# Inspection Report

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

# Derwent House Residential Home

Riverside Care Complex, Hull Road, Kexby, York, YO41 5LD

Tel: 01759388223

Date of Inspection: 24 April 2013

Date of Publication: May 2013

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

| | |
|---|---|
| **Consent to care and treatment** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Meeting nutritional needs** | ✗ Action needed |
| **Management of medicines** | ✗ Action needed |
| **Supporting workers** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✗ Action needed |
| **Records** | ✗ Action needed |

## Details about this location

| | |
|---|---|
| Registered Provider | Sure Health Care Limited |
| Registered Manager | Miss Victoria Louise Towse |
| Overview of the service | Derwent House Residential Home provides personal care and support for 32 older people, some of whom may be assessed as needing nursing care. The service is set in a rural position, east of York. There is ample car parking on site. Information about the service and how it operates can be obtained by contacting the home. |
| Type of service | Care home service with nursing |
| Regulated activities | Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>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 24 April 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

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 spoke with seven people living at Derwent House, three visitors and a healthcare professional. All were very satisfied with the care and support provided. Two people had lived in other care homes prior to this one and both said that Derwent House was much better in every way. One person said "My time here has gone very quickly because its (the home) a good place to be." Another commented "The care is marvellous. The staff know what help I need."

Despite these positive comments we found -

Medication systems were not robust, so the service couldn't evidence that people were always being given their prescribed medicines safely and at the times they needed them.

The service did not have a robust way of monitoring and supporting people who were identified as at risk of becoming malnourished. This meant healthcare support may not be requested appropriately or in a timely way.

The service did not have systems in place to monitor and assess the way the home was operating. This meant there was no evidence to show the service was being kept under constant review to ensure the health, safety and welfare of the people who live in, work in and visit the home.

Records describing people's care needs were not always accurate and up-to-date. Other records to demonstrate the service was running well were also not well maintained. Accurate records were needed to evidence the service is running well as well as for staff to check they were providing the right care.

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

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

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** ✓ Met this standard

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

### Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

### Reasons for our judgement

People we spoke with told us staff routinely checked with them before providing any care and support. We observed care staff knocking on people's doors and in some instances waiting to be invited in. We also observed staff inviting people to go to the dining room, and where appropriate, checking whether people wanted to walk there or use a wheelchair. We spoke with two relatives and they too thought staff were polite and respectful and always checked with people that it was alright before providing care. Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

We noted the service had displayed information about services provided by the home, and local advocacy services, where people or their families could go to for support or guidance. This showed people were given information to support their rights.

We looked at five people's care records and found the quality of these varied. Some older records were very individualised and showed that people's preferences and choices had been explored with them. More recent ones did not provide this level of detail. We saw a few care records were signed by the individual or their representative to demonstrate they agreed with what was written down about them. This showed these decisions had been discussed with them, and they agreed with those decisions. The provider may wish to consider whether routinely obtaining signatures of consent from individuals was a way of showing that people had been consulted about their care.

We did not see any reference, in those care plans we looked at, to show the home had assessed people in relation to their capacity to make their own choices and decisions around care. This meant there was no evidence to show people's capacity to take risks or make decisions had been considered.

We spoke with two care workers who recognised that people had the right to refuse care and this had to be respected. They told us they didn't know about the Mental Capacity Act, so were unaware how this could impact on the care and support they offered. This

meant people may not be being supported with the decisions they chose to make.

We spoke with the registered manager and she too was unclear about how the Mental Capacity Act affected the way care and support was provided to people living there. However she understood that people had the right to refuse care and support and knew of the professionals she would consult to support her should that situation arise. Nevertheless the provider may find it useful to note that greater staff awareness of the Mental Capacity Act may help to ensure people's rights, choices and decisions were always respected appropriately.

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

## Reasons for our judgement

People we spoke with told us they received good care, in line with what they were wanting. They made comments like "We are well looked after by everyone." And "I'm very satisfied. If I am not well they look after me." A third person told us "This is a place that really looks after you." Another person told us the staff looked after them in other ways too, like organising a sewing group, exercise classes and social trips in the community.

We spoke with three visitors and all spoke positively about the care their relative received. One person said "Whatever time I visit my relative always looks well cared for." And "My relative always looks clean and tidy and has clean clothes on. The staff are very good." One person also told us they were always "contacted when their relative was unwell."

We noted people looked well cared for. The ladies wore stockings and appropriate footwear. The men were clean-shaven. People had access to drinks and to call bells, so they could ring for assistance if needed.

We looked at five people's care records. We saw assessments had been completed prior to the person moving to the home. Some of these were not signed and dated though, so it was difficult to check that this had been completed before the individual moved to the home. People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We saw the service referred appropriately to health care professionals for advice and guidance. We spoke with a healthcare professional visiting the service. They said the service had improved in recent months. They thought this was because less agency staff were now used, which meant the staff team were more knowledgeable about people's care needs. They added that the service asked them for advice appropriately and followed the advice offered. This meant people were receiving the right care and support, as recommended by other professionals.

We asked care staff how they knew they were providing the right care. They said they checked the care records when necessary and also had a handover at the start of each shift, where people's care needs were discussed. This helped to ensure they provided safe and appropriate care.

**Meeting nutritional needs** ✖ Action needed

**Food and drink should meet people's individual dietary needs**

## Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration.

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

We looked at this outcome because concerns had been raised with us since our last inspection that meals at Derwent House were of poor quality and provided limited choice for people. We found that whilst people were very happy with the quality of the meals some of the underpinning processes to minimise the risk of harm from malnourishment were not robust.

People we spoke with all praised the meals provided. Their comments included "The food is fresh and very good." And "I once came back from hospital very late and they made a meal for me." People told us they were provided with a choice of two meals and plenty of drinks. They added that staff went out of their way to make something different if they didn't want either of the meal choices. We noted people were provided with a choice of suitable and nutritious food and drink. We observed people had drinks and these were topped up as needed. We saw, for example, one person was given a cup of hot milk as they liked this after they had had a bath.

We observed the mealtime experience and we saw care staff were available and attentive. Those people needing extra support were provided with this in a respectful way. The meals looked appetising and hot, with good portion sizes. People were offered drinks both with their meal and afterwards too.

We spoke with a member of the catering team. They said care staff kept them informed of changes in people's dietary needs. They knew people's particular likes and dislikes and we noted alternative meals to the two choices had been requested for lunch for some people. The staff member had good knowledge of enhancing foods so that those people at risk could have extra calories added to their meal.

We looked at the care files for three people with poor appetites. This meant they were at risk of weight loss or malnutrition. We wanted to check how the service minimised and managed that risk. We noted one person had been referred to their GP, so their nutritional needs could be reviewed.

We saw the service used a nutritional assessment tool to help identify which people were

at risk. However one risk factor was whether the individual's body mass index (BMI) was low. But we noted people's BMIs weren't recorded anywhere. One senior staff member said staff could find BMI information on the internet. When a service doesn't have a robust way of determining which people were at risk then people may not receive appropriate or safe support.

We noted one person had been at Derwent House for just a few weeks. They were assessed as at 'high risk' of malnutrition on admission, but records said they had only been weighed on one occasion. There was no evidence that the service were, or had been monitoring their food intake to help determine whether they needed to be referred to their GP or a dietician. When we spoke with a care worker they said people were usually weighed just once each month. And although food and fluid monitoring charts were sometimes maintained, these were not regularly used. We did not see any one being weighed more frequently than once a month, nor any food or fluid monitoring charts.

We also noted the nutritional care plans stated the GP was to be informed should an individual lose 3.5kg in a month. This though took no account of the person's 'normal' weight, as this weight loss would be much more significant and harmful for a small person, compared with a larger individual.

**Management of medicines** ✖ Action needed

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

## Our judgement

The provider was not meeting this standard.

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

We have judged that this has a 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 observed part of the medicines round and found that medicines were given to people in a patient and sensitive manner. People weren't rushed and we saw that the nurse locked the medicines trolley whenever she left it, to prevent unauthorised people having access to the contents. However, we found that appropriate measures were not always in place in relation to recording and storage of medicines. We also asked the registered manager to send us a copy of the home's medication policy, but we have not received it.

We looked at the Medication Administration records (MARs) for five people. Appropriate arrangements were not in place in relation to the recording of medicine. We found recording for regular medicines were overall correctly and appropriately completed however, we saw gaps in the records for 'as required' medicines and topical creams. We noted mostly that staff were not signing these records to show they had offered people these medicines. The service needed to evidence that as required medicines were being offered as this helped to show people's health and well-being was being monitored and protected. The MARs also mostly had no signatures to say that prescribed creams had been applied. This meant the service could not evidence these had been used and applied in line with the prescription.

We saw some medicines had been hand-written on the MAR, where new medicines had been prescribed in the middle of the four week cycle. We noted that whilst some additions had been checked and counter-signed by a second person, this was not always the case. Having two people check the prescription and dosage on the MAR would help to minimise the risk of incorrect information being written down.

We noted on one person's MAR that they had not received their prescribed eye drops for four weeks. There was no evidence that their GP had been informed of this. We referred this concern to the local authority safeguarding team for them to look at under their safeguarding powers.

We looked at some of the medicines used by the service. We checked the quantities of

three people's boxed medicines and found in each case that the actual numbers didn't tally with the numbers we would expect from the signatures. This meant the service could not account for the medicines they received into the home.

We noted two items were stored in the medicines trolley, which should have been refrigerated. Medicines needed to be stored in line with the manufacturer's guidelines so that they work as effectively as possible. We also noted those medicines with a limited shelf life did not have a record of when they were opened. This was needed to ensure they were discarded in line with the manufacturer's guidance.

We saw that people were supported to look after their own medicines if they wished to. We spoke with one person and saw their medicines were stored in a lockable drawer and their ability to manage this had been assessed and regularly reviewed to ensure they could complete this task safely. The provider may find it useful to note whether obtaining the individual's signature at each review would better evidence the person's continued agreement to have this responsibility.

**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

People we spoke with told us the staff were kind and considerate. All thought the staff were competent and they felt safe in their care. One person commented "The staff are very good. They are lovely." Another told us "The staff are marvellous. They know what help I need."

We spoke with three visitors and they too were satisfied with the quality of the care staff. One said "There used to be more agency staff. Now there's more permanent staff and they're very good. I've never been concerned about the way staff behave with the people living here."

We spoke with two care staff and they said they found the managers approachable and available. They said overall their support needs were being well met.

Despite these positive comments we found systems relating to staff support and training were not well maintained. We looked at three staff files for evidence of induction, staff training and ongoing staff support records. We saw staff had recently had a supervision meeting with a manager, where their work and training needs were discussed. We could not see records of previous meetings. These meetings needed to become established and sustained so that staff could discuss difficult situations and learn from them. They also enabled the manager to check on staff's learning needs, so they could be satisfied that care was being provided safely and appropriately.

Staff told us they used to attend staff meetings, but there had not been any for some time. Regular staff meetings enabled staff to share information and helped staff to feel valued and part of a team.

We could find no reference to induction processes and recent staff training in the staff files we looked at. The registered manager told us she had some processes on her computer but had not yet set these up for individual staff members. So we did not see any planned induction records, to demonstrate that the newly recruited staff worker had completed a range of training and received appropriate support and guidance from senior staff.

**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 to regularly assess and monitor the quality of service that people receive.

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 people we spoke with told us their concerns were always listened to and addressed. One visitor told us their relative had asked for female care staff when they needed personal care. Since they requested this, then this preference had always been respected. Another person, when asked, told us they had never had cause to complain, adding "I have nothing at all to complain about."

The service has sent us the minutes from some resident's meetings in the past few months. We did not though see any minutes or action plans from resident's meetings displayed in the home. One person told us they knew of these meetings but chose not to attend.

Although people living there, their visitors and a visiting healthcare professional provided us with positive experiences of the service we found little evidence to demonstrate the quality of the service was being monitored.

We noted though that mostly people's individual risk of harm relating to their health and well-being was being regularly reviewed. However we asked the registered manager to show us her quality monitoring processes to demonstrate compliance to the regulation. And to demonstrate she was monitoring and managing risks to the people, who use, work in or visit the home. She told us she had no systems in place, though knew these needed to be established.

We did not see any systems for gathering, recording and evaluating information about the quality and safety of the care, treatment and support the service provides. There was no evidence that learning from incidents / investigations took place and appropriate changes were implemented. We did not see any systems to demonstrate the service was identifying and analysing risks and adverse events like people falling. We did not see any audits relating to medicines management, or care records. A robust system would have ensured medicines failures, identified during our inspection, would have been identified

and addressed.

Whilst it remained the case that people were happy with the care and support they received at Derwent House this lack of an underpinning system of checking and monitoring the quality of service provision meant that people living, working and visiting there may be at risk of harm.

**Records** ✖ Action needed

**People's personal records, including medical records, should be accurate and kept safe and confidential**

## Our judgement

The provider was not meeting this standard.

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

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

We noted that people's care records we looked at were tidily kept and securely stored in an area accessible by care staff. Care staff spoken with told us they used the care records to check they were providing the right care. We observed staff checking and writing in people's care records during our visit.

We looked at five people's care records. We found the quality of the information varied. Some older records were very personalised. This meant people's preferences and choices were recorded in good detail to identify what made one person very different to another. We noted this quality of record-keeping was not evident in more recent records.

For example one person's care plan said they were cared for in bed, though their visitor and care staff spoken with confirmed the person was now sitting out of bed on occasions. The care records were neither up-to-date nor did they explain how care staff were to transfer the individual safely from their bed to their chair. When this sort of information isn't recorded there is a risk that different staff may carry out the manoeuvre in different ways. This may place the individual or the care workers at risk of harm.

We noted the service had referred a second person appropriately for healthcare support, but the individual did not want the treatment, as recommended by their GP. Although the service told us they had informed the GP of this, there were no records to demonstrate this communication. This meant the records were not an accurate record of the support and care provided.

We saw another person required specific support on one occasion each week to ensure their health and well-being was being promoted. The care records did not state which day this support was to be provided. Nor did we see any reference to this specific care in the person's daily care records we looked at. This meant the service could not evidence this support was being provided.

We noted staff records and other records relevant to the management of the service were

not always accurate and fit for purpose. We saw medication administration records (MARs) were not always well completed, particularly in relation to 'as required' medicines and the application of prescribed creams and ointments. Those staff records we looked at were not well maintained and recruitment records were not robust. This meant the service was not keeping accurate records of other documents required by the Care Quality Commission (CQC) so they could demonstrate the regulated activity was being well managed.

**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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Meeting nutritional needs** |
| | **How the regulation was not being met:**<br><br>People were not protected from the risks of inadequate nutrition and dehydration. |
| Regulated activities | Regulation |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Management of medicines** |
| | **How the regulation was not being met:**<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. |
| Regulated activities | Regulation |

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

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Assessing and monitoring the quality of service provision** |
| | **How the regulation was not being met:**<br><br>The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. |
| Regulated activities | Regulation |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Records** |
| | **How the regulation was not being met:**<br><br>People were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always well maintained. |

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 04 June 2013.

CQC should be informed when compliance actions are complete.

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

## About CQC inspections

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

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

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

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

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

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

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

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

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

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

## How we define our judgements

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

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

| | |
|---|---|
| ✓ **Met this standard** | This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made. |
| ✖ **Action needed** | This means that the standard was not being met in that the provider was non-compliant with the regulation.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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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