Inspection Report

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

Tripletrees

70 Ferndale Road, Burgess Hill, RH15 0HD

Tel: 01444243054

Date of Inspection: 12 June 2013

Date of Publication: July 2013

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Follett Care Limited
Registered Manager	Mrs. Mary Follett
Overview of the service	Tripletrees is a care home that provides care for up to 28 older people, some of who have dementia. The service provides long term placements as well as short term care. Accommodation is presented across two floors with a shaft lift providing access to the first floor. All rooms provide toilet en-suite facilities. A shaft lift provides level access to some parts of the upper floors.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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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 12 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by other regulators or the Department of Health. We reviewed information sent to us by other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We used a number of different methods to help us understand the experiences of people who used the service. This was because some people had complex needs which meant they were not always able to tell us about their experiences themselves. We spoke with three staff, four relatives and a health care professional, and we read documents and records held at the service.

Our observations showed that people were treated in a kind and respectful way by staff. They were given choices about their meals and what activities they would like to participate in. We saw many positive interactions between staff and people who lived at the service, which resulted in people showing signs of being relaxed in the company of staff and enjoying the interaction. Staff responded to people's needs promptly and were knowledgeable about peoples individual needs.

There were 23 people who lived at the service at the time of our inspection who had a wide range of needs, including some people who had complex physical and dementia care needs. People consistently told us that they liked living at Tripletrees and said that this was because it had a relaxed, friendly atmosphere and it was a comfortable place to live. One person told us "Love it here, I can do what I want when I want". They also told us that they felt safe and that they liked the food.

Relatives spoke positively about their experiences at the service and how the service cared for their relative. They told us how attentive staff were and how well staff knew and understood the needs of their relative. A relative told us "Although the environment could do with a lick of paint the care here is excellent".

People who lived the service told us they felt staff knew what they were doing, and that they had the skills to meet their support needs. However, not all staff had undertaken the necessary training in order to help ensure that they are able to work safely with people.

There was not a process in place to ensure that people consented to their care or had their capacity assessed to be able to consent. Not all records were being maintained to protected people from the risks of unsafe or inappropriate care and treatment.

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 30 July 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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There was not suitable arrangements in place for obtaining, and acting in accordance with the consent of people who used the service in relation to the care and treatment.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We observed informal consent being sought on numerous occasions from people who used the service. For example, we saw that staff asked people for their permission before they helped them with an activity or with personal care. We observed medication being administered, where consent was sought by the staff member who explained what the medication was and the benefits of taking it. People gave their consent to the treatment being provided by the visiting health care professional. Staff were clear about the importance of giving people all the information necessary and time to make their own decisions.

We found that none of the care plans, which identified the care and treatment needs of people, were signed by the person or their representative to indicate their agreement and consent to its contents and their planned care and treatment. It was therefore not possible to evidence if people had been involved in this process.

Where people did not have the capacity to consent there were no suitable arrangements in place for ensuring that decisions about their care and treatment were made in their best interests by relevant people. We were told that many people who lived at the service had dementia or dementia type symptoms. For some people this meant that they were not able to sign their care plan as a sign of their valid consent to the day to day care and support they received. There was no process in place to assess people's capacity to consent to help ensure that their rights were being protected and to identify the level of decisions people could make about their care and treatment.

This meant that some people may have had significant decisions made about them by others which impacted on their safety and freedom. For example a person was sitting in a type of chair that they were unable to get out of independently, which therefore restricted

their movements. We were told that the decision to use this chair was based on discussions with their representatives and the chair was obtained in order to support their posture. However there was no record of how this decision had been made in order to establish that this was in the best interests of the person as they we were told that they would not able to consent themselves.

Staff told us that they have not undertaken training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and were unaware of the procedures that should be followed if people did not have capacity to consent or decisions about their care and treatment. This meant that people were at potential risk of their rights not being protected.

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

People who lived at the service had a wide range of needs that included people who had complex dementia and physical needs. Staff told us that many people had lived at the service for some considerable time and whose needs had become more complex since they first moved to the service. We were able to see that this had enabled people to develop close relationships both with one another and with the staff. It is the service's policy for people to remain at the service during end of live care with support from District nurses. A health care professional told us how well the service had recently supported a person during their end of life care with sensitivity and dignity.

People consistently told us that they liked living at Tripletrees and said that this was because it had a relaxed, friendly atmosphere and it was a comfortable place to live. One person told us "Love it here, I can do what I want when I want". Some people who lived at the service did not use verbal forms of communication. Observation showed that some people used single words and some sentences. Other people had their own communication style which used body language, facial expressions. We saw that staff clearly understood and responded to these individual forms of communication. People we observed showed relaxed body language and enjoyed interacting with staff.

Relatives consistently spoke positively about their experiences at the service and how the service cared for their relative. They told us how attentive staff were and how well staff knew and understood the needs of their relative. A sample of their comments included: "Although the environment could do with a lick of paint the care here is excellent", "staff are all so very caring there is always several staff around to ask for assistance and they all know what is going on with my mum" and "In the short space of time mum has been here I am really impressed. The staff have really got to know mum and what she needs, she does not want for anything".

People's needs were assessed and care was planned and delivered in line with their individual care plan. Documents seen showed that people who were considering moving to the service had an assessment of their needs, prior to moving to the home. This helped to identify whether their needs could be met by living at the service. The assessment involved obtaining information from various sources that included the person, their

relatives and various health care professionals. This information was then used to create an initial care plan. This helped staff become aware of the person's basic needs when they first arrived at the service. A person who had recently moved to the service told us how well supported they had felt and that their move had been a positive experience.

Staff were clear on how they needed to support each person in line with their individual care plans. Staff were knowledgeable about the individual preferences of people and we observed that staff used different ways to communicate with people in order to help orientate them to time and place.

Care and treatment was planned and delivered in a way that generally ensured people's safety and welfare. People who used the service were assessed for potential risks they faced and posed. Mobility assessments were in place that identified any assistance, aids or equipment that people needed to ensure they moved about the service safely and to minimise the risk of falls. The provider way wish to note that there was no risk assessment process in place to identify the potential risks of people who had diabetes. This meant that there was no guidance for staff to follow where they were expected to manage people's diabetic needs.

People's health care needs were being met. Records showed that people were supported by a range of health care professionals including GP's, dentists, opticians, district and specialist nurses and chiropodists. A health care professional and relative told us that staff always sought prompt medical advice and assistance. A health care professional told us that staff always followed medical advice or any instructions they provided. They told us that staff cared for the people at the service "very well". A relative told us "Staff that have accompanied mum to appointments are very caring and have been able to answer any queries from medical staff about mum's health". We saw records of most people's monthly weight, which showed that the majority of people maintained or slightly gained weight over the previous few months. We were told that the purchase of new sit on scales would in future enable non weight bearing people to also be weighed regularly.

There was evidence in care and activity plans that people who lived at the service had their welfare and wellbeing promoted because the service took account of their mental and social care needs. We were told that two activity co-ordinators were employed for several hours across the week. Activities that people told us about or that we saw records for included games, crafts, beauty therapy and visiting musical entertainers. We saw how much people enjoyed participating in singing to music they recognised which was being played. A relative told us that there was "always something going on" and how much their relative enjoyed the one to one involvement of the activities coordinators. The service was preparing for a forthcoming BBQ where relatives had been invited.

There were arrangements in place to deal with foreseeable emergencies. Staff told us the service had contingency plans in place for people in case their health needs changed. For example the service had information prepared for people if they needed to transfer to hospital in an emergency and this was confirmed by people's records.

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

People were provided with a choice of suitable and nutritious food and drink. We saw people being offered and provided with regular drinks and snacks throughout the course of our inspections.

We observed the main meal of the day being served at lunch time. We received consistent positive feedback about the food from people who lived at the service and they described their meal as "wonderful" "lovely" and "delicious". Meals were well presented with people's individual preferences being catered for and reflected any medical requirements such as diabetes. Menus and records of meals showed that a range of meals were provided. A person told us that although there was one choice of main meal each day if they did not like the main option there was a list of alternatives that were always available. We saw that people were offered alternatives when their body language or actions indicated that they did not like the food item they were being served.

Relatives told us that they are invited to stay for meals. A relative told us that they frequently did and commented "very nice home cooked food, it always looks really nice, I have eaten here a couple of times and it's always good".

The meal time was very busy with the majority of people eating their meals in the dining room. This meant that the room was crowded which made it difficult for staff to move around easily and had to support people to eat their meals whilst standing up. This was because there was no room for them to sit down next to the people they were supporting. Staff were observed being very attentive to people who needed support and prompted them to eat their meals. However the provider may wish to note that staff were not always able to support people to eat their meals in a dignified way. This is because staff were seen supporting several people at once who were seated on different tables, which was not conductive to aid orientation or a relaxed environment. We observed that people were given time to eat their meal.

We were told that whilst a cook was being recruited, meals were cooked by additional senior staff on duty who had undertaken the relevant food safety training. Staff told us that the menus had been discussed with a dietician to help promote a balanced and nutritious menu.

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 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.

Reasons for our judgement

We saw that staff used safe ways of working, for example, when they assisted people who lived at the service to mobilise and move around the home. People were observed to be content and at ease with staff. Staff's approach towards people was respectful and supportive. Staff spoke fondly about the people they were supporting and it was clear from observation that professional bonds existed with some staff and people who lived at the service. We observed that some people sought out staff for some affection such as hand holding.

People told us that they felt safe. A relative told us "I have only ever seen residents treated with the upmost respect from staff". People and carers told us that they felt confident to raise any concerns they had with staff and felt that this would be dealt with promptly

We saw written policies that covered safeguarding and whistle blowing and were available for staff to reference. These made clear the vulnerability of people who used services and the duty of staff to report any concerns to the responsible authority for investigation. Staff in charge in the absence of the manager knew what to do to report concerns regarding any suspected abusive practices to the appropriate authority for investigation. Staff had not yet received formal training in safeguarding vulnerable adults, but confirmed that they had undergone such training in their previous employment.

Staff confirmed that they have worked collaboratively with the local authority to implement safeguarding plans in the past to protect people from complex relationship issues between relatives.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not always cared for by staff that were trained to deliver care and treatment safely and to an appropriate standard.

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 who lived the service told us they felt staff knew what they were doing and that they had the skills to meet their support needs. A relative told us that staff "were very skilled at what they did." Another relative told us how understanding and patient staff were towards people who had dementia. A health care professional told us that senior staff were knowledgeable and skilled at supporting people who had complex needs, for example during end of life care.

We found that not all staff had received appropriate training which reflected their job role and the needs of people who lived at the service, in order to ensure that all staff were equipped to be able to work with people safely. Staff told us they had not attended much training in the last 12 months. Records reflected this and showed that not all staff were trained in key areas such as safeguarding, health and safety, fire safety, first aid, food hygiene and the MCA 2005 and DoLS. Without this training people may be at risk of inappropriate and unsafe care.

Some specialist training had been provided in accordance with people's needs for example insulin monitoring, which had been provided by District nurses. Senior staff had completed medication training in order to enable them to administer medicines safely. We were told that some staff held oversees nursing qualifications and many held National Vocation Qualifications (NVQ) in care, where many topics such as dementia care were included. However no specialist training had been made available for the whole staff team to help ensure that the specialist needs of people who lived at the service including those people who had dementia, Parkinson's disease and diabetes were able to be met in a safe and consistently way.

Staff meetings and supervision sessions gave staff an opportunity to talk through any issues of concern about their role, or about the people they provided care and support to. We saw there were systems in place to provide support to staff, as staff told us they received regular supervision which enabled them to discuss any concerns. Staff said that they felt well supported by management to undertake their roles and felt able to approach

them for advice and guidance.

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 in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

The service had an informal quality assurance and monitoring system in place that was based on seeking the views of people who lived at the service, their representatives and staff that monitored and influenced services and facilities. Reviews of some people's care and treatment at the service had been held annually or after they have moved into the service. These were held with the funding authorities, the person and their relatives and provided a forum for seeking feedback on the person's individual experiences. Staff gave us examples of how this has changed some aspects of peoples care and support, for example in relation to the persons daily routines, diet and occupations. Staff told us and records showed that peoples' care plans were reviewed monthly to identify any changes in people's needs. This would then influence any changes to the services for example through staff deployment where a person needs had increased

Relatives told us that they were frequently asked if everything was "ok" and if there was anything that could be improved. A relative told us they had discussed with the management suggestions around their relatives care and how practices were changed to include their feedback. People who lived at the service told us that they felt confident to share with management any feedback they had at any time. They told us how they had suggested different activities and meal options and how this had been adopted. The provider may wish to note that there was currently no system in place to regularly audit the services processes for example the record keeping of activities or training undertaken in order to ensure that these were kept up to date and accurate.

The safety of people who lived at the service was being promoted through the monitoring of maintenance and equipment, which included fire safety and accident monitoring. Recorded incidents and accidents showed that these were investigated and actions taken to minimise risks and any improvements made where identified. Records shows that all of the necessary servicing and testing of health and safety equipment had been undertaken. Systems were in place to support fire safety, which included: regular fire alarms and emergency lighting checks, and maintenance of fire equipment and fire drills had been undertaken.

The registered manager was temporarily not in day to day management of the service, this role had been delegated to the deputy manager. Staff and relatives were clear however about the reporting structure and spoke positively about the management of the service consistently saying how approachable management were.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

At our last inspection on the 29 January 2013 we were concerned that the provider did not have up to date policies in place in order to guide staff on the practices at the service. Following the inspection the provider sent us an action plan of how they would address this, which included the development of new policies and procedures for the service. During this inspection we saw that this had been implemented and was now operational.

We saw that records were stored securely. When records were needed they were accessed and returned to their secure storage promptly. A staff member told us that that staff were particularly careful with care records when there were visitors in the home as it would not be appropriate for them to see other people's confidential information.

People's personal records including medical records were not always accurate in order for the service to evidence the care and support being provided. We looked at the care plans for five of the people who lived at the service. We noted an example whereby there was contradictory information across various records. A persons 'wall chart' displayed in their bedroom stated "two hourly turns" and "mouth care" to be undertaken. However this was not noted in their care plan or a record maintained of when it was being undertaken in order to evidence that these care needs were being addressed. Through observations and talking to staff it was apparent that these instructions were being undertaken and therefore the person was not placed at risk, however the service could not evidence this or that these instructions were being undertaken in a consistent way.

We noted examples of poor recording in care plans which placed people at potential risk of unsafe and consistent care and support. For example one care plan simply noted a person as "aggressive". Although in discussion with staff on duty they told us what this meant and what the person's triggers were, there was no explanation or guidance for staff as to what this term meant and how to manage any behaviour in a safe and consistent way. It was recorded that a person liked listening to the radio as their main form of stimulus while they were immobile. However there was no guidance for staff as to the specifics of this to ensure that this was being implemented in accordance with this need.

A person was noted to have Parkinson's disease, their care plan although noted this, staff made reference to the person's greatly fluctuating needs due the nature of their disease. There was no guidance for staff regarding this to ensure that their needs could be met consistently.

Not all records relevant to the management of the service were accurate and fit for purpose. This was because the fire risk assessment was basic in detail, for example it did not assess the potential risks that we noted during the course of the inspection. This is in reference to there being no clear guidance for staff on the management of keys for an emergency exit located through a person's bedroom. We were told that this door had just been accidentally locked by domestic staff. There was no record of the arrangements in place to effectively manage keys and to ensure that this would not occur again.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The registered person must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them. Regulation 18
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Suitable arrangements are not in place to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately trained in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard. Regulation 23 (1) (a)
Regulated activity	Regulation

This section is primarily information for the provider

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: Service users are not protected against the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. Regulation 20 (1)(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 30 July 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. 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.

Contact us

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