Inspection Report

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

Cotswold Care Hospice

Burleigh Lane, Minchinhampton, Stroud, GL5 2JZ

Tel: 01453886868

Date of Inspection: 19 December 2013

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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	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Cotswold Care Hospice
Overview of the service	Cotswold Care Hospice supports people with life limiting illnesses and their families. The service runs a day therapy service, an outpatient service, 'Hospice at Home' and a counselling service.
Type of service	Hospice services
Regulated activities	Transport services, triage and medical advice provided remotely 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 announced 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 19 December 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We spoke with people who use the service, family members, staff, the head of care and chief executive. People who attended the hospice told us that it was a "fantastic place" and would be "sad when their therapy ends." People receiving hospice at home care said the service was "wonderful, my saving grace" and it "gives me a breather." Staff said they "loved their job" and the chief executive said that they "enjoy coming to work every day." One staff we spoke with said they felt privileged to help people to "pass away with dignity and respect."

We looked at people's individual files which incorporated their personal profile, care plans and risk assessments and found they encompassed the safety and well-being of people who use the service. Family members, people who use the day service and staff told us that they knew how to raise a concern or complaint and felt confident in doing so. People and relatives said if they had any issues or concerns they could "talk to staff" or their "key worker."

There were policies and procedures in place providing guidance and all staff had received relevant training which was identified on the training schedule. We looked at the cleanliness and infection control and found that the provider had adequate systems in place to ensure the safety of the people who use the service.

We looked at the quality of the service and found the provider had systems and procedures in place to monitor and evaluate the quality of the service provided.

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

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. People's views were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Having considered all the available evidence we found that the service could demonstrate that people were respected and involved in decisions that related to their care and support and the way they spend their time at the location.

We spoke to people who visited the hospice, family members, staff, the head of care and the chief executive. People visiting the hospice and relatives told us the service was "brilliant" and staff were "wonderful, my saving grace."

Cotswold Care Hospice provides day services which includes day therapy/out patients, counselling and bereavement support and Hospice at Home service. The day therapy service can include for example, physiotherapy, counselling, complementary therapy and pastoral care. People who wish to use the day service can either self-refer or be referred by their health professionals, families or relatives. Hospice at home provides support and care to people who wish to spend their remaining days at home and referrals are made by healthcare professionals.

After the referral to the day service, people were invited to attend and complete an assessment which included an outline of their present illness, their medical history and physical issues for example, mobility, breathing or eating and drinking. When people's needs are met by the hospice they are invited to attend a twelve week session where they meet with their key worker and work towards their discussed goals. This meant that people were given an informed choice and the opportunity to decide whether they were happy with what the service had to offer. The people we spoke with told us they felt that they were able to express and have their views listened to. People told us they found it was helpful to have a key worker as they had a "point of contact" and it was "someone who knew them" and who they could speak to with any concerns they may have. One person told us that the hospice provided "continuity" which was" what they needed."

The hospice used a computerised system for all their paperwork and we looked at four

people's records. We saw the information from the initial assessment had been input onto the system together with copy letters for example, the letter inviting participation to the day therapy and the confirmation letter. The hospice at home's system differed in as much as the assessment was completed by the health professional and not the provider. We looked at three records and noted that each had an assessment in the form of a pen picture which outlined people's personal details, their diagnosis and medical and physical needs.

During our visit we observed people being discreetly supported by staff during lunch which allowed them to make an informed choice which promoted their independence and autonomy. Relatives informed us that they were able to take part in decisions regarding the care and treatment of their family and that they had also used the service of the hospice for example, reflexology sessions which they found really helpful. We saw a sample of the care plans and noted that they incorporated an action plan for the person to achieve during their twelve week sessions. We saw that the care plans were comprehensive and included the person's dignity and choice. We found that the care and action plans were reviewed at six weeks and prior to discharge from the twelve week sessions. We saw evidence within the records of people's involvement in the reviews.

People's diversity, values and human rights were respected. We observed staff discreetly asking people if they required assistance with their personal needs. We saw from the daily records checked that staff attended to people's needs and wishes as identified in their care plans, action plans and care assessments.

During our visit we observed people participating in an "art therapy" session." We observed people becoming involved and noted good interactions with staff encouraging people's social skills. We were informed that pupils from the local school and people who use the service had worked together on a project and we saw a collage which had been produced.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

Overall from the evidence we reviewed we found that people were supported and assisted to have their needs met in a manner which ensured their safety and well-being.

Cotswold care works in partnership with a range of NHS providers to offer specialist care at the hospice and via the Hospice at Home service. When a referral was received people's needs were assessed and people were provided a service according to their level of priority and placed on a waiting list. People told us that it was a "marvellous place to come to" and said staff were "amazing" and that they "hadn't waited very long" to access the service.

People had an assessment which included their contact details, medical history, current illness, physical and psychological issues which included people's coping strategies. People attended day therapy once a week for up to a three month period. We observed that people's care and treatments were planned and delivered in line with their individual care/action plan. The information contained within the assessment enabled staff to support people's individual needs. Staff who delivered hospice at home care told us they had available all the information needed for their role. Staff told us that it was very important to have details of people's history as it provided them with all the "information needed to do their job" and also it helped them to "chat" with people.

The seven records we read detailed what care and support was needed and how it should be given. We noted the care/action plans were linked to the initial assessment which identified people's anxiety and concerns. The assessment of wellbeing tool was used to assess people's thoughts when accessing day therapy. People were asked to assess if they had these thoughts; never, rarely sometimes and frequently which enabled staff to support people at an appropriate level. We noted staff approached people courteously and with respect. People we spoke with at the hospice told us they were involved in the paperwork and were able to discuss anything with their assigned key worker. People had a review of their needs after six weeks which looked at their care/action plans and a further review prior to discharge. The records showed the care/action plans were regularly reviewed and updated. We found the care plans we read ensured the rights of the individuals to take informed risks were addressed. The seven records we read detailed

what care and support was needed and how it should be given. We saw comprehensive risk assessments in place which identified the hazards and the support required. We found the risk assessments provided comprehensive guidelines for staff to follow. This meant that staff had the relevant information to understand and meet people's needs.

The hospice had a range of complementary therapies for example, reflexology, reiki and massages. We saw a collage which had been created by people who use the service and the local junior school. The head of care informed us that pupils from the school and people who attended the hospice worked closely together and the experience had provided a good insight to pupils about hospice care. On the day of our visit the staff had arranged a carol service during people's lunch time and we saw people singing and appearing to enjoy the entertainment.

Day therapy staff completed a de-brief handover twice a day. The morning handover meeting identified who was looking after whom and discussed the needs of people who were visiting for the day. The afternoon handover highlighted how people had got on throughout the day. The volunteers who worked at the hospice attended a morning meeting which identified any specific information for example, a person who may have mobility issues.

The records for those who used "hospice at home" service included the referral completed by the health care professional, which outlined people's personal details, medical condition and care needs. Care plans and risk assessments were in place and were implemented and updated by the district nurse. Staff told us that if they had any concerns they would contact the relevant people for example, families, district nurses. Staff said they wrote the daily recordings in the nursing notes but if there relevant changes to people's welfare, they would also notify the hospice who would update people's daily recordings.

The hospice was currently undertaking a six month research project in conjunction with Cambridge and Manchester Universities. The "carer support needs assessment" booklet had been sent to the carers of people who use the service. Staff we spoke with said that the results of the research and the information from the carers would help them with providing the support required by carers.

There were arrangements in place to deal with foreseeable emergencies. We saw the provider had a fire procedure policy which included emergency evacuation. The training schedule identified staff had completed their fire training and staff we spoke with said they had regular fire safety tests.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

We found that people visited a clean and tidy environment. There were systems in place to monitor the control of infection and the cleanliness of the hospice together with procedures regarding the control of substances hazardous to health (COSHH).

There were effective systems in place to reduce the risk and spread of infection. We walked around the building with the head of care and found the hospice to be clean and tidy. The provider had policies and procedures for the control of infection with guidelines in place for hand washing techniques. The policy identified and provided staff with clear guidelines on how to manage an outbreak of infection and the handling and disposal of clinical waste. The hospice at home staff we spoke with were informative regarding the use of personal protective equipment (PPE) such as disposable gloves and aprons.

We visited the kitchen and this was clean, tidy and well ordered. We saw that the provider had recently received a "premises intervention report" from Stroud District Council. We noted the areas inspected were the kitchens within the hospice. The report identified the provider's "compliance with food hygiene and safety procedures" and "confidence in management/control procedures." We noted the report looked at infectious disease control and cross-contamination/temperature control. We saw the action required and noted that the issues identified had been dealt with. We were informed the provider had maintained the highest food hygiene rating of five which we saw on display in the kitchen.

There were daily and weekly cleaning tasks in place which included for example, the mopping of floors and the polishing of hard surfaces. We noted these had been completed by staff and reviewed by management. Food probe and fridge and freezer temperatures were recorded daily. The kitchen had on display colour coded guidelines for the use of chopping boards. Overall this meant the provider had in place suitable arrangements to ensure that people employed were supported in relation to their knowledge to enable them to maintain a hygienic environment.

We observed the bathrooms and toilets were clean and well-presented. We observed the fridges were clean and tidy. People's risk assessments and care plans, if applicable, identified the risk of infection and provided guidelines for staff to follow. We were informed

it was the responsibility of staff to clean the hoists/wheelchairs/baths after use to ensure their cleanliness. We observed staff cleaning wheelchairs after use to ensure their cleanliness. The contamination and the disposal of waste contract were up to date. This meant there were effective operating systems in place to assess the risk and to prevent, detect and control the spread of infection within the hospice.

The provider had a water and legionella policy and we saw water temperature checks had been regularly completed. The hospice used the facility of external launderers and only carried out the laundry of small items for example, pillow cases used in the therapy rooms. Staff we spoke with informed us they were aware of the different coloured clinical bags and the use of personal protective equipment (PPE). Overall, this meant that the provider had
systems and procedures in place to assess the risk of and to prevent, detect and control the spread of infection within the hospice.

We saw the provider had a control of substances hazardous to health (COSHH) policy. We found that there were appropriate storage of chemicals and cleaning materials with all behind locked doors. Staff had completed COSHH training and the COSHH folder had guidelines for staff to follow. The records we read had data sheets on each product currently in use which had been regularly reviewed. We observed there were no risk assessments in place for the products currently in use. The health and safety officer informed us they were aware of the shortfall and were in the process of constructing risk assessments which would identify the hazard and the outcomes required.

The provider had in place an annual infection control audit which looked at twelve areas for example, policies and procedures, hand hygiene and the cleanliness of "patient areas" and clinical rooms. The findings identified that a percentage of 95.7% was achieved in the cleanliness of the patient area and the clinical rooms. Overall, the analysis identified a range of 80.7% to 94.1% over the twelve areas. An action plan was identified for areas of development for example, the instillation of alcohol gel dispensers which we saw as having been completed. This meant the provider had systems in place to ensure that staff were able to carry out their role effectively.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We saw the records of ten staff members, five from the hospice day therapy team and five from hospice at home team.

The provider had an induction programmes in place which included a "departmental induction" which incorporated; values and strategic objectives, ethos, confidentiality and code of conduct, and a "role specific induction" programme which incorporated infection control and the use of personal protective equipment (PPE), fire procedures and the management of medicines. Staff who were employed to provide hospice at home care attended a three day "hospice at home induction programme" which included for example, lone working. We saw the induction followed a case study to support staff through the principles of palliative and end of life care. Staff were given a "palliative care competencies" booklet which they completed alongside their induction programme. The booklet was divided into three sections. Section one looked at "core competencies" for example, clinical practice which incorporated the "principles and practices of palliative care" and the "potential impact of bereavement on relatives and carers" as well as communication needs. Section two of the booklet covered staffs "personal learning and development plan" which outlined the competencies to be achieved and the agreed action plan. Section three was a "reflection on the practice" and looked at what staff did or didn't do well and what steps they could take to "make those improvements." Staff informed us they were assigned a mentor who supported and guided them until they were deemed competent to support people who use the service.

We saw the rota took into account work life balance. Hospice at home staff told us they worked four days on and four days off and had "time to spend with their families."

The provider had a rolling training programme and we saw that training for 2014 had been identified. The records showed that staff training was up to date with staff having covered a variety of topics including moving and handling and food hygiene as well as additional training for example, palliative care, stress awareness and person centred care. We were informed that some refresher training was provided via e-learning which included the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act.

We looked at ten staff records, five from the hospice and five from "hospice at home." We noted that all staff within the hospice had received six monthly reviews but only one staff was identified as having a six monthly review within the hospice at home team. The head of care informed us they were aware of the shortfall and had recently had a "clinical supervision meeting" and were in discussion regarding the way forward. We saw a copy of the minutes which looked at "suggested routes for supervision" for example, whether to conduct group supervisions or to use an external agency. The records read identified staff completing and "appraisee preparation form" which asked them to reflect on for example, "what you consider as your strengths". We saw the form had been followed by a review with management. Topics covered included; communication skills and quality of work which identified objectives and actions. Staff we spoke with confirmed they had received appraisals and new staff said they had met with their mentor during their induction period. Staff said that the chief executive had an "open door policy" and they were able to "discuss anything."

Staff meetings took place regularly to discuss any concerns. Topics discussed centred around the people who use the service. The chief executive informed us they also had an open house policy at staff meetings to discuss any other related concern. Staff we spoke with told us they were aware of the minutes of the staff meeting and the actions identified. This meant the provider had suitable arrangements in place to ensure that staff received appropriate training, professional development, supervisions and appraisals.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We found that the provider had appropriate quality assurance monitoring procedures in place which ensured that the provider had asked the views of people regarding the service .
The provider had a three year audit/survey programme which outlined the areas to be covered and the implementation dates. We saw that the following had been completed the health and safety and the infection control audits and also the complaints policy had been updated. We saw audits/surveys in place for 2014 which included consent to share information and a "user feedback survey."

We saw the last provider visit which looked at the premises and complaints. The provider also conducted interviews with people who use the hospice and staff. Feedback from people were positive with the only concerns identified being the use of the word "hospice" and its perception.

We noted the incidents; accidents and complaints policies outlined the procedures to follow. We saw the "your comments matter" brochure which outlined how to make a complaint. People and staff we spoke with said they knew how to make and complaint and had no issues in doing so. Staff informed us that the manager had an "open door" policy for any issues or concerns. The chief executive told us they reviewed all complaints and we saw in place three monthly reports which outlined the accidents, incidents and complaints. The chief executive told us they collated all the quarterly reviews and submitted an annual review to the board which reported the trends for example, the number of personal accidents, clinical incidents, fire incidents and any violence/abuse. We noted complaints were completed in line with company policy. The accident report log and the incident report log included details of the accident/incident, the treatment given and the action taken.

The chief executive showed us a "learning from our mistakes or being blamed for them" leaflet they had produced. The chief executive informed us they gave a copy to staff and would discuss the merits of the leaflet with staff personally. The leaflet identified what staff should do in the event of identifying an error/mistake and how they company did not have

a blame culture but supported staff in learning from the errors.

We saw compliments received which included "my counselling sessions have been so helpful" and how they "helped me cope with my grief." We saw a thank you to staff for being "pleasant, king and caring."

The provider completed a review of staff turnover which included an overview of staff retention and the reasons for staff leaving. The overview identified a reduction of lost staff down from 24% to 20% over the last three years. This was attributed to improved management practices around recruitment and skills.

We saw the provider held monthly meetings with staff which covered a variety of topics for example, competency framework, absence procedures and training.

We noted the hospice certificates and risk assessments had been regularly reviewed for example, cuts and bruises, slips and falls, electrical certificates. We saw the health and safety records covered emergency evacuation procedures. We noted that the fire alarm checks had been regularly tested. Overall, this meant the provider had systems and procedures in place to assess the quality of the service provided.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

The hospice had systems in place to monitor, review and update people's records.

We looked at the daily recordings of people's records and found the entries to be comprehensive. Each person had an allocated key worker who co-ordinated their care and acted as a point of contact for them. Each time people attended for day therapy they would spend time with their key worker who would later record the discussion they had about the person's well-being. We looked at four records from day therapy and found all had been fully completed. We looked at three records from hospice at home and found all had the completed forms showing people's personal details for example medical and care details. This meant that the provider had systems in place to ensure the appropriate care and treatment of people who used the service

There was a medicine policy in place which outlined the procedure for administering medicines. People attending the hospice for a day service usually managed their own medicines but in some circumstances it was necessary for staff to assist them. People had a self-medicine assessment record with regard to the taking of medicines. The hospice had secure storage for medicines brought into the service with arrangements in place for "controlled drugs." This meant that the provider had systems in place regarding the management of medicines.

The provider reviewed the quality of the service which included care plans, supervisions, medicines and the premises. Hospice staff received six monthly reviews and management informed us they were currently reviewing the clinical supervision reviews for hospice at home staff. Staff we spoke with confirmed they received reviews and annual appraisals. The staff records we looked at had all the relevant information for example application forms, signed contracts and enhanced Disclosure and Barring Service check (DBS).

The provider had in place a rolling training programme and we saw in place identified training for 2014. Staff confirmed they had received training as well additional training for example, end of life care.

The provider had a complaints policy. We looked at the complaints records and found that

all complaints had been completed in line with company policy. Staff and relatives we spoke with said they would be able to make a complaint if necessary. People who use the day therapy service us told us should they have any issues or concerns they would "speak with their key worker." The provider had in place accidents and incidents recording sheets. We saw that all accident/incidents had been addressed with identified outcomes. Staff told us that any concerns were written in the daily recordings.

Records were found to be stored securely. The provider had policies and procedures relating to the transmission of patient information which provided guidelines for staff in the use of fax machines. The confidentiality policy provided guidance to staff for example, confidential information should only be "passed on when it is necessary to avoid harm to the patient."

The hospice had a storage and destruction policy in place for maintaining records which provided guidelines to staff regarding computerised held records, the completion of daily records and the destruction of records.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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