Inspection Report

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

Preston Private

Midgery Lane, Fulwood, Preston, PR2 9SX

Tel: 01772796801

Date of Inspection: 30 June 2014

Date of Publication: August 2014

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Cleanliness and infection control	✔ Met this standard
Staffing	✖ Action needed
Complaints	✔ Met this standard

Details about this location

Registered Provider	Parkcare Homes Limited
Registered Manager	Ms Siobhan Bailey
Overview of the service	Preston Private care home provides nursing and personal care only to 106 people. The home consists of four separate units. One unit provides personal care to people living with dementia, one personal care to older people and two units providing nursing care. The home is located in the Fullwood area of Preston. The home has three regulated activities. Accommodation for persons who require nursing or personal care, treatment of disease, disorder or injury and diagnostic and screening procedures.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an 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 30 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, talked with commissioners of services 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 supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We considered our inspection findings to answer questions we always ask: -

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well-led?

Below is a summary of what we found. The summary is based on our observations during the inspection, speaking with people using the service, the staff supporting them and from looking at records. The inspection team consisted of three inspectors, a specialist advisor and an expert by experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Is the service safe?

People we spoke with told us they felt safe living at Preston Private. Staff spoken with had an understanding of the procedures in place to safeguard vulnerable people from abuse and had received training on this subject. This meant staff knew how to recognise and respond if they witnessed or suspected abusive practice.

We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. Policies and procedures were in place and training had been provided to guide staff in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However we found assessments of people's capacity to support best interest decisions and their advanced wishes was not always in line with best practice.

Staffing levels were continually assessed and monitored to ensure there was sufficient staff available to meet the needs of people who lived at the home. However from our observations and from what people told us during the inspection visit, there was not enough staff to meet the needs of people who lived at the home.

Is the service effective?

People were encouraged and supported to express their views about how they wanted their support delivered. This started before the person moved into Preston Private. The staff team worked with the person to plan, communicate and develop relationships so that everything about them, their needs and desires were understood.

People discussed their healthcare needs as part of the care planning process and we noted there was guidance for staff on how best to meet people's health needs. However we did not find this in all cases. This meant staff were not always aware of people's medical conditions and may not know to respond if there were any signs of deterioration in the person's physical or mental health.

Staff had the training and support to meet the individual and diverse needs of the people they supported.

Is the service caring?

We found staff to be caring and compassionate to people who lived at the home treating them with respect. People confirmed to us that staff were caring and told us they were happy with the care and support provided.

Care records we looked at showed people's needs were assessed. We saw evidence that people's needs were assessed before they started to use the service. This ensured staff had the required skills and training to meet people's needs. Assessments included aspects of the person's health, personal and social care needs.
During the morning we observed at times there was limited staff interaction with people who lived at the home. However in the afternoon we saw an activities co-ordinator actively engaging people in a programme of activities. There was also a 1940's singing group entertaining people on one of the units. We saw people responded positively to this. There was a notice board with information of forth coming events and activities planned.

Is the service responsive?

We observed staff being responsive and attentive to people who required support. This confirmed people who required care and support were being treated with respect and dignity.
People's needs were assessed prior to their admission to the home. Records showed people and their family members had been involved in making decisions about what was important to them. Each person had a key worker who liaised closely with them and their family members. People's care needs were kept under review and staff responded quickly when people's needs changed.

The management and staff at the home worked well with other agencies and services to make sure people received care in a consistent way. This demonstrated the service had an open and co-ordinated approach in ensuring people received the support they needed.

Is the service well-led?

The provider had policies and procedures in place to monitor the quality of the service. These included seeking the views of the people they supported by way of surveys, care reviews and regular monitoring. We saw copies of surveys completed by the people being supported. This meant that people who lived at the home and their family members had the opportunity to give their views about how the service was run.

Records reviewed showed that the service had a range of quality assurance systems in place, to help determine the quality of the service offered. During our inspection there were a number of concerns we had in respect of capacity assessments, record keeping and staffing levels. Through the quality systems, the registered manager had identified a number of the concerns and had actions in place to address them.

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 14 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

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

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

Our judgements for each standard inspected

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.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.

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

Reasons for our judgement

The service had policies in place in relation to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care.

We spoke with staff to check their understanding of MCA and DoLS. Staff demonstrated an awareness of the code of practice and confirmed they had received training in these areas. This meant procedures were in place to enable staff to assess peoples' mental capacity, should there be concerns about their ability to make decisions for themselves, or to support those who lacked capacity to manage risk.

We looked at the care records of ten people who lived at the home. Each of the records showed that people who lived at the home or their representative, had consented to a photograph being taken for care and medication records. There was also a consent form for people to have annual health vaccinations.

It is the home's policy that people should have a capacity assessment on admission. We found that majority of the records we viewed, did not have a capacity assessment on file.

We found good examples of where capacity assessments had been completed following a change in a person's care or health needs. For example one person had been reluctant to be treated for a pressure ulcer. A capacity assessment and best interest decision had been taken to ensure the person received an appropriate level of care. This had been recorded in line with the requirements of the MCA code of practice.

However during our visit we were approached by a family member who informed us of their concerns that a decision had been taken by the home without their consent. The family member explained they held a 'Lasting Power of Attorney' for care and welfare for

their relative. A lasting power of attorney is a legal document which gives a person the legal right to make decisions about a person's care and welfare where the person in question lacks the mental capacity to make such decisions.

The family member told us, "My relative has been here a long time and they have always had excellent care. We have never had any complaints, until now." They told us bed wedges had been used as a safety measure to protect their relative from falling out of bed. However a decision had been taken by the provider to remove the bed wedges. The family member told us, "I got a phone call to say my relative had fallen out of bed. This was the first I knew about the wedges being removed. They should have consulted me." This was a breach of the MCA code of practice.

We spent time in each of the four units of the home. This helped us to observe the daily routines and gain an insight into how people's care and support was managed. We observed staff communicated with people by their preferred method and people were engaged in making choices about their daily routine, for example what time they got up and dressed in the morning. We saw that if people had chosen to stay in their rooms, their wishes were respected.

We looked at care records to review how people's advanced wishes were being managed by the home. We saw a number of care records included notices which would tell an emergency crew not to attempt to cardiopulmonary resuscitation. These are known as Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. We found one person had a DNACPR form which had not been completed. We asked a senior member of staff to remove the document as it could have been taken accidentally as a DNACPR in an emergency situation. The document was removed immediately.

Another person's care records held two DNARCPR forms. Neither were completed fully and there was no record of capacity assessments or consultation with relatives. This meant people's dignity, quality of care and choice could be compromised because best practice was not followed.

We spoke with the registered manager and operations director about our concerns. They confirmed that MCA and best interest forms were not being utilised fully and that there was an inconsistent approach for completion of DNARCPR forms. They have committed to seeking clarification and best practice from the Clinical Commission Group (CCG) and to ensuring staff have further training and support to fully understand the recording processes.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

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

Reasons for our judgement

We spoke with a range of people about the home. They included the registered manager, the operations director, 7 staff members, 17 people who lived at the home and 13 visiting family members. We also asked for the views of external agencies in order to gain a balanced overview of what people experienced living at Preston Private.

Majority of the people we spoke with during our visit were happy with the service and care they received. People told us they had a good relationship with the staff, who they described as "caring, supportive, patient and considerate." One person told us "The staff here are excellent. Overall I'm very happy here." Another person told us, "The staff do a darn good job."

A family member we spoke with, told us, "I can't praise the staff highly enough. They are absolutely brilliant. They know Mum to a tee." Another family member singled out a member of staff for special praise as they had helped their relative settle in to the home after their recent admission. The family member explained the staff member had shown real compassion. This was in understanding the difficult situation from which their relative had been admitted to the home.

However there was mixed feedback from family members. One family member we spoke with had concerns about their relatives clothing being soiled after meals. Another family said they had found their relative in urine soaked clothing in the past. On the day of the visit we saw the person was clean and well dressed with no obvious signs of discomfort. We did speak with the registered manager and operations director at the end of visit about the mixed comments we had received, to ensure actions were taken to deliver consistency in the care people received.

During our visit we were informed by family members there had been two incidents where people had rolled from their beds after bed wedges had been removed. They told us the bed wedges acted as protection to stop the person from falling out of bed. During our observations we saw in some of the bedrooms the bed height was lowered. A soft

protective mat had been placed on the floor next to the bed. We also noted one person's bed had protective rails.

The registered manager informed us the removal of bed wedges and the introduction of a lower bed height and protective mat had been recently been introduced. This was seen as best practice by the provider. They told us as a result of these two incidents, risk assessments had been carried out. Also bedrails had been placed on people's beds where there continued to be a risk of injury. The home had acted appropriately in responding to incidents. However they had not considered the impact on people's safety from the introduction of a new practice within the home. Individual risk assessments had not been carried out for each person before the bed wedges were removed.

During our inspection we used a method called Short Observational Framework for Inspection (SOFI) in each of the four units. This involved observing staff interactions with the people in their care. SOFI helps us assess and understand whether people who use services are receiving good quality care which meets their individual needs.

We noted some very good practice where staff were attentive and dealt with requests without delay. We observed one person appeared upset. A staff member went and sat with them smiling, speaking to them in a reassuring and calming manner. This interaction calmed the person and they responded by smiling back. We saw another person was agitated and their behaviour became challenging to other people in the lounge area. A member of staff demonstrated patience and understanding of the person's condition to diffuse the situation safely in a caring and compassionate way.

However our observations of staff interaction were mixed. During time spent in one unit for a half hour period before lunchtime, we saw there were three people sat at a table in the lounge/dining area of the unit. The three people were not engaged in any activity either talking to each other, or watching television and there was no staff interaction or communication with them.

As part of our observations we checked on people who were nursed in bed in order to gain an insight into how their care was being delivered. We saw that people were comfortable and were attended to regularly throughout the day. Call bells were responded to quickly when people required assistance.

We looked in detail at ten people's care records and other associated documentation. We saw evidence people who lived at the home, and/or their family members had been involved with developing the person's care plans. The records were not well organised. They were laid out in such a way that it was at times difficult to locate information. A member of staff told us, "We all have our own systems but we are in the process of introducing new care plans to so they are all the same."

We had been informed by the registered manager that one person at the home had an infection. Staff we spoke with were aware of the infection. We looked at care records and there was no mention of infection or what precautions and general care was in place to manage the infection. We noted from other care records two of the people were diabetic. Neither had a diabetes care plan and there was no mention of the specific care requirements for someone with diabetes. This meant people were not always protected from the risks of unsafe or inappropriate care and treatment. This was because accurate and detailed care plan records were not always maintained.

We spoke with the senior person in charge on the unit and a care plan was written out

whilst we were still at the home. This ensured staff had the appropriate information they required to support people safely.

Records we looked at showed the home worked closely with other health professionals. Two community nurses we spoke with during the visit told us that appropriate referrals had been made. They told us timely referrals had been made for people who were at the end of their life and any advice given by the nurses had been followed.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Safeguarding procedures were in place to protect people from abusive practices.

Reasons for our judgement

Following recent safeguarding investigations undertaken by the local authority, we looked at the service's related practice.

Over the last year the registered manager had raised four safeguarding alerts with the local authority and notified the Care Quality Commission. We saw any safeguarding alerts, accidents and incidents were investigated. Where appropriate, detailed action plans had been put in place to prevent recurrence. This demonstrated the home had a system in place to ensure managers and staff learnt from untoward incidents.

People who lived at the home and their family members told us they felt safe when being supported. One family member told us, "We know Mum has had falls but the staff are on the ball and have been absolutely brilliant. They never take any chances. If she's in pain they get the GP or the paramedics. We have never had to worry."

The service had procedures in place for dealing with allegations of abuse. Staff were able to confidently describe to us what constituted abuse and the action they would take to escalate concerns. Staff members spoken with said they would not hesitate to report any concerns they had about care practices. They told us they would ensure people they supported were protected from potential harm or abuse. Training records confirmed staff had received training on safeguarding vulnerable adults.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of infection because appropriate guidance had been followed, and people were cared for in a clean, hygienic environment.

Reasons for our judgement

We looked at what procedures and systems were in place to manage infection control in the home. We did this by speaking with the registered manager and staff members on duty. We also looked around the home to see what hygiene controls were in place.

We found the service followed national guidance in respect of infection prevention and control as detailed in the Department of Health's Code of Practice 2010. The service had also developed its own infection prevention and control policies, procedures and training.

Staff we spoke with demonstrated a thorough understanding of the need to follow infection prevention and control procedures and gave examples of how this worked in practice. Staff confirmed they had undertaken infection control training during their initial training and said they received regular updates.

We saw cleaning schedules were completed by the domestic staff confirming that tasks had been completed.

People we spoke with told us they thought the home was clean and they had no concerns about infection control within the home.

We observed the home was clean and tidy on the day of our visit. A tour of the building confirmed bathroom and toilet areas were clean and hygienic.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people`s needs.

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

Reasons for our judgement

We looked at how the service was being staffed. We did this to make sure there was enough staff on duty at all times, to support people who lived at the home. We looked at the staff rotas and spoke with the manager about staffing arrangements. The registered manager told us she reported on a monthly basis the staffing levels required to meet people's needs and dependency levels.

We spent time in areas of the home, including the lounge and the dining areas. This helped us to observe the daily routines and gain an insight into how staff spent time supporting people. We saw staff members were responsive to the needs of the people they were supporting. Staff spent time with people if they were upset or agitated and call bells were responded to quickly when people required assistance. However during our observations we found at times there was limited interaction with people especially in the morning period. In the afternoon we saw staff engaged in activities with people on each of the four units.

The majority of people we spoke with expressed concerns about current staffing levels at the home and how this impacted on their care. One person told us they felt insecure when there were shortages of staff on night shift. Another person told us they received their medication at various times when there was not enough of staff on duty. Another person told us, "I would like to go out more such as to the shops, but they haven't got the staff to go with me."

The staff members we spoke with also expressed concerns about current staffing levels. One staff member told us, "I don't feel we get enough time with residents. Some of the residents have complex needs and we just don't get enough one to one time with them." Another person told us, "We are having to work such long hours to cover shifts and morale is low."

We spoke with the registered manager about our concerns. They told us they were actively recruiting to increase staffing levels at the home. This was confirmed by the operations director.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

People who used the service were confident their comments and complaints would be listened to and acted upon.

Reasons for our judgement

The home had a complaints procedure which was on display in the hallway for the attention of people who lived at the home and their visitors. We saw any complaints received had been acknowledged and responded to appropriately.

People we spoke with told us they were aware of how to make a complaint and felt these would be listened to and acted upon. One person said, "You feel like you can raise any concerns and they will be acted upon and not taken personally."

There were some issues which were brought to our attention during the inspection. We discussed these with the registered manager. We have been informed since our visit action has been taken to resolve these concerns.

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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures 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: The registered person did not have suitable arrangements 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.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures 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: The registered person had not taken proper steps to ensure that those using the service were always protected against receiving inappropriate or unsafe care, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service user's individual needs and ensure the welfare and safety of the service user. Regulation 9 (1)(b)(i) & (ii).

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The health safety and welfare of service users was not safeguarded as the provider had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22.

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 14 August 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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