Inspection Report

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

St Dominics Residential Home

London Road, Kelvedon, Colchester, CO5 9AP

Tel: 01376570359

Date of Inspections: 02 May 2014
25 April 2014

Date of Publication: May 2016

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

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✗ Action needed
Care and welfare of people who use services	✗ Action needed
Safety and suitability of premises	✗ Action needed
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	St Dominics Residential Home Limited
Registered Manager	Mrs Jean Dolmor
Overview of the service	St Dominic's is a service where up to 38 people live who may require support with their care, welfare and health due to being older.
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 25 April 2014 and 2 May 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

We 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.

What people told us and what we found

As part of this inspection we spoke with six people who used the service, seven care staff, two visitors, the activity co-ordinator and two members of the management team. We looked at five people's care records. Other records we reviewed included, staffing records, quality and monitoring records, health and safety records and satisfaction questionnaires completed by the people who used the service and their relatives.

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?

This is the summary of what we found:

Is the service safe?

People told us that staff always respected them and that they felt safe. Signage around the whole service was well lit and clear, this included all emergency exits which enabled people to move around the service freely and safely.

The rotas seen provided information with regard to how many staff were on duty each shift. However we saw that some people were left for unacceptably long periods of time before receiving the support and care they required. This created unnecessary anxiety and stress to some people because there were not enough staff to respond to people in a timely manner.

We found the service to be unsafe with regard to the current systems in place for the prevention and risks of fire. We have asked the provider to tell us what they are going to

do to meet the requirements of the law in relation to the prevention of fire for the people who live, work and visit the service and in relation to staffing .

Is the service effective?

People's health and care needs were assessed but these were not always completed in consultation with either the person themselves, relatives or their advocate. People had a plan of care in place that reflected their healthcare needs. However some of these care plans had not been reviewed or updated to reflect the person's current and changing needs. We have asked the provider to tell us what they are going to do to meet the requirements of the law in relation to the assessing and monitoring of people's care, and how they were going to involve people in the planning of their care.

We found that the service had not followed the appropriate procedures in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards with regard to appropriate assessments being completed for people who were unable to give consent. We have asked the provider to tell us what they are going to do to meet the requirement in law and in relation to ensuring that people who do not have capacity are assessed appropriately to ensure they are safeguarded from harm or inappropriate care.

Is the service caring?

People were supported by staff who were kind, caring and respectful. Care workers supported people with patience and genuine affection and assisted people who required additional support in a dignified manner and at their own pace.

People commented: "All the staff are very kind. I really like it here especially the daily activities." People's preferences, interests and choices had been recorded along with the care and support offered in accordance with people's wishes.

Is it responsive?

People who used the service and their relatives involved in the service had completed a satisfaction survey and some of the issues raised had been addressed and an action plan completed.

People were involved in participating in a range of interesting and varied activities both within the service and were also offered regular visits from outside entertainers.

People told us that they knew how to complain if they needed to. One visitor stated that they had been provided with information on how to raise a concern when they first moved their relative into the service. There was information displayed around the service on how to make a complaint.

Is the service well led?

The service had a quality assurance system in place but records seen showed us that not all areas of the service were monitored or reviewed regularly. This included the records that relate to the monitoring of the environment, health and safety monitoring and the monitoring of individual care records.

We have asked the provider to tell us what they are going to do to meet the requirement in law in relation to quality assurance.

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 21 May 2015, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People's diversity, values and human rights were respected. We found that staff supported people in a way that promoted their privacy and dignity. We talked with seven care staff who all told us how they supported people. They told us that issues of dignity and respect were covered as part of their induction and on-going training. We spoke with the provider's representatives and care staff on duty who were all knowledgeable about the people who lived within the service.

The care plans included people's preferences and dislikes. For example, one person's care plan stated that they 'liked to get up before 8am.' Another person's care plan included information about the particular foods that they liked to eat. We saw that the provider had implemented 'flexible' meals times to suit people's preferences and choices. This meant that the service had ensured they had respected and upheld people's individual preferences and choices. Where it had been difficult to obtain people's views, care staff had spoken to relatives which also ensured people's preferences were respected.

We spoke with seven care staff who all described to us how they ensured people's needs were met. They told us they had benefited from training and had been given practical guidance on how to respect people's privacy and dignity. We observed that staff knocked on doors before they entered people's private spaces.

Six people we spoke with confirmed that staff always knocked and waited before they entered their room. One person told us that: "I cannot fault them, everyone is lovely here and they always knock and wait before they come into my room which is very important to me." Another person told us that they considered all the staff treated their relative with respect and always found that they were dressed and cared for with: "The upmost patience." Three people we spoke with all told us that they considered the service in which they lived felt safe. This meant that staff had ensured that people's dignity was maintained and that they were treated with respect.

We saw some positive interaction between the care workers and people who used the service. For example, one person had become quite anxious during the lunchtime meal.

We saw a member of staff gently reassured this person and offered them a choice of where to go. We saw this person was supported and reassured in a calm and gentle manner by the member of staff. However the provider may wish to note that we also observed a person being hoisted in the main lounge. This procedure was carried out with no interaction or reassurance between the two staff members and the person who used the service. This information was passed on by us to a senior member of staff for their immediate attention.

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 had not acted 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

As part of this inspection we spoke with four care staff and the registered manager with regard to the Mental Capacity Act 2005 (MCA) and their responsibilities which ensured people's rights and decisions were appropriately assessed and upheld. We found that none of the four staff or the manager were aware of their duties and responsibilities under the Act. People's capacity to make decisions should be assessed as part of their normal assessment and care planning arrangements. Staff should support people to make independent decisions where possible and keep clear records of the different levels of capacity assessment.

We looked at three care plans of people who we were told were unable to give consent and lacked capacity to make their own decisions. None of the care plans seen provided evidence that there had been a MCA completed with regard to the consent for the flu vaccination which had been given. We saw another care plan where there was no consent record or assessment in place for the use of bed rails. We found one care plan had a DNAR (Do not resuscitate) record in place that stated the person was unable to consent to this decision. However there was no evidence in place that confirmed a relative, representative or advocate had been involved in this decision. The DNAR for this person was dated 10 October 2012 and had not been updated or reviewed. This meant that there was a risk that people would not have their rights upheld appropriately.

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.

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

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

As part of this inspection we looked at the arrangements in place which ensured that people received safe, appropriate care and support that met their needs. We reviewed the care records of five people who used the service. We were told that care plans were reviewed on a monthly basis. We found that three out of the five care plans had not been reviewed. This included one care plan where the moving and handling assessment had not been updated since 26 November 2013 and another care plan where the risk assessment in relation to choking was last reviewed on 27 February 2012.

We saw one care plan that stated the person required 'hourly checks'. This care plan was dated 13 January 2014. However we saw that no checks had been recorded in April 2014. We were told by one of the care staff that these checks had been discontinued. However there was no information recorded within the care plan that explained the reason why these hourly checks had stopped and the care plan had not been updated to reflect this person's needs had changed.

We saw in one person's care plan that they had been referred to the community psychiatric services on 10 March 2014 but there was no evidence or information within the care plan that confirmed this referral had been followed up or had taken place. There was also no behavioural care plan in place for staff to follow in situations where this person had become challenging. There were also no measures in place to minimise these incidents from re-occurrence. We spoke with four staff with regard to this person and how they managed their behaviour. They were unable to describe how they supported this person in challenging situations. They told us that they were unaware of any guidelines in place on how to best support this person.

People who live with dementia can become anxious, confused or distressed with certain situations. There was no evidence that their behaviours were considered as a form of communication that could be associated with their diagnosis. Therefore we were not assured that the service had completed all the necessary steps that ensured the welfare and safety of people who use the service. This meant that people could be placed at risk

of harm because inadequate information and guidance was in place.

The service provided a range of meaningful activities which people enjoyed. This included weekly bingo, singing, carpet bowls, skittles, music quiz's and craft sessions as well as trips out during the warmer months. We saw that there was a monthly newsletter produced by the activity coordinator that offered an interesting and useful catalogue of forthcoming events, fundraising information and reflections on the previous month's events and entertainment. Five people we spoke with all told us that they thoroughly enjoyed the newsletter and looked forward to reading it each month. One relative told us that: "The newsletter gives me an insight into what services and entertainment St Dominic's provides which I enjoy reading and I am quite amazed at some of the achievements of the people who live and work here."

We noted that during our inspection the call bell system was activated on 49 occasions. We were told that the call bell system in place was required to be answered within three minutes before an emergency buzzer was activated where all staff were required to respond. Although there was only one occasion when this emergency buzzer was activated during our inspection the provider may wish to note this extremely loud call bell system could have an adverse effect on people's health and welfare. One person told us that: "I hate the sound of the buzzers going off at all times, it drives me mad and interrupts me sleeping."

Safety and suitability of premises ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

As part of this inspection we looked around the premises to ensure that these were well maintained, suitable and safe for the people who used the service. We found that all aspects of the service were clean and well maintained throughout.

We saw that people had a number of communal areas in which to relax and socialise in and a spacious dining room where people took their meals. All external areas were accessible with garden furniture and seating available for people to use.

Corridors were wide and free from clutter. Signage around the whole service was well lit and clear, this included all emergency exits. This meant that the provider had ensured that all areas were accessible, safe and easily located for the people who used the service.

We spoke with six people about the environment in which they lived. All six people told us they found it comfortable and homely. One person told us: "My bedroom is lovely and I overlook the garden so I can watch the birds which I love." Another person told us that: "It's such a nice building and very spacious. There's plenty of room and it's always nice and warm."

We looked at a number of records in relation to health and safety which included hoist service records which showed that the service regularly serviced and maintained its equipment. However during our inspection we saw that door wedges were being used to prop people's bedroom doors open. This practice placed people at risk as it would seriously impede on the fire evacuation process if the fire alarm sounded. This information was passed on to the provider for their immediate attention.

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 wanted to check and ensure that there were enough qualified, skilled and experienced staff available to meet people's needs. This was because we had received two concerns that related to the current staffing levels provided. In particular, concerns had been raised with regard to a high usage of agency staff during recent months. This issue was discussed with the manager as part of the inspection. We were informed that twelve staff had left the service over the Christmas and New Year period which meant that there had been a high usage of agency staff during this time. The manager confirmed that this had: "Affected the consistency of staffing provided and had impacted on the people who used the service in relation to being familiar with the people who cared and supported them."

As part of this inspection we checked the rotas for the periods of April 2014 and May 2014 and found that the usage of agency staff had been considerably reduced with only two agency staff required to cover each daytime shift. Waking night care hours were all covered by permanent care staff during April 2014. The rota confirmed the current staffing levels were seven care staff on the morning shift, six care staff on the afternoon shift and four waking night care staff per shift. All shifts included at least one senior member of staff. The manager and clinical lead were supernumerary to these staffing levels.

We spoke with seven staff as part of this inspection. Three staff told us that they felt that they did not have enough time to carry out all the tasks required of them. One person told us that: "We never have time to just sit and chat with people." Another person told us that: "I am always being called away to help another carer with something." During our inspection we noted that the activity worker was called away on five separate occasions whilst they endeavoured to co-ordinate a game of bingo in the main lounge. This was because they were required to support care staff with a variety of tasks relating to the care of people who used the service. This meant that the provider had not taken appropriate steps to ensure sufficient numbers of appropriate staff were provided.

We were told that people's dependency assessments were completed on a monthly basis. The manager confirmed that currently 11 people out of 39 people had been assessed as requiring two staff to support them with all their personal care needs. This meant that on

occasions there would be a reduced level of staffing for the remainder of the people who used the service. For example on the evening shift where six staff were provided, this would be reduced on occasions to four staff available to support 38 people. In addition this would include people who had been assessed as having a high risk of falling. We looked at the falls records from January 2014 to March 2014. There had been 15 falls recorded during these three months and 10 of these had occurred in March 2014. This information combined with the information from staff who told us that they did not have time to complete all the tasks required of them, meant that people could be placed at risk of harm from inadequate staffing provided, at all times.

During our inspection we noted that one person had called out seven times in a 15 minute period before a staff member came to assist them. On another occasion we saw that one person had become extremely agitated in the main lounge area after their lunch and called out. Although two members of staff acknowledged this person it took a further ten minutes for anyone to actively respond to this person's needs. One member of staff approached the person and told them that they were: "Too busy to help them but would come back in a minute." We saw that it took the staff member a further ten minutes before they assisted this person. We saw that this incident also created anxiety for the two people sat in chairs immediately either side of this person. This caused them both to be verbally abusive to this person who they both told to: "Shut up and go away." We saw the delay in responding to the person who called out for assistance, exacerbated the situation and created distress to all three people involved. This meant that people could not always be assured that they received the prompt care and attention in a timely manner.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a 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

As part of this inspection we looked at the systems that the provider had in place to monitor and review the quality of service provided.

We saw that the most recent care plan audit completed on 30 April 2014 had identified 17 out of 39 care plans as "need updating". This meant that people could be placed at risk of not receiving the care and support required because care plans were incomplete and not up to date. We were told that fluid and repositioning charts were checked as part of both the care plan audits and the daily monitoring sheets. However we found that one repositioning chart was blank for 28 April, 30 April and 1 May 2014. The impact of not receiving regular repositioning placed this person at risk of poor care.

We saw that although health and safety checks were carried out we found some records were incomplete. We found that the monthly water temperature checks were last recorded on 27 February 2014. We saw that the fire policy was last updated in October 2007 and the fire procedure was dated June 2007. We asked the provider for a copy of the most up to date fire risk assessment but this could not be located. We saw that the provider had completed fire risk assessments for the use of door wedges on the bedroom doors of six people. After this inspection we contacted the Essex County Fire and Rescue service for further advice regarding the use of door wedges. They confirmed that these should not be used to keep bedroom doors open. This practice we saw placed people at risk as it would seriously impede on the fire evacuation process if the fire alarm sounded.

We saw that in November 2013 satisfaction surveys had been completed by the people who used the service or their families. We saw that most were positive. Comments seen included: "The activities are very good here. Another person stated that: "The manager always puts things in place." However we saw one questionnaire that stated: "The carers should have more time with residents." Another questionnaire stated that: "There should be more staff to deal with residents who require more care." There was no evidence of action having been taken to address these issues.

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
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of people in relation to the care and treatment provided for them. Regulation 18.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not taken steps to ensure people were protected from the risk of receiving care that is inappropriate or unsafe because care was not planned and delivered in a way that ensured their welfare and safety. Regulation 9 (1) (b) (ii).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met:

This section is primarily information for the provider

	The registered person failed to ensure that service users and others having access to premises where a regulated activity is carried on were protected against the risks associated with unsafe or unsuitable premises. Regulation 15 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There was a risk to health, safety and welfare of service users as there were not sufficient numbers of qualified, skilled and experienced staff to meet their needs. (Regulation 22).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not operate an effective system to regularly assess and monitor the quality of the service. Regulation 10 (1) (a).

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 21 May 2015.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk