Inspection Report

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

Moorgate Lodge

Nightingale Close, Moorgate, Rotherham, S60 2AB

Tel: 01709789790

Date of Inspection: 23 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	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Park Lane Health Care (Moorgate) Limited
Overview of the service	Moorgate Lodge is a care home providing care for 56 older people. The service is located on the outskirts of Rotherham. The service is divided into three units on three floors accessed by a lift. There is parking and people have access to secure gardens.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 23 April 2013, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We 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

People expressed their views and were involved in making decisions about their care and treatment. People were confident that their relatives would ensure they received appropriate care. One resident said "I know my son would make sure I got what I needed. And I have!"

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. However staff said they found the care records difficult to follow.

We found that people received adequate food and hydration to meet their needs. However some people told us that the quality of food was sometimes not as good as it should be, and the food could be hotter. People told us there was always plenty of choice of meals.

We found systems protected people who used the service against the risks associated with the unsafe use and management of medication. However the storage of medication required attention.

People we spoke with and their relatives told us they felt there were not enough staff to meet people's needs. One relative said that she sometimes struggled to find staff to talk to when she visited her relative because the staff were always busy.

Complaints were investigated and responded to in a timely manner.

Some records did not reflect the care and treatment provided to people who used the service.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ 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

We looked at five care plans. We found evidence that some people were involved in making decisions about their care and treatment. For example the plans included preferences for 'end of life' care. We also found completed do not attempt to resuscitate (DNAR) forms which were signed by the doctor. Some had also been discussed with the person's relative. The manager told us they used the 'Liverpool Care Pathway' ((best practise arrangements covering palliative care options for patients in the final days or hours of life.) We were shown a copy of the documentation which included treatment plans agreed by relatives.

Relatives of one person were very complimentary about the 'end of life' care provided for their relative who had transferred from a hospice and spent the last 8 weeks of her life at Moorgate Lodge. They appreciated the large attractive room, patio doors, pretty garden view, being able to visit at any time, the care plan and the attention from the carers. The daughter said "It really has been a home from home and we couldn't have wished for any better for mum's last few weeks."

People we spoke with told us they had made an informed choice to move to Moorgate Lodge. Relatives said they received sufficient information about the care or treatment that was available. Most relatives said they were able to discuss the care and treatment options at admission and this had continued.

People told us they were happy for their relative to deal with matters about their care and treatment, and were confident that their relatives would ensure they received appropriate care. One resident said "I know my son would make sure I got what I needed. And I have!"

Two people we spoke with said they had taken up the option of a short stay before they decided to move into Moorgate Lodge. One resident said that her preference for female carers had been respected. She said "I wouldn't like a man helping me to get dressed, so my daughter asked them and they said I could always have help from a female member of

staff."

We found evidence on the care plans we looked at regarding people's mental health and wellbeing. However the provider may find it useful to note that there was no evidence to confirm that mental capacity assessments had been considered. This was in respect of people who had limited capacity. This meant the provider may not be acting in the best interest for those people who had limited capacity.

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

We looked at five care plans and found them to be untidy and difficult to follow. We discussed our concerns with the manager and operations manager who informed us that they were introducing new documentation which would address issues identified in the current care records.

We spoke to four care staff to assess their understanding of the care being delivered. They were able to tell us that they had responsibility to complete daily records, which described the care and treatment given to people who used the service. Staff told us that they did not have time to read the entire care plan but handovers were used to ensure they knew the needs of people who used the service. The staff told us that if people's care needs changed, they would inform the nurse or the manager so they could seek appropriate advice and change the person's care and treatment.

We spoke with seven people who used the service. People said "It's a lovely place and the staff are really helpful." "If you can't live at home anymore, this is a good place to be." "I'm glad I decided to come to live here. I've got friends now and I feel safe." "The staff will always help you and you never feel alone."

We spoke with six relatives. They told us that they thought the care was good. They said they were confident that they would be informed if their relatives care needs changed.

One relative of a person with high level long term needs was less happy. She felt that her relative had received a good level of care when she first arrived at Moorgate Lodge and she was able to socialise in the lounge area. But her dementia and health needs had increased so she was now isolated in her room and did not receive much attention from carers during the day other than meals and drinks. She said "It all seems to have gone downhill since mum has had to stop in bed all day. She needs someone to talk to and hold her hand. There's room for improvement."

We observed staff assisting people with their personal care. They carried out their tasks efficiently and ensured people's dignity was respected.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We spent time speaking with people who used the service about the choice of food and about how staff supported them during meal times. We also observed lunch being served to people who used the service in the three dining areas.

All care plans we looked at contained a Malnutrition Universal Screening Tool. This was to identify risk of malnutrition and demonstrated that people were regularly weighed and referrals made when appropriate. For example, following weight loss of one individual, a referral to an NHS dietitian led to a change in the individuals nutritional care plan. Food and fluid charts had been put in place to enable staff to monitor the person's nutritional intake.

People's weights were taken regularly, and recorded. We saw evidence where speech and language therapist (SALT) team had been involved when there were risks to people from choking.

There were mixed views on the quality of the food. Most of the people we spoke with said the meals were satisfactory, but not of a high quality. One person said "Well, they have to cook for so many people; I suppose you can't expect proper home cooking." "Sometimes the food isn't very hot, but they can heat it up for you." "I think they could do better on the food, but there's plenty of it. You never go hungry."

People we spoke with could recall being asked about what meals/ snacks they would like to be offered. Some relatives said they bought particular food in for their relatives that they felt would not be provided, for instance fresh fruit and egg custard tarts.

People spoken with said they had plenty to drink all day and could ask for drinks at any time. Staff were observed in the lounge offering people drinks that met their individual preferences. Residents said that fresh water was always available in bedrooms. One person said "You'll never die of thirst here!"

People said they could eat either in the dining room or in their bedrooms. Staff were observed serving people lunch in their bedrooms.

Lunch in the dining room on the ground floor was served on small tables accommodating friendship groups. The dining room had been recently refurbished and was a kitchen/ diner. The hotplate and a dishwasher were in the room, so it was a busy room to eat in

and not very relaxing.

Staff were observed giving people time to eat their lunch and supporting people to eat their meals, both in their rooms and in the dining room. Four people required full support with their meal. Three carers were on duty and they served a two course meal for ten people in the dining room, several people in their bedrooms and provided full meal support for three people (one person had a visiting relative to support them with their meal).The carers served the meals from the hotplate, supported people who needed help, cleared the plates and then placed the used crockery etc in the dishwasher. It was a busy atmosphere and more staffing would have been helpful to make the experience more relaxing.

We observed lunch being served to people on the first floor and second floor. They experienced similar support; however we found the dining areas to be unwelcome. Table cloths were not available and we did not see anyone being offered a napkin. We observed staff probing the food to ensure it was served at an acceptable temperature. We noted the vegetables fell below the recommended temperature of 63 degrees and the staff member had to telephone to the cook to ask if it was safe to be served.

We observed there were not enough fabric clothes protectors for people eating lunch in the dining rooms. Several people had to ask for protection. They were given thin polythene aprons (the type used by carers). This seemed to compromise their dignity.

We saw that menus available to people to look at did not reflect the food served. The operations manager removed the menus and gave us a week's menu which the cook was working with. The provider may find it useful to note that the dining experiences for people who used the service was not satisfactory.

We looked at the meals and nutrition audit completed by the manager in April 2013. The audit identified similar areas that required improvement. However the section which described the action needed was not completed. This meant we were unable to assess how they were going to address the issues.

Minutes from 'family and residents' meeting held in March 2013 also identified problems with the quality of the meals. However we were unable to assess what action had been taken to resolve the concerns raised.

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 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 we spoke with and relatives spoken with said that they felt their medication was given appropriately and they had the choice to take their own medication if it was safe to do so. People said they had taken the same medication for many years and so did not feel they needed any more information about it.

One relative said that her relative had complex needs and needed medication reviews provided by hospital consultants. She said that she had struggled to get the hospital, GP and nursing home to communicate appropriately, so appropriate medication and treatment could have been delayed. The relative continued to try to resolve the problem. Another relative said her relative had frequent hospital admissions and was always discharged with a medication plan that the nurses implemented appropriately on return to Moorgate Lodge.

We looked at the records used in the management of medicines. The medication was mainly dispensed from a monitored dosage system. Staff used a medication administration record (MAR) to confirm they had given medication as prescribed. The MAR record gave staff information about the side effects of some medicines and if the person had any allergies to any medication. We found that there were a number of hand written entries, some of which were difficult to read. The nurse told us that they had recently changed to a new supplier of medication and some of the records had not been updated.

The staff told us that the supplying chemist carried out periodic audits and offered advice and support to staff when required. We looked at medication audits completed by the manager which identified problems. There was no evidence to confirm action had been taken to address the problems.

We found that controlled drugs were stored in cabinets that complied with the law. Correct stock levels were found and were written correctly in the register. However the back of the register was also used to confirm that staff had checked stock for all controlled drugs held at the home The register had entries crossed out and the book was generally untidy. This meant it was difficult to audit. The medication fridge was locked, however the keys were still in the lock. There were records of checks to ensure medication was stored at the

correct temperature, however these were not always completed.

We looked at the storage arrangements for medication and found the three stores to be dirty and not suitable for medication. The floor covering was not suitable making it difficult to clean. None of the internal cupboards were locked and door handles were missing. The air conditioning units which were stood on work surfaces were not working effectively to reduce the temperatures in the rooms. One of the rooms with a thermometer recorded the temperature of 74 degrees. This meant that medication was not stored correctly and may result in deterioration of medicines and in some cases; it may harm the person who takes it. There were no hand washing facilities in any of the store room, however hand gels were available at various points in the home.

The nurse told us the medication to be returned was stored in the plant room. When we looked in the room there were four very large containers and a number of small containers. The room was unsuitable and this could potentially become a fire hazard as they were within a few feet of the homes boilers. We spoke to the manager and operations manager who arranged for the medication to be collected. The nurse had informed us that the medication was only collected every three months which resulted in storage difficulties.

Staff told us they had attended training in the safe administration of medication. We saw a list of staff that had been deemed competent to administer medication was displayed.

We observed staff administering medicines to people who used the service. They took time to ensure drinks were provided. The nurse took over one and half hours to administer morning medication to people who used the service. This was because there was only one nurse working, where there would normally be two nurses sharing the responsibility. This meant people did not receive their medication in a timely manner, which could affect their health and wellbeing.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

We looked at the number of staff employed at the home. We noted that there were only three substantive nurses and one bank nurse working at the home during the day. This meant there were insufficient numbers of qualified staff to ensure adequate cover throughout the week. We discussed this with the manager and operations manager who told us they were actively recruiting additional qualified staff. We were given assurances that two nurses would be deployed during the day.

The operations manager showed us a staffing tool which was used to determine the number of hours required for care staff. The tool looked at individual dependency for bathing, feeding, mobility and continence needs. However the provider may find it useful to note that people who used the service and relatives we spoke with raised concerns about staffing levels.

We spoke with the nurse who told us there would normally be two nurses on duty. We observed that she was extremely busy. The nurse had to administer medication to 29 people who used the service with nursing needs. We observed several interruptions while she had to attend to people's needs. The provider may find it useful to note that people's needs should be met in a timely manner.

We spoke with the four care staff. We received mixed comments about the levels of staffing at the service. Some care staff we spoke with told us they felt rushed when carrying out their duties with the current levels of staff. One member of staff told us: "We don't have enough staff due to the high level of needs of the residents. Some people require two staff for moving and handling and a lot of people need assistance with feeding." Staff said "We have to ask for help from staff working in other areas of the home, which means people sometimes have to wait for personal care."

People we spoke with said they felt there were not enough staff around at busy times. People said "Staff work really hard and they're rushed off their feet. I don't know how they do it." Another person said "I don't use my buzzer unless I really need to. Then I know I'll have to wait because they're so busy." "You don't like to bother them because they've got lots of poorly people to see to."

One relative said that she struggled to find staff to talk to when she visited her relative because the staff were always busy.

We looked at the training plan and spoke to four staff about access to training. They told us that most of the training was provided by e-learning, although practical training was provided in areas of moving and handling. The senior carer we spoke with told us she was undertaking a train the trainer course to enable her to deliver moving and handling training to staff. She told us she had completed safe handling of medication training. This enabled her to administer medication to residential service users if only one nurse was on duty.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

None of the people we spoke with could recall being given any information about how to make a complaint.

One person told us they had made a complaint about a meal and had spoken directly to the manager about it. The person said the complaint was dealt with swiftly and appropriately. The problem had not recurred.

Other people spoken with said that if they had a complaint they would tell their relatives and would ask them to deal with it. One resident said her daughter had complained about the food on her behalf, but she hadn't seen any improvement as a result.

People we spoke with said that if they wanted to report anything minor, they would tell one of the carers or a nurse and they were confident their issue would be referred to the right person and dealt with. One resident said "The staff are just like friends – they wouldn't let you struggle with anything."

Some of the relatives spoken with said they had been given information on how to make a complaint. They said that they would approach the manager directly if they had a concern. One relative said that she had made three formal complaints in the three years that her relative had been living in Moorgate Lodge and had been disappointed with the response on two occasions. However her recent complaint (that her relative's bedroom was not being cleaned daily) had resulted in a better cleaning service for the room.

One relative said that she had regularly visited for three years and had only attended one "family" or relatives' meeting. This was because she did not know the dates of the meetings and she only found out about this particular meeting by accident. She did not know whether any relatives' meetings were planned for the future. At the meeting she attended she said the issue of laundry being "lost" or given to the wrong person was raised, but she could not see what action had been taken as a result. She felt regular relatives' meetings would be helpful to raise issues of concern in a less formal way than making a complaint. The meetings would need to be well advertised.

We looked at the minutes from a family meeting held in March 2013. Issues raised were relating to staffing levels and the quality of the meals.

The service had a complaints policy and procedure which we found within the homes statement of purpose. It was also on display within the service. The policy was available in a clear print format, and explained the timescales to respond to any complaints. However the provider may find it useful to note that the policy did not state the timescales for acknowledging complaints only that they would be investigated and responded to within 28 days.

Checks of the complaints register showed that there had been 9 formal complaints in the last 12 months. The manager showed us the investigation notes and the complaints had been dealt with appropriately.

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

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 found that care plans for people who used the service were stored on cupboards on each of the floors at the nurse's station. The cupboards were locked but the keys were left in the lock. This meant the confidential information could be read by anyone including visitors and people who used the service.

The records we saw were disorganised in such a way that information about people's needs were difficult to follow. The operations manager told us that a new care plan format was being introduced. However the transfer from the old care plan onto the new document had not been completed. This had resulted in a mixture of documents being used which made auditing care records very difficult. Some of the photocopied records were not copied correctly and this meant the records were difficult to read. The staff we spoke with told us they found the care plans difficult to read, however they said they knew what was required to meet the needs of people who used the service.

We found one example where a body map identified an abrasion to just below the person's eye. The person did not respond to the treatment but records did not demonstrate the next step to get further advice from medical professionals. The nurse told us a referral had been made to the tissue viability nurse but was not able to confirm if the referral had been made or the date it was made. Records did not confirm that further treatment options had been discussed with the person's relatives. This meant the person may not receive the care and treatment required.

We found one care plan identified the person as being at risk of choking. There was no risk assessment to manage the risk. This meant the person may be put at significant risk of harm if left unsupervised during meal times.

None of the care plans we looked at had information relating to the persons capacity to make decisions about their care and treatment. It was difficult to determine if people or their relatives were involved in developing and agreeing the care plan. We found evidence of communication with relatives although most entries did not relate to the person's care and treatment.

We found three different medication administration records (MAR) were being used. There were several hand written MAR's and some of them were difficult to read. Clear records would help to prevent drug errors. The controlled drug register had been used to record audits of the complete stock of controlled drugs although the records were untidy and some were illegible. A number of entries had been scribbled out. The nurse advised us that she had been given a new controlled drug register to transfer existing stock to.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: Medication was not stored correctly and this may result in deterioration of medicines and in some cases; it may harm the person who takes it. Regulation 13
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 20.(1)(a)(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 18 May 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 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

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