were any issues we would discuss these with the person and then report any issues to the manager if changes were noticed over time".

Both the support workers and the 'carers' had received training around the Mental Capacity Act 2005 (MCA) and when we spoke with them they were able to give us examples of how they would pick up on changes to someone's capacity and the ways in which they would report this.

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

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**Our judgement**

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The provider was meeting this standard.

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

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**Reasons for our judgement**

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People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

The supported living part of the service provided support workers for packages of support that ranged from a few hours a week to 24 hour support in people's own homes. The type of support included domestic support, prompting and support with medication, support with cooking, eating and diet, shopping and paying bills, going out in to the community and working towards to achieving personal goals. The shared lives service employed 'carers' who in turn gave support on either a full time or respite basis in the carer's home. Each service was managed separately.

We looked at the care and support plan files for four people who received support from the supported living part of the service. We also looked at two files for 'carers' and people who used this part of the service. We found that people had very personalised plans that they had been involved in writing themselves. Sections included 'What's important to me', 'People who support me', 'My support requirements' and common areas such as communication, health needs and medication, emotional needs, choices and staying safe. There were sections about regarding increasing independence and specific activities being undertaken by the person such as learning to read and write. We spoke to people about their support plans. One person told us "I have a plan that's all about me. I have meetings to talk about what is working". Another person told us "They are a fantastic bunch of people and I have been able to work with them to be more independent".

When we spoke with people who used the supported living service they told us that they had 'teams' of staff that worked with them on a regular basis. Staff only worked with people they knew and when any new staff were due to become part of the team they would shadow existing members of staff. One person who used the service told us "My staff are lovely, they have guided me through all sorts, like angels". Another person told us "I like my staff. They are all ladies and we have a laugh". Within files there were sections that recorded the type of staff that people wanted to be supported by and what staff would need to know about them. This meant that staff could be matched with people to ensure that the support was delivered in the most appropriate way for the person.

Support plan files also contained risk assessments. The headings within these included 'Why this is a good thing', 'What is likely to go wrong', 'What might be dangerous', 'What I and others can do to make it safer'. We saw examples for activities such as going out for a drink, cleanliness and safety of the environment, using the laptop and physical activities. The provider may wish to note that in some files there were several 'risks' listed within one risk assessment which may have made it difficult to identify the appropriate actions for specific risks.

Files also contained customer outcome sections which recorded different things the person wanted to achieve and how they were progressing in these areas. Headings included 'How I can achieve my outcome' and 'What I have done'. Staff and people themselves then recorded any progress made and what the next steps might be. We looked at examples such as living independently, maintaining relationships, communication and finances. The provider may wish to note that these had not been updated for some months in the files that we looked at. Support delivered and the associated support planning documentation was very focussed on developing independent living skills and improving the quality of the person's life. All the plans we looked at were very person centred and individualised.

We spoke with people who used the service about their support. One person told us "I cannot think of anything that could be made better about the support I get". Another person told us "I love it. I can be independent and it is fun". A third person told us "I am absolutely happy with my support. They have brought me such a long way and it's like having an extended family". A fourth person told us "It makes my life better and it makes me happy".

Within files there were records about people's tenancy agreements, referral letters and information regarding input and contact with other services such as the GP, health action plans and agreements where appropriate for areas such as key handling and financial support. One of the plans we looked at included a behavioural support action plan and another included a budgeting plan. All the plans we looked at had been reviewed within the last six months.

We looked at the 'carer' files which included information about the type of support that could be offered and some information about their families and lives. This helped the service match potential service users with carers for either long term or respite support. Information in the files for people who used the shared lives service was structured in a similar way to the supported living files. One shared lives 'carer' told us "The paperwork isn't always enough to make decisions on whether someone will be right but you meet the person several times before they come to make sure it will work". Another 'carer' told us "I am happy with the level of information that I receive".

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

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## **Our judgement**

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The provider was not meeting this standard.

People were not protected against the risks associated with medicines because staff were not always following arrangements in place to manage medication recording.

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.

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## **Reasons for our judgement**

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Although appropriate arrangements were in place in relation to the recording of medicine, these were not always being followed.

We looked at the ways in which the service was involved in, and recorded medication administration. The majority of people that used the service were able to self-administer medication and staff or 'carers' were not involved in this. There were however several people where the provider was involved in the process. All staff and 'carers' received training in medication administration and we saw that staff were up to date with this training. No staff were responsible for collection of medication or prescriptions although some people who used the service were supported by staff to do this themselves.

People who used the service had medication files. At the front of these files there was a section that contained memos to staff about any changes or information regarding the medication that people were assisted to take. The files contained information about the medication that people were taking and a medication administration chart (MAR) to record the type and dose of the medication. The MAR chart was then used to record when the medication had been taken. Some of those we looked at were provided by the pharmacy and some were handwritten by Avalon staff. There was also information for staff regarding the procedure for incident reporting, a customer consent form, a medication administration competency assessment signed by staff who were likely to be giving the medication and a copy of the medication policy. Where needed there were also risk assessments relating to medication in some files.

When we looked at records for people using the shared lives service we found we were unable to check the records against the stocks of medication. The MAR charts did not record any stock count and so it was not possible to see if the amount recorded as given tallied with the remaining medication. We also found some small discrepancies in recording which was not up to date in the example we looked at. This may have meant that people were not receiving their medication as prescribed.

When we looked at records for people using the supported living service we found that the same MAR charts were in use. In the examples we looked at we found several missing entries. There were also no running totals or stock counts recorded so it would not have been possible to check these against the stocks held in the home.

We looked at the audits that took place of the medication charts. These were carried out by a team leader in the supported living service. Although these had been done every month, they highlighted discrepancies such as missing entries and apparent incorrect amounts of medication in stock. However it was unclear what action had been taken when the discrepancies had been found. Where the team leader had noted incorrect stocks there were no further notes detailing whether any investigation had been carried out. For several months preceding the inspection no stock count had been recorded.

The audits of medication charts for the shared lives service were carried out by the manager and although these were up to date, they also did not record information such as stock counts and whether the amount of medication held by the 'carer' was correct.

We discussed this with the managers from both parts of the service. They informed us that this was a process used across the whole provider and that the inspection had highlighted that the process was not always being used correctly. Although we only looked at a small amount of records, the managers felt that it might have been possible to have highlighted similar issues in other records.

The team leader that had carried out the audits of the supported living service records was not present at the inspection to clarify if any action had been taken when discrepancies had been found. The manager was not aware of what action had been taken as this responsibility was delegated to the team leader. It was not possible to ascertain if there had been any risk to the person using the service as it was not possible to ascertain whether the medication had been given and not signed for, or the dose had been missed. Another team leader explained that some people who received a service would cancel visits to stay with family or to go on holiday and that this may have been why the entries were missing. However, we did not see any records to clarify this. This could have meant that there was incorrect administration of medication occurring, or that recording was not being completed properly. It was not possible to ascertain this during the inspection.

There was a medication policy in place. There was also a policy in place for the recording of incidents which may have included medications incidents. We did not see any completed incident reports concerning medication.

## 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

Appropriate checks were undertaken before staff began work.

We looked at the ways in which the provider recruited and inducted staff. For the supported living part of the service recruitment included completion of an application form and an interview with Avalon staff and people who used the service. We looked at staff files for three support workers and all of these contained an application form and the notes taken at the interview as well as offer letters. Files also included copies of photographic identification, proof of criminal records bureau checks that had been carried out, copies of references and contracts. Where support workers used their own vehicles there were also copies of car insurance and MOT documents. Where gaps in employment had been identified on application forms. These had been followed up with further questions at the interview stage which ensured that the provider had a clear picture of the experience that people had and any reasons for gaps in employment.

The support workers completed induction training and were awarded a certificate that stated their training was equivalent to the skills for care induction standards. The induction covered a wide range of topics and included a 'first day' process where the manager went through various elements of the role and the requirements. It also explained the organisation's policies and procedures. Practical training was included across a five day programme that covered areas such as moving and handling, safeguarding, medication, planning and risk assessments, infection control and food hygiene.

For 'carers' who worked on the shared lives side of the service, a similar induction programme was undertaken. The application process was more detailed and included several interviews and approval by a decision making panel before any people were placed with the 'carers'. All the same mandatory training was completed by 'carers' as with the support workers. We looked at files that showed that similar documentation was in place such as photographic identification, criminal records checks and references. This ensured that the provider was aware of people's backgrounds and their suitability to work with vulnerable people.

**There should be enough members of staff to keep people safe and meet their health and welfare needs**

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## **Our judgement**

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The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

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## **Reasons for our judgement**

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There were enough qualified, skilled and experienced staff to meet people's needs.

We looked at the ways that staffing was allocated and monitored within the two sides of the service. For the supported living side a four week rolling rota system was in place. As each person had a 'team' of staff to support them, work was allocated across the week and support workers usually worked the same or similar shifts across each week with each person. This meant that people who used the service knew which staff they would be supported by on which day. In some cases this was done according to the activity being taken part in on specific days. For example, if someone attended a particular group, it was usually the same person that would support them with this each week. The rotas were done for each person who used the service and this was monitored on a weekly basis to ensure that all the shifts were covered. The provider had started using a new electronic system to organise rotas but this had only been in use for three days at the time of our inspection and was not yet fully functional.

There was no use of agency staff and sickness or leave was usually covered by existing staff. If people who used the service had a small team of staff to support them, then other members of staff would be inducted on to the team to provide extra cover when needed. This meant that people would not be supported by staff they were not familiar with. As all the support workers had contracts, there were some occasions where their hours might not be fully allocated. They would make up their hours by covering sick or leave for other people they knew. The hours staff were contracted for were monitored to ensure that the service always had the right amount of hours available.

We spoke with support workers about staffing levels and working hours. All those we spoke with felt that the amount of extra shifts they were asked to do was manageable and that they were able to refuse extra work without any repercussions. They also felt that the staffing levels were good in the service and the rota was managed well. One staff member told us "I pick up extra shifts but would be able to refuse and management are very supportive". Another staff member told us "I work more than my contracted hours because I choose to pick up shifts but I am able to say no. It would be good to have a couple more people". The manager for the supported living service explained that they were currently recruiting more support workers.

The way that placements were allocated for the shared lives service was different in that 'carers' would usually know well in advance when they were going to have someone placed with them. There were some 'carers' who picked up emergency placements but most were organised in advance. As 'carers' knew in advance when the placements were going to be, and as the majority were respite, this meant that there were few occasions that would be affected by leave or sickness. When we spoke with 'carers' they told us that they were very happy with the way placements were allocated and that any problems could easily be sorted out as they was usually plenty of time to make changes if needed.

All the people we spoke with who used the service told us that they had not had any missed visits and that support workers were mostly on time. They also explained that if a staff member was going to be late then the office or the support worker would always let them know straight away. They all said that this was a rare occurrence.

## Assessing and monitoring the quality of service provision

✓ Met this standard

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

### Our judgement

The provider was meeting this standard.

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

### Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

Avalon had a programme of quality assurance in place that was managed regionally through a quality assurance manager. Each part of the service completed various types of quality assurance tools and these were tailored to the service and the local delivery.

A questionnaire was carried out with people who used the supported living service on an annual basis. These results were then analysed centrally to show where there were common areas for improvements that might be system or procedure based. The most recent questionnaire had been carried out in March 2013. The results showed that overall customer satisfaction was high. People were asked questions regarding support, arrival times, support plans, appropriate support, emergency contacts, opportunities to get involved, clear information, Avalon 'listening' and making improvements to people's lives. 90% of people who completed the questionnaire felt that the support they received had improved their lives. 77% were happy with the opportunities they were offered to be involved in the development of the provider.

A questionnaire was also carried out with staff. This included questions about communication, support, complaints, opportunities to get involved, views listened to, access to learning and overall satisfaction with the role. Results showed that the majority of staff were either 'very satisfied' or 'satisfied' in all the areas asked about.

The manager explained a regional meeting would be held following the questionnaires being analysed. Action plans were produced based on the results. This was also discussed at the 'Avalink' meeting ? a group for people who used the service to feedback and be involved in the development of the organisation. These action plans were in the process of being produced for 2013- 2014.

There were systems in place for managers to monitor staff issues such as training and supervision. Records were held to record when these were due and the manager would then ensure that these were carried out on a regular basis. There was also a system for

monitoring the review of support plans and risk assessments. This ensured that people who used the service were able to have their support regularly reviewed. Checks were also carried out on staff on a regular basis using 'direct supervision'. This was where a manager or senior attended a visit and ran through a checklist to look at the support workers practice. We saw evidence that this was done with all staff and repeated several times a year.

A six monthly quality assurance assessment was carried out by the manager of each part of the service. This looked at areas such as support plans, risk assessments, training and support and supervision, and provided a further oversight as to how the service was performing. This was then submitted to the quality assurance manager who would identify any issues and work directly with the manager to address any areas for improvement. We saw evidence that all these checks were up to date.

The manager or the team leader carried out monthly checks of finance where support was given to people in this area. Finance books recorded all transactions and receipts were kept. The team leader checked these records every month and the manager checked them every three months. As part of the audit transactions were also checked against bank statements and other financial records. These checks were up to date in the files we looked at.

We spoke with people who used the service about the ways that they could feedback. One person told us "I feel very involved and I ring the team leader and talk about things. I have been to the trustees meeting and the staff have helped me to fill out the questionnaire. They ask me regularly if I am happy". Another person told us "They check with me that everything is alright". A third person told us "People ask me if I am happy with my support and if I am okay". When we spoke with 'carers' they told us that they felt involved in giving feedback and developments in the service. One carer told us "We have a support visit every eight weeks and we can discuss anything. We also do surveys quite regularly". Another carer told us "We have regular reviews. The communication is good and we can ring the manager whenever we need anything or want to give feedback or raise issues".

There were policies in place for quality assurance and monitoring and the quality assurance system.

**This section is primarily information for the provider**

## **✕ Action we have told the provider to take**

### **Compliance actions**

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

Regulated activity	Regulation
Personal care	<b>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</b> <b>Management of medicines</b> <b>How the regulation was not being met:</b> Regulation 13. The registered person was not protecting service users against the risks of the unsafe use and management of medicines as there were not appropriate arrangements in place for safe administration and recording of medicines used for the purposes of the regulated activity.

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 07 September 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.

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**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.

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**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.

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**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

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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)

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### **(Registered) Provider**

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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'.

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### **Regulations**

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

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### **Responsive inspection**

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

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### **Routine inspection**

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

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### **Themed inspection**

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

## Contact us

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