Inspection Report

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

Cedar Grange

Main Street, Cherry Burton, Beverley, HU17 7RF

Tel: 01964551580

Date of Inspection: 21 January 2014

Date of Publication: January 2015

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

Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Roseberry Care Centres UK Limited
Registered Manager	Mrs Jane Margaret Anderson
Overview of the service	Cedar Grange is a large detached property that is situated in the village of Cherry Burton, close to the town of Beverley, in the East Riding of Yorkshire. The service is registered to provide accommodation and personal care for up to 31 older people, including those with dementia related conditions. The registration incorporates a detached bungalow described as The Lodge. The Lodge provides accommodation for eight people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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 21 January 2014, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information given to us by the provider and talked with commissioners of services.

What people told us and what we found

In this report the name of a registered manager appears who was not in post and not managing the regulatory activities at this location at the time of the inspection. Their name appears because they were still a Registered Manager on our register at this time.

Due to people who lived in the home having a variety of communication needs we were not able to speak directly with everyone. During the day we sat with people who used the service, observed their daily activities and observed interactions between people who lived at the home and staff. We spoke with the manager and three members of staff. We reviewed documentation, including three care plans.

We checked the care records for three people who lived at the home and saw that they had been updated consistently so that staff had current information about the people they supported. We saw positive interactions between people who lived at the home and staff.

There were systems in place to promote the safe administration of medication; this ensured that people received the right medication at the right time.

The home was clean and well maintained. Quality audits had been carried out to monitor that systems in the home were being followed consistently and that people received safe and appropriate care.

Staff had been employed following robust recruitment procedures; this ensured that only people considered suitable to work with vulnerable people had been employed. Staff had received appropriate training.

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We spent time in communal areas of the home and observed the interactions between people who lived at the home and staff. We saw that these were positive and that staff tried hard to meet people's individual needs. We saw that staff did not hurry people; this created a calm atmosphere within the home. There was always a member of staff in or around the communal areas of the home and staff responded promptly to call bells.

We checked the care records for three people who lived at the home. We saw that a '72 hour' admission draft care plan was put in place when people were first admitted to the home. A more in-depth care needs assessment was then carried out by staff. This identified whether a person needed assistance with an area of care and whether this was a high, medium or low dependency need. Areas addressed in the assessment included nutrition, continence, pressure area care, medication, eating and drinking, personal care, mobilising and working/playing. Assessment tools had been used as part of the care planning process, such as the Malnutrition Universal Screening Tool (MUST). There were risk assessments in place that addressed areas such as the risk of falls and the risk of developing pressure sores; these advised staff how to reduce the identified risk.

Information gathered during the assessment process had been used to formulate an individual plan of care. Each care plan area consisted of the person's strengths and needs, the aim of the care and the care planned to meet the person's needs. These documents contained sufficient information to guide staff about how the person wished to be supported and about the level of assistance they required. For example, "I can choose what I would like to wear. I do require assistance with all aspects of personal care, as I cannot do it myself due to poor balance" and "I am a sociable bloke. I like quizzes, TV, dominoes and reminiscing".

Each care plan area also had a section entitled, "This is Me". This included information

about the person's previous lifestyle, work life, home life, family and friends and hobbies/interests and contained information such as, "I have two daughters and grandchildren. I look forward to them visiting and I enjoy our chats". There was also a record of any activities that the person had taken part in and a form to record any communication with relatives. There was evidence that people's individual needs had been recognised and that every effort was made to meet these.

People had signed their own care planning documentation when they were able to do so to evidence that they were aware of the content. We saw that, when alterations had been made to care plans to update them, these entries had not always been signed to record when the person's needs had changed. Most assessments, care plans and risk assessments had been reviewed each month but the provider may wish to note that some monitoring forms had not been completed for two or three months. This could have resulted in staff not having up to date information to follow.

Daily records were made of the care or support provided by staff, and staff also completed a check list each day to record the assistance people had required with personal care. Two of these forms that we saw had been completed consistently but the provider may wish to note that there were three days in January where no entries had been made on this form for one person. This provided a lack of evidence that this person had received the support they needed.

Visits from health care professionals had been recorded, including the reason for the visit and the outcome. We saw that, when relevant, this information had been transferred into care plans to ensure that they were up to date. Correspondence that had been sent to the person following any hospital admissions or appointments had been retained for future reference, and appropriate equipment had been obtained to promote pressure area care and safe moving and handling.

We saw an incomplete patient passport in one care plan and the other two care plans we saw did not include a patient passport. These are documents that people can take with them to hospital appointments or admissions to inform hospital staff about their support needs when they are not able to communicate this themselves. The manager assured us that everyone had a patient passport in place and that she would ensure that there was a copy in each person's care plan file.

The manager was very aware of the particular needs of people with dementia. She understood that adaptations needed to be made to the premises to provide a suitable environment and gave examples of the improvements they intended to make. These included the provision of plain carpets rather than patterned carpets. We saw that the doors were painted in bright colours and had a number and door knocker; the manager said that they intended to replace the gloss paint on the doors with matt paint. There was also signage around the home to assist people to recognise specific areas, such as toilets or the dining room, and the menu was displayed in the dining room in pictorial format. The manager also told us that the organisations maintenance personnel had attended training on environmental issues for people with dementia. This evidenced that the manager and staff were aware of good practice guidelines in respect of dementia care.

Most staff had completed a National Vocational Qualification (NVQ) at either level 2 or 3 in Care. In addition to this, they had completed training on topics that gave them the skills they needed to support people who lived at the home, such as dementia, pressure care, safeguarding adults from abuse, nutrition and moving and handling.

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 risk of infection because appropriate guidance had been followed.

Reasons for our judgement

People were cared for in a clean, hygienic environment.

The manager told us that one of the team leaders was the infection control lead at the home. A folder had been developed that held relevant information on the topic of the prevention and control of infection. The service had an infection control policy and procedure that included information on standard infection prevention and control precautions. We noted that the policy was based on the 'Health and Social Care Act 2008, Code of practice on the prevention and control of infections and related guidance' which is guidance and best practice for preventing infections.

The manager had undertaken three infection control audits in 2013; these included checks on the environment, hand hygiene/training, the kitchen, handling and disposal of linen, disposal of waste, dealing with spillages, personal protective equipment (PPE), catheter management, managing acute events, universal precautions and the management of specific infectious diseases. We saw that the audit recorded areas of compliance and areas of non-compliance with the action that needed to be taken to improve, such as "Staff supervision needed" and "Repair needed". The outcome of these audits was included in the organisations 'key performance indicator' return that was submitted to the head office each month.

There were appropriate policies and procedures in place on hand hygiene, the colour coding of equipment, decontamination, how to deal with an infection outbreak, laundry facilities and information about the control of specific infectious diseases. This ensured that staff had information available to them about safe hygiene practices.

We noted in recruitment records that new staff completed a 'food handler's agreement' that recorded information about their health, such as any outbreaks of diarrhoea and vomiting or skin conditions. This was to control the risk of the spread of infection.

We saw that liquid soap and paper towels had been provided in toilets and bathrooms and that paper towels had been provided in bedrooms; this reduced the risk of cross infection. Throughout our time at the home we observed that staff used personal protective equipment (PPE) such as plastic aprons and disposable gloves when needed and that

they followed good hygiene practices when assisting people with personal care. We noted that this equipment was available for staff in various areas of the home.

We saw that there were satisfactory laundry facilities at the home. The laundry room was spacious enough to provide 'clean' and 'dirty' areas to reduce the risk of cross contamination. The' red bag' laundry system was used; these are bags to hold soiled linen that dissolve in the wash and this reduced the risk of infection. The manager explained the colour coding of equipment used in the home such as mop heads and buckets; this alerted staff to which colour equipment should be used in which area of the home.

There were two domestic staff on duty on the day of the inspection. The manager described the cleaning schedules to us, although we did not check these on the day of the inspection. We found all areas of the home to be clean and free from unpleasant odours

Records seen at the home evidenced that all staff apart from three had completed training on the topic of infection control during 2012 or 2013. All staff had completed training on the control of substances hazardous to health (COSHH) during 2013. This ensured that all staff were aware of good practice guidelines.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Appropriate arrangements were in place in relation to the recording of medicine. Medicines were handled appropriately and kept safely.

We saw that each care plan included a list of the medication that had been prescribed to the person at the time of their admission to the home. One person's records included an assessment and care plan in respect of the administration of medication and recorded their agreement to staff administering their medication. The provider may wish to note that the other two care plans we saw did not include specific reference to a person's medication needs. This was acknowledged by the manager, who said she would explore this further.

Medication was provided by the pharmacy in blister packs as part of a monitored dosage system. They were stored in a locked trolley that was fastened to the wall within the medication room when not in use. The blister packs were colour coded to assist staff to select the correct medication for each time of the day when they administered medication.

Some medicine was not included in the monitored dosage system, such as antibiotics and pain relief medication. Packaging for medicine that had a limited shelf life and for 'as and when required' (PRN) medication had been dated when opened so that staff could ensure medicines were disposed of by the due date.

Medication that required storage at a low temperature (included fortified drinks) were kept in a medication fridge within the medication cupboard; fortified drinks that did not require refrigeration were stored in a separate cupboard in the medication cupboard. The temperature of the medication fridge and medication room had been taken each day to ensure that medication was stored within recommended temperatures.

We checked the storage of controlled drugs (CDs) and the records of administration. CDs were stored in a locked cabinet within a locked cupboard and the cabinet was attached to the wall. We saw that two staff had signed each entry in the CD book and that one member of staff had also signed the medication administration record (MAR) chart. In addition to this, the MAR chart was signed by two members of staff to record CDs that had

been received into the home. We checked the records against a sample of medication held and found the recording to be robust. We checked the records for medication that needed to be returned to the pharmacy and found these to be appropriate and accurate.

One of the senior care workers was responsible for the ordering of medication. She explained how they were able to check that the medicines delivered by the pharmacist matched the medicines recorded on the prescription issued by the GP. She also told us about the competency checks that were undertaken for all staff that had responsibility for the administration of medication and how these were recorded. These checks assessed whether staff continued to be competent when carrying out this task.

We observed the administration of medication at lunchtime. We saw that the senior care worker wore disposable gloves and that they took medication to the person at the dining table or wherever they were eating their lunch. They gave the person a glass of juice to assist them to swallow their medication. They did not sign the MAR chart until they had seen the person take their medication. Another senior care worker told us that staff wore an apron that recorded "Do not disturb" whilst they were administering medication so that they could carry out the task uninterrupted; they said that staff did observe this policy and that this had reduced the risk of errors occurring.

In most instances the pharmacist had recorded 'as and when required' (PRN) medication on the MAR chart with the instruction such as, "Take 1 when required" or "Take 2 when required" rather than "Take one or two when required". This reduced the necessity for staff to record whether the person had taken one or two tablets. The pharmacist had also recorded when the medication was not in the blister box but had been supplied in a separate container.

MAR charts were accompanied by a laminated sheet that recorded the person's name, date of birth, their photograph, their room number, the name of their GP and any known allergies to medication.

There was a sheet at the front of the MAR book that recorded the names of staff that were trained in the administration of medication, with sample signatures. This enabled MAR charts to be checked to ensure that only people who had received appropriate training were administering medication. The training matrix evidenced that staff who had responsibility for the administration of medication had completed appropriate training.

Some medication had been obtained mid-cycle and this had been recorded on a spare MAR chart by staff. Most of these entries had been checked and signed by two members of staff to reduce the risk of errors being made. Some of these records also noted instructions such as, "1 in ear twice per day. Verbal authorisation from Dr X on 07/11/2013". Appropriate codes had been used by staff when people had not required or had refused their medication.

The manager told us that creams that had been prescribed for people were stored in their bedroom. These were administered by the senior care worker responsible for administering medication, who then signed the MAR chart. The MAR chart included a body map to direct staff where on the body the cream needed to be applied. Staff had also recorded where on a person's body they had applied pain relief patches so that they were not applied to the same area of the body each time.

The manager carried out a medication audit each month. The audit monitored stock control, management of controlled drugs, recording of temperatures, and disposal. This

information was forwarded to the head office each month, and included separate information about any medication errors that had occurred.

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 checked the recruitment records for two new members of staff. We saw that prospective employees completed an application form that recorded their employment history, their education/training, the names of two employment referees and a criminal conviction declaration. This provided the home with initial information about the applicant to assess their suitability for the post.

People had a face to face interview prior to being offered a position and a copy of the questions asked and responses received during the interview had been retained. Prospective employees also completed a health questionnaire to check that they were physically and emotionally capable of carrying out the role for which they had applied.

We checked the safety checks that had been undertaken prior to people commencing work at the home. Each person had two written references and a Disclosure and Barring Service (DBS) check in place. We also noted that documents to confirm a person's identity had been retained. We saw that a 'staff file audit' had been undertaken to make sure that all of the required documentation was in place. This ensured that only people considered suitable to work with vulnerable people were employed

We saw evidence in personnel files of the induction training undertaken by new staff. This included the topics of food hygiene, health and safety, safeguarding adults from abuse, infection control, nutrition, customer care, challenging behaviour, dementia, personal care and fire safety. New staff had also worked alongside an experienced member of staff prior to working on the rota unsupervised; the manager told us that this was usually for a period of approximately two weeks.

New staff were issued with a copy of their job description so that they were clear about their role within the staff group and their responsibilities towards people who lived at the home.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development.

We checked the training matrix in place at the home. This recorded that staff had undertaken various training courses during 2012 and 2013. All staff had completed training on fire awareness and COSHH during 2013. Most staff had completed training on food hygiene, moving and handling, health and safety, safeguarding adults from abuse, infection control, nutrition, personal care, dementia, falls awareness, pressure care and challenging behaviour. The staff who had not completed a specific training course had covered most of these topics as part of their induction training.

As well as in-house training, staff had completed a National Vocational Qualification (NVQ). Eighteen staff had achieved this award at Level 2 and three staff had achieved this award at Level 3; three staff were working towards the Level 3 award.

Those staff who were responsible for the administration of medication had completed appropriate training plus refresher training.

The manager told us that they aimed to have one to one supervision meetings with staff six times a year. The staff who we spoke with confirmed that they had supervision meetings and told us that they felt well supported by the manager and the organisation. One member of staff told us about recent training they had attended and said it had been facilitated by "A very good external trainer".

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.

Staff told us that they had meetings and that these were a "Two way process". Staff told us that they could raise issues with each other in a professional manner and that they could make suggestions and debate issues at their meetings.

The manager told us that most of the people who lived at the home would have difficulty taking part in a meeting and that she was considering ways of reinstating meetings that would give people the opportunity to express their views. One idea was to hold resident and relative meetings so that family members would be able to speak on behalf of their relative. We saw the minute of staff meetings and noted that people were encouraged to express their views and were listened to.

Staff also had regular supervision meetings with a manager. They told us that the manager was supportive and that they could share information with her and know that it would be dealt with appropriately and confidentially.

Surveys had been distributed to people who lived at the home during 2013 and we saw that the results had been collated and were displayed on a notice board in the entrance hall. We noted that the survey had only been on the topic of food provision. This was acknowledged by the manager who said that other topics would be included in future surveys. A staff survey and a relatives/friends survey had also been carried out in 2013 and this information, including an action plan, had been displayed on the notice board. These surveys gave people the opportunity to express their views about the way in which the home was operated.

The manager and other staff had carried out various quality audits. These included audits on catering, infection control, medication and a financial/administrative audit and accidents/incidents. The manager told us that accidents and incidents were recorded on the organisations database so were dealt with as soon as they were recorded rather than waiting until the monthly audits were submitted to the head office.

In addition to the audits, the manager produced a 'key performance indicator' report each month. This recorded information about people who lived at the home, such as weight loss/gain, the development of pressure sores, hospital admissions, infections, special dietary needs and medication errors. This information was forwarded to the head office and monitored by senior managers.

We checked the maintenance records and saw that there was a current gas safety certificate and electrical installation certificate in place. There were current service certificates in place for the passenger lift and bath/mobility hoists and portable appliances had been tested. There was a current fire safety certificate in place and weekly in-house checks of the fire alarm system were being carried out. This ensured that the premises had been maintained in a safe condition.

There was a detailed business continuity plan in place. This included information about utility failures, passenger lift failure, flood, laundry facilities and fire along with essential contact telephone numbers. There was also personal emergency evacuation plan for each person who lived at the home.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People's complaints were fully investigated and resolved, where possible, to their satisfaction.

We saw that the complaints procedure was displayed in the entrance hall of the home. This included details of who a complaint should be addressed to and how the organisation would deal with any complaints they received, including the timescales for acknowledgement and investigation. The policy also included information about who people could speak to if they were dissatisfied with the investigation undertaken by the organisation.

We checked the complaints record seen at the home. This recorded that six complaints had been received during 2013. There was a record of the date the complaint was received, the name of the person recording the complaint, the topic of the complaint, details of the action taken, the date resolved and the manager's signature. We saw that appropriate action had been taken by the manager of the home or a senior manager within the organisation. The investigation had been progressed to disciplinary action with staff when this had been appropriate. The complainant had been informed of the outcome of the home's investigation and, when relevant, there was a record to confirm that the person had been satisfied with the outcome.

The manager told us that complaints information was included on the monthly return that was submitted to the organisation's head office so that complaints received by each care service could be monitored. We saw evidence of this on the day of the inspection.

The staff we spoke with told us that relatives were aware of the complaints procedure. They said that people who lived at the home did express concerns and dissatisfaction but may not have been able to make a formal complaint. They said that they would initially try to alleviate their concerns, but they would assist people to make a formal complaint if they felt this was the correct course of action.

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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