Inspection Report

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

Queen Elizabeth's Foundation Dorincourt

Dorincourt Development Centre, Oaklawn Road, Leatherhead, KT22 0BT

Tel: 01372841300

Date of Inspection: 05 March 2013

Date of Publication: April 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Queen Elizabeth's Foundation
Registered Manager	Miss Julie Tugwell
Overview of the service	Queen Elizabeth's Foundation Dorincourt is a large charity run residential centre set back off the main road. It offers independent living services to people with a range disabilities. There are 14 self contained flats, a group home with a maximum capacity of six and a residential centre with a maximum capacity of 18.
Type of services	Care home service without nursing Domiciliary care service
Regulated activities	Accommodation for persons who require nursing or personal care 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 5 March 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us.

What people told us and what we found

There were 37 people using the service at the time of our inspection visit. We spoke with the ten members of staff that were on duty and with six people who used the service. We also spoke with two relatives and we made observations throughout the visit. We saw that staff communicated with people in a calm manner and in a way that they understood. We observed that they were doing this respectfully and treating each person as an individual. For example, one person became upset so staff took them to a quiet room to talk in private. We saw that staff supported people during mealtimes and offered regular refreshment.

All the people we spoke with told us that there were lots of activities and outings on offer at the centre. We observed a wide range of these activities during our inspection. For example, arts and crafts, sports activities and life coaching. One person told us that they had the opportunity to have one to one time with a life coach so that they could talk about their aims and achievements.

We spoke to staff about their knowledge of safeguarding. All staff were able to tell us that they were aware of their role and responsibilities in relation to safeguarding and knew what to do when reporting incidents.

All the staff members we spoke with told us that they felt supported. However, they all said that there were concerns about staffing levels. This was confirmed by the manager and by people using 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 20 April 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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected and people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who used the service were given appropriate information and support regarding their care or treatment.

We were unable to speak to all the people using the service as they were unable to communicate verbally. However, we did speak with six people, two relatives and ten members of staff. We reviewed their care plans and we spoke with staff members on duty to see how they treated people with dignity and respect. By speaking with staff and reviewing records, it was clear that every effort had been made to inform people who used the service about any treatment, interventions or support decisions. For example, we saw that appropriate strategies had been used to support their ability to make a decision for themselves where possible.

The six people we spoke with all told us that they were asked what mattered to them when their support plans were produced. Staff also told us that it was important that people were given choices and that they respected those choices. For example, we heard a staff member discuss a change of menu with one person as they didn't like what was on offer.

We observed that staff communicated with people in a way that they could understand. We also saw that some people who used the service had laminated cards attached to their wheelchairs. This was done so that the person was able to communicate with other people. We saw this first hand when we spoke to one person who had a pictorial communication card. We were able to see the person spell out what they wanted to say. This showed us that they were happy to speak with us and give us their views. This also demonstrated that people who used the service could be understood by staff.

We saw lots of examples where staff treated people with dignity and respect. We saw that all the toilets had picture signs on the outside. This meant that when a person was using the toilet, a sign was displayed to show that the toilet was being used. We also saw that

people were being supported during mealtimes. We saw that protective equipment was used to cover clothes and that appropriate cutlery was used. We also observed that all the people who required one to one support with eating and drinking had this provided by members of staff on a one to one basis. We spoke to one staff member who said "We always make sure that people are presented well and always offer to change clothes after meals to ensure that people are clean."

We saw that there was a wide range of activities available to people at the centre. We saw that there was a fun day where members of the public, relatives and people who used the service were able to attend. People were actively involved in growing flowers and vegetables to sell at the fun day in order to raise money to go towards their centre. This meant that people were supported to be independent and to be involved in their local community.

We spoke with two relatives of people who used the service. One person told us that staff were happy to provide assistance in all circumstances to ensure that their relative felt happy and comfortable within the centre. For example, on moving into the centre they had a very large TV which was relocated within 24 hours so that they were able to view it from their bed. We also saw that the centre offered a range of accommodation to suit people's needs as they developed their independence. For example, there was a choice of residential accommodation, which included a six bedded home and self contained flats. This meant that the centre was able to provide appropriate opportunities, encouragement and support to service users which promoted their autonomy and independence.

We spoke to people about how they expressed their views. They all told us that they found the life coaching sessions good as they were able to discuss their goals, aims and achievements. They were also given the opportunity to discuss any changes that needed to be made to their support plans. We observed a life coach session being carried out and saw that the staff member was communicating well and noted any requests or concerns, and provided praise and encouragement when discussing achievements. This showed us that people were able to express their views as to what is important to them in relation to the care or treatment.

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 always experience care, treatment and support that met their needs and protected their rights.

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 needs were assessed and care and treatment was planned but not always delivered in line with their individual care plan.

We spoke to people who used the service about their care and welfare. We also gained the views from relatives and staff. We saw that all clients had individual risk assessments and that they were reviewed on an annual basis. For example in relation to transfers, medication, and community involvement. We could see when we reviewed records that any changes to a person's risk levels had resulted in their risk assessment being updated. For example, a person had a change to their wheelchair so a new transfer and moving and handling risk assessment were carried out.

We also saw that the centre had implemented a new Medicare call bell system. The manager told us that the system was radio controlled so that if a power failure occurred, the call system would still function. We saw that there were six panels around the centre so that staff could be aware at all times when a person required assistance. The system was functional for all people using the service and could be activated by voice, movement or by pressing a button. For example, if a person had fallen from their bed an alarm would sound after six minutes of them not returning to their bed. This showed us that in relation to this particular aspect of care, the care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

We observed a staff handover where all morning shift workers were present along with a care manager. We heard staff discuss any important events and any issues that had been raised. For example, a person had become ill and a doctor had been called so regular observations were needed. Staff discussed observations that had been made in relation to people's behaviour. For example, in relation to one person displaying a certain action which meant they were feeling distressed. This meant that the provider was actively trying to provide an ongoing assessment of people's needs.

When we reviewed records we saw that people who used the service had been given a comprehensive assessment of need prior to moving into the centre. For example, the

centre required a five day period of assessment. This was to ensure that the person's needs could be met and the appropriate support provided. We also spoke with the parents of one of the people using the service. They said "We were invited to visit the centre and were told that we could go as many times as we wanted with or without our child."

They also told us that during visits, people who already used the service were allowed to speak for themselves and were never prompted by staff. The manager told us that every person had a full assessment of their needs so that they were able to fit the support programme around them, and what suited them as an individual. We could see from this that care was centred on the person as an individual. It also considered all aspects of their individual circumstances, and their immediate and longer term needs.

The manager told us that every person had a review after six weeks so that any initial problems could be identified and support plans could be adjusted. We were also told that plans were reviewed every six months after this but any changes that were identified could be added to the plan at anytime. We spoke with one relative who told us that their relative had received a six week review and that it had been very helpful. For example, additional personal needs had been identified and their care plan was reviewed and adjusted to ensure that appropriate care was being delivered.

However, one relative told us that they had requested some additional personal care for a person on several occasions and these needs had not been met. This had been highlighted to staff who said that the provision of extra care had been challenging due to issues with staffing levels. Staff told us that they sometimes felt like they did not have enough time to spend with people as they felt rushed. The manager told us that they had recruited a new Head of Care. They also told us that not having a Head of Care in post had impacted on reviews of care plans not being carried out as promptly as they should have been.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. We spoke to people using the service who told us that they liked living at the centre. One person said "I am able to speak for myself and I can see that others that can't are supported with their one to one support". Another person said "If you need care and support the staff always provide it."

However, one person said that they sometimes felt rushed when getting up in the morning as the service was always understaffed. Another person told us that they had missed some of their life coach sessions due to getting up late as support was late. We spoke to relatives about the way they felt care was being delivered. One person told us that they had experienced a relative having to wait from evening through to morning to have their toileting needs met. They told us that they had made the manager aware and this.

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

People who used 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.

We spoke with staff members and with people who used the service. We also spoke with relatives of people using the service. All the staff we spoke with were able to tell us their understanding of safeguarding adults and all were able to identify that they were fully aware of the relevant processes and procedures. They also told us how to spot the signs of abuse if and when they arose.

We saw that there were appropriate policies and procedures in place which had been reviewed and were all accessible to staff. This included a copy of the Local Authority Multi Agency Safeguarding Adults' Procedures. We saw evidence of posters and leaflets which were located on notice boards around the home and also in the staff office which provided information on whistle blowing procedures and also further out of hours emergency numbers for safeguarding alerts.

Staff members were able to tell us that they had all received training in safeguarding and this was reviewed annually. We were shown training files which provided us with evidence to show that staff had received training. The training was in both preventative and responsive safeguarding and also ensured that staff had a good knowledge of safeguarding practices. The manager told us that they had organised a meeting for all the people using the service. This provided them with information which related to safeguarding adults. For example, how to report things they weren't happy with, what to do if they felt staff hadn't taken them seriously and what abuse was. This was supplied to them by way of a visual presentation using an 'easy to watch' DVD. This meant that the provider was taking reasonable steps to identify the possibility of abuse and prevent it before it occurred.

All the people that we spoke with who were using the service told us that they felt safe at the home. One person told us "If I needed to report something or make a complaint then I would." One of the relatives we spoke with told us "I can honestly say that this is the first time in years that I can sleep at night and not have to worry about my daughter."

We saw that there had been a safeguarding incident which had been identified by a relative. We reviewed the records related to this complaint and also our records CQC. We saw that the complaint had been reported properly and in line with the procedure. We also saw that the service had cooperated with the relevant authorities. This meant that the provider was responding appropriately to any allegation of abuse.

Throughout our visit and during observations, we could see that people using the service and also the staff appeared happy, engaged and comfortable. We felt that there was a positive engaging environment.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

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

There were not always enough qualified, skilled and experienced staff to meet people's needs.

We spoke to staff members on duty, the manager and also people using the service and their relatives. The manager told us that they had 38 permanent members of staff, a bank of 16 members of staff and 9 regular agency staff. They also told us that the daily requirement was 16 care staff for the morning shift and 13 care staff for the afternoon shift. The requirement for the night shift was three waking staff across the whole site. At weekends the requirement was nine to ten care staff. Care staff consisted of care assistants, life coaches and occupational therapists (OT's).

We asked the manager if they had carried out a needs analysis or risk assessment as the basis for deciding sufficient staffing levels. They told us that they based the staffing on the amount of people who were using the service. We reviewed the rotas from the week commencing 04 February 2013 up to and including the week commencing 25 February 2013. We saw that during that time there were only three days where the service had its full requirement of staff. We saw that on one day the requirement was short by up to three care staff. This was during the day on 01 March 2012 when according to the rota that was given to us, there were only ten care staff available for the morning shift and eight for the afternoon shift.

They told us that they were at full capacity at the time of our inspection and that there were people on site who required one to one care and support. All the staff we spoke with told us that there had been regular incidences of staff shortages and that this had resulted in there being insufficient numbers of staff available to meet people's needs. For example, we were told by staff that people could not always attend life coach sessions due to people being got up late. Another staff member told us that some people were not getting their one to one support due to a lack of staff. We were told by the staff that we spoke with that they had been asked to assist in providing personal care to other people rather than the one to one support they were scheduled to provide. When we reviewed the rota provided to us, we were able to confirm that staffing numbers were below the required level on

several occasions.This meant that the provider was failing to ensure that there was sufficient staff to provide care.

We found that, as a result of the identified staffing shortages, this impacted on people's daily routines. For example, we spoke to people using the service and one person told us "Sometimes our activities are cancelled as there weren't any drivers." Another person told us "I feel quite rushed in the morning as they are always short staffed. I don't like being rushed." Two people told us that if they could change anything about the home it would be for them to have more staff. The manager said that they were not aware that any activities had been cancelled due to a lack of drivers.

One relative told us that staff do not get enough time to sit and just talk to people due to understaffing and that this was leading to a lack of social stimulation. This meant that people's agreed needs were not being met and that they had missed opportunities to maintain their social interests.

We asked the manager about the staffing problems and they told us that they were aware of this. They told us that they did have a few staff vacancies and were actively recruiting. Staff told us that there had been a long running problem covering for absence, such as annual leave and sickness and that they were regularly asked to cover extra shifts.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a 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 who use the service, their representatives and staff were asked for their views about their care and treatment but they were not always acted on.

We spoke with the manager about what systems they had in place to gain the views of people using the service and their representatives. They told us that surveys had been sent out every 12 months to all relatives and that their views were taken into consideration. We were also told that an action plan had been drawn up so that they could identify any shortfalls and make improvements where possible. We saw that people who lived in the six bedded home had weekly resident's meetings and that minutes had been taken. We saw that one person had asked for more activities in the evenings. We spoke to the manager who showed us that this had been reiterated to evening staff. They were all informed that they were to offer games and suitable activities with the people who wanted to join in.

We were shown some statistics in relation to the surveys in the form of a bar chart. These related to the survey results from 2012. For example, a bar chart showed how many people had responded on questions related to support, information and health care needs. The surveys for 2013 were in the process of being amended so that pictorial information could be used for people using the service. We saw evidence of this.

We were provided with a one page feedback form with a number of suggestions on how the service could be improved. For example, five people had requested more outings and activities at weekends. Another four people asked for more support at night. However, staff were unable to show us evidence that the feedback had been acted upon. We were not shown any action plan in relation to how people's views had been accommodated. We spoke with people who used the service and they all told us that they still do not have enough outings and weekend activities. This meant that the provider was able to ensure that people could express their views but was failing to act on them.

The provider's systems that were in place to identify, assess and manage risks to the health, safety and welfare of people who used the service were not effective. We were told by the manager that regular audits of the service were carried out, such as quality audit checks. We saw evidence of six monthly audit checks. For example in relation to care plans and risk assessments. We were also told by the manager that people using the service had a review of their needs and changes or issues were then fed back in a Multi Disciplinary Team meeting (MDT).

We saw that there were action plans to address areas that had been identified for improvement through the quality monitoring process. We also saw that three reviews had been done in February 2013. However, one of those reviews was the first review for two years. We spoke to a relative who also told us that reviews were not regular enough and that reviews were regularly cancelled at short notice by both the provider and the local authority. They also told us that that there was not enough feedback from the service and this had resulted in relatives forming their own monthly parent's forum.

Relatives told us that feedback was provided once a month in the form of a newsletter. However, relatives that we spoke with all told us that there were so many changes with staff, building work and changes to the service, which they would prefer to be updated on more of a regular basis. This meant that although there were audits in place to identify areas of improvement these were not always followed through and feedback to the appropriate people.

There was evidence that learning from incidents and investigations had taken place and appropriate changes were implemented. We saw evidence that the service carried out audits, for example in relation to health and safety, the environment, moving and handling equipment and fire safety checks. We noted that these check were all up to date. We also saw a statistical summary of incidents, accidents and near misses from April 2012 to December 2012. The manager told us that this was carried out every six months. It identified various items in relation to accidents. For example, the type of event, person affected and the place where the accident occurred. This was done to show any trends or changes to a person's behaviour pattern.

The summary identified two people who were at risk due to an increase in falls related to a change in their health care needs. We saw that as a result of this, a review had been carried out and actions put into place to prevent further incidents. In another example, a person who suffered from epilepsy had had a new alarm system fitted in their room so staff knew when they were at risk of a seizure.

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 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 had not always had their care needs met appropriately. This was because they sometimes had to wait for personal care, or had been rushed or left waiting to receive support. Regulation 9 (1) (b) (i)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** The provider was failing to safeguard the health, safety and welfare of people who used the service as there were insufficient staff to meet people's identified needs. Regulation (22)
Regulated activities	Regulation
Accommodation for	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

persons who require nursing or personal care Personal care	**Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Whilst the provider had carried out a number of quality monitoring activities, there was no systematic approach, and people's view were not being taken into account. Regulation 10 (1) (a) (b) and (2) (b) (i)

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 20 April 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