Inspection Report

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

Castle Hill House

Bimport, Shaftesbury, SP7 8AX

Tel: 01747854699

Date of Inspection: 07 January 2013

Date of Publication: February 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✖ Enforcement action taken
Supporting workers	✖ Action needed
Complaints	✖ Action needed

Details about this location

Registered Provider	Cedars Castle Hill
Registered Manager	Mrs. Nora Bernadette Ballard
Overview of the service	Castle Hill House provides accommodation and personal care for up to thirty older people, including people with dementia.
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 7 January 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 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

People's independence was supported and they were involved in making decisions about their care. However, people's privacy and dignity was not always maintained.

People were at risk of receiving inappropriate care or treatment because risk assessments were not reviewed, care plans did not always reflect the needs of people and people's individual needs were not always met.

People had the opportunity to participate in activity events and we observed people participating in a variety of activities.

Staff were supported to carry out their role and received training, supervision and appraisals. Staff were aware of the need to report any allegation of abuse.

Medication was not always stored or administered safely and accurate records of administration were not always maintained.

Written complaints were dealt with appropriately, however verbal or informal complaints were not always dealt with and information given to people did not detail how to complain.

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

What we have told the provider to do

We have asked the provider to send us a report by 14 February 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 taken enforcement action against Castle Hill House to protect the health, safety and welfare of people using this service.

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 ✖ Action needed

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 not meeting this standard.

People's privacy and dignity was not always respected and they were not always treated with consideration.

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

People's privacy and dignity was not always maintained. We saw some people's bedroom doors were closed when they were being assisted with personal care. However, we also observed a person being assisted with personal care with the bedroom and bathroom doors left open.

We spoke with four people who used the service. Three people told us that staff always knocked on their door before entering. One person told us that staff were polite and respectful. We observed staff knocking on doors before entering people's rooms.

We observed a member of staff undertaking a medicine round in a communal area. We observed the member of staff administer a person's topical medicine at a table in the communal area, whilst two other people were also sat at the table. There were also other people sat in the communal area. The member of staff did not offer to administer the medicine elsewhere or seek the person's agreement that the medicine could be administered with other people in the room.

We used the Short Observational Framework for Inspection (SOFI). We observed staff in a communal area interacting with people. We saw acts undertaken and no verbal interaction was made by the staff. For example a person, who was asleep, was awoken by a member of staff putting a protective garment over them before the drinks were brought around. However, we also saw interactions where staff were polite. For example a member of staff offered refreshments to people in a friendly, respectful way.

People's independence was supported. Two people told us that they managed their own personal care needs and were independent, and another person told us that staff supported them to do as much as they could for themselves.

People were involved in making decisions about their care. We saw that people were offered choices, for example, people were asked if they would like to be involved in activities or not. One person told us they "can choose what to eat." Staff told us that people were able to make choices including what they ate, when they get up in the morning, what to wear and where to sit.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs. Care planning did not incorporate issues around medicines management.

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

People were at risk of receiving inappropriate care or treatment. We spoke with four people who used the service and a relative. People told us that the care and treatment they received met their needs. One person told us that staff "help us every way they can."

People told us that call bells were responded to promptly. However, one person told us that occasionally, at night, there was a delay. We observed call bells being responded to in a timely manner. People had access to the call bell system when they were in their room so were able to summon assistance if required. When in communal areas, we observed staff interacting with people and there were members of staff in the lounge with people most of the time.

Care plans did not always reflect the needs of people. We reviewed three people's records. One example was a person had a care plan for Methicillin-Resistant Staphylococcus Aureus (MRSA). The care plan had been last reviewed in September 2012. In the doctor's notes it stated in December 2012 that the person was clear of MRSA. The care plan had not been updated to reflect this. However, we also saw evidence that some care plans were reviewed and reflected people's needs. For example, one care plan covered a person's personal care needs and included the detail of what the person could do to assist themselves. The registered manager told us that the home were undergoing a complete review of people's care plans and risk assessments and showed us a plan of when people's records were going to be reviewed.

Staff understood people's needs and were delivering care according to their needs. For example we observed a member of staff support a person with an activity. The member of staff understood the person's needs and tailored the information they gave the person to assist them.

Risk assessments were not always reviewed. One example was a person who had risk assessments for the risk of falls and diabetes. These risks were last reviewed in September 2011. We also saw a risk assessment for another person regarding falls and

in October 2012, they had been deemed at a medium risk. The risk assessment stated that the risk needed to be reviewed monthly. Since the assessment in October 2012, the person had two recorded falls, however the risk assessment had not been updated following these falls.

The provider told us that there was one person living in the home who required medicines administered covertly at times. We reviewed the person's records. There were no care plans regarding covert administration. There was evidence of discussion with the person's GP, Community Psychiatric Nurse and the person's relative, but there was no evidence of a formal assessment or care planning. Covert administration of medicines should only take place within the context of existing legal and best practice frameworks.

People did not always receive safe and appropriate care. For example, one member of staff administered eye drops to a person. The member of staff was able to explain why the person received the medicine for one of their eyes. The member of staff administered the drops to both eyes. We reviewed the person's Medication Administration Record (MAR). The MAR sheet stated that the drops were to be administered "to dry eye". However it did not detail which eye this referred to. When we asked the member of staff why they had administered the drops to both eyes, they told us that they "presumed it was both eyes". We reviewed the person's records. The eye drops were not included on the medicine form. There was mention of an eye condition in the doctor's notes on 14 September 2012 and 11 December 2012, however it did not detail to which eye any drops were required to be administered to. There was also no care plan regarding the dry eye or medicine to be administered.

There was not a clear process in place for the monitoring of air mattress settings. The provider told us that visiting healthcare professionals informed staff of the appropriate air mattress settings. There was no record of the optimum setting for people's mattresses. The provider told us that the home did not have a chart to identify the settings for air mattresses, and they were unable to confirm the appropriate setting for a person's air mattress. We checked the air mattress in the person's room and it was on a setting of four. There was a monthly audit undertaken for air mattress settings by a member of staff who was not on duty at the time of our inspection. The provider told us that other than the monthly checks, the air mattress settings were not checked. The provider told us that if staff felt the mattress and felt it was soft they would report it to the manager. However, ongoing monitoring is required for this type of equipment to ensure people are not at risk of skin breakdown as a result of inaccurate settings.

We reviewed the monthly air mattress checks. The most recent checks the provider was able to find were dated July 2012. For the person with the mattress set on four at the time of our inspection, the check in July 2012 stated the air mattress was on a setting of five. We reviewed the person's records. There was no care plan detailing that the person was on an air mattress, nor was a setting for the mattress identified. The previous pressure area assessment review was dated January 2012 where the person was deemed to be at very high risk.

People had the opportunity to participate in activities. We reviewed the activities programme for the previous week. Activities that had taken place included exercising, skittles, word games, music and memories. We observed people involved in activities. We saw people knitting, playing games and people were involved in crafts activities. We also observed staff sitting individually with people and talking with them.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

One person told us that they felt "quite happy and safe here."

The home had policies on whistle blowing and the protection of adults together with guidance on protecting people from harm. The guidance defined the types of abuse, actions to be taken, referred to local authority's policy and included contact details for the local authority. When we spoke with staff they knew where to find the policies.

Staff understood their responsibilities regarding safeguarding and whistle blowing, but five out of 36 members of staff needed safeguarding training. However, three of the five had been employed within the organisation for less than four weeks. The provider had dates booked for these people to attend safeguarding training.

Staff knew what actions they would take if they had any concerns about abuse or malpractice. Staff told us about the types of abuse and how to report allegations of abuse.

The home had policies on the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were able to describe the Mental Capacity Act but not all staff understood Deprivation of Liberty Safeguards. There were no people subject to Deprivation of Liberty Safeguards authorisations living in the home. Deprivation of Liberty Safeguards authorisations allow for an authorisation to be put in place which provides a representative to act on behalf of the person subject to the safeguards in order to protect their interests. The home had made safeguarding alerts to the local authority and the Care Quality Commissions as required. The provider may find it useful to note that all staff must understand Deprivation of Liberty Safeguards.

We reviewed the home's training matrix and 18 out of 36 members of staff had completed Mental Capacity Act training which incorporated Deprivation of Liberty Safeguards. The provider demonstrated that this training was booked for staff to attend.

Management of medicines ✖ Enforcement action taken

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.

Medication was not always safely stored or administered. Accurate records of administration were not always maintained and people were not protected against the risks associated with the unsafe use and management of medicines.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We spoke with people using the services but their feedback did not relate to this standard.

Arrangements were in place in relation to the recording of medicine. Clear records were kept of all medicines received into the home, and any unused medicines disposed of.

We looked at three people's Medication Administration Records (MAR). These records showed that medicines were not always administered as prescribed. For example, two of the three people's medicine records we reviewed had gaps on the charts. At times reasons for not giving people their medicines were recorded. However, this was not consistent and there were gaps in the charts without reasons for the medicine not being administered. For example, if a person refused medicine, the MAR had a code which was to be used to record the person's refusal.

Medicines were, at times, kept safely when not in use and were stored securely for the protection of people who used the service. All medicines were stored in locked cupboards and medicine trolleys within a clinical room when not being used. We observed elements of two medicine rounds. Medicine rounds were undertaken by one member of staff. During the medicine round, we observed a member of staff leave a number of compliance aids (system from which prescribed medication was administered, such as a blister pack or dosette box) full with prescribed medication on the top of the drug trolley in a corridor. The member of staff left the drug trolley unsecured and unattended with the medicine on top in the corridor and went to a person's room to administer them their medicine.

There was a separate lockable cupboard to store controlled drugs. Controlled drugs are some prescription medicines which contain drugs that are controlled under the Misuse of Drugs legislation. Keys to access the drug trolley and controlled drugs were kept on the person of the staff member responsible for administering medicine. However, we

observed the member of staff lock the medicine in the drug trolley and then put the keys to the trolley in a low level window in the corridor whilst they went to another person's room to administer their medicine. This meant that people, staff and other visitors had access to the prescribed medicine and other medicine such as homely remedies left within the trolley. Current guidelines from the Royal Pharmaceutical Society of Great Britain published in 2007 state that states that key security is an important part of medicines security therefore only authorised members of staff should have access to them.

Medicines requiring cool storage were stored in an appropriate fridge. The maximum and minimum temperature of the refrigerator was recorded, but there were a number of gaps in the daily records where no temperature had been recorded.

The provider had a policy for medicines management which had been reviewed in July 2012. The policy stated that maximum and minimum temperatures were to be taken daily. The policy also stated "Temperatures 8 degrees or higher must be reported to maintenance immediately for corrective action and this must be documented." The policy did not define what action should be taken with regards to the medicine in the fridge. The failure to store medicines correctly can reduce their effectiveness and cause medicine to fail.

Medicines were not always administered safely because people did not always receive their medicine at the time it had been prescribed for. We observed a member of staff administer a medicine for diabetes to a person over two hours after the time it had been prescribed for. It is important that people receive their medicine at the time prescribed for and that they receive it at the same time each day.

No one living in the home was looking after or taking any of their own medicines. Staff had access to copies of the home's medicines handling policies for guidance.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard because their competency was not assessed or recorded.

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

People told us that they thought staff were well trained.

One member of staff told us that they found supervision good because "You can say if anything bothers you".

We reviewed the records of three members of staff. There was evidence in the staff records that all staff received regular supervision. Staff received formal supervision in the form of a meeting, however there was no evidence of management spot checks of staff competency when performing their role were undertaken. Supervision was recorded and focused on areas for development. There was evidence of appraisals. Appraisals focused on staff learning, development and training needs.

Staff who gave medicines to people had received appropriate training, however their competency to handle medicines had not been assessed. We were told by the deputy manager that, following a medicine error, the member of staff received supervision. We reviewed the supervision records. We saw that the member of staff was shadowed during a medicine round and the error was discussed, however there was no mention of additional supervision, training, or a competency assessment to minimise the risk or the error happening again. Current guidelines from the Royal Pharmaceutical Society of Great Britain published in 2007 state that "In social care settings, people who are unable to manage their own medicines are entitled to have someone who is adequately trained and knowledgeable to give medicines to them. Only staff who have been given appropriate training and have demonstrated they are competent should do this. Care providers are responsible for assessing a care worker's competence to give medicines to the people they care for. They should not make assumptions based on that care worker's previous experience."

The provider did not ensure that all staff were competent, and maintained that competence to administer medicines. The registered manager told us that once staff had undertaken training in medicines they were shadowed by a senior member of staff. There was no

formal assessment of competence and there were no records to demonstrate this shadowing had been undertaken. Once staff had been shadowed after completing their initial training, they were not observed undertaking a medicines round and their competence was not assessed.

Training was updated and we saw evidence that the majority of staff were up to date with training such as, emergency first aid, fire, food hygiene, food safety, infection control and moving and handling. Where the need for training had been identified, the provider demonstrated that sessions were booked to ensure that all staff had completed the training.

Staff undertook additional training for qualifications. The provider demonstrated that the majority of care staff had completed a National Vocational Qualification (NVQ) level 2, 3 or 4 or equivalent.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

Formal complaints were being managed but informal or verbal complaints were not always identified or investigated. Also, information given to people did not include contact details of the local authority or the Local Government Ombudsman.

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

People and a relative told us that they had not made any complaints. One person told us they had "nothing to complain about". However, one person told us that they had informed staff that they had run out of toiletries despite ordering them well in advance. There was no record of this in the complaints book.

Formal complaints were handled and responded to appropriately. There was one complaint recorded in the complaints book in the last 12 months. There was evidence of contact with the person who had made the complaint and the action taken to resolve the issue. The provider did not respond formally to the person making the complaint.

The homes policy did not include contact details for making complaints outside the home. We reviewed the home's complaints procedure. There was no mention of the Government Ombudsman or how to manage verbal complaints in the procedure. People had an information booklet in their room with detail of how to complain. The information did not explain that people could make a complaint to the local authority or the Local Government Ombudsman, nor were there any contact details for these.

Informal and verbal complaints were not managed in the same way as formal complaints. The registered manager told us that the home did not record informal or verbal complaints. The home did not have systems in place to identify verbal and informal complaints in order to implement a process to improve care for people. People's verbal or informal complaints were not always identified, investigated and responded to. Staff did not always identify that verbal or informal concerns could be complaints when we spoke with them. This meant that as these complaints were not always recognised, recorded or passed on and themes were not identified or acted upon to address issue.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's privacy and dignity was not always respected and they were not always treated with consideration. Regulation 17 (1) (a) (2) (a) (f).
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: People did not experience care, treatment and support that met their needs. Care planning did not incorporate issues around medicines management. Regulation 9 (1) (b) (i) (ii).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met:

This section is primarily information for the provider

	People were cared for by staff who were not supported to deliver care and treatment safely and to an appropriate standard because their competency was not assessed or recorded. Regulation 23 (1) (a).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met: Formal complaints were being managed but informal or verbal complaints were not always identified or investigated. Also, information given to people did not include contact details of the local authority or the Local Government Ombudsman. Regulation 19 (1) (2) (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 14 February 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 12 February 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Medication was not always safely stored or administered. Accurate records of administration were not always maintained and people were not protected against the risks associated with the unsafe use and management of medicines. Regulation 13.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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