Inspection Report

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

BMI The Princess Margaret Hospital

Osborne Road, Windsor, SL4 3SJ

Tel: 01753743434

Date of Inspection: 02 October 2013

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

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
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard

Details about this location

Registered Provider	BMI Healthcare Limited
Registered Manager	Mr. Paul McPartlan
Overview of the service	BMI The Princess Margaret Hospital is an independent hospital offering both inpatient and outpatient services.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 2 October 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, reviewed information given to us by the provider and took advice from our specialist advisors. We were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed all the information we have gathered about BMI The Princess Margaret Hospital.

What people told us and what we found

The focus of this inspection was the experience of patients who use the location for surgical outcomes. This included pre-admission procedures, the medical imaging department, operating theatres and the surgical nursing wards.

Patients we spoke with during the inspection confirmed they had individual treatment and care plans. One person we spoke with commented, "I had detailed discussions about my care with my consultant and I have found this very reassuring". The second patient we spoke with said, "My doctor explained the operation I was going to have before surgery, came to see me after and we discussed the care I would need after the operation". Care documentation we reviewed confirmed patients had risk assessments and treatment plans tailored to their individual needs.

Staff we spoke with in the operating theatre and ward were knowledgeable about the fasting procedure and we saw this was adequately explained to patients who underwent surgery on the day of the inspection. Nursing staff on the wards followed the surgeons' and anaesthetists' instructions about when patients could recommence oral intake. Sufficient assessment was completed by nursing staff to determine that patients could take food and fluid once again.

The provider responded appropriately to any allegation of abuse. In the surgical wards, we observed there was signage available in staff stations about how to raise safeguarding matters. This included signs and symptoms to be aware of regarding abuse in adults and children, and who to contact both internally and externally in the event that abuse was

suspected. The provider had named nurses, midwives and doctors available on site or via bleeper in the event that a safeguarding case needed to be raised.

We spoke to patients about medications in the surgical wards and patients had positive comments. One person told us they had their medications explained to them by the doctor. They said, "My consultant told me about the risk and benefits of taking the medicines". Another person we spoke with said they understand potential effects that the medication may have had. They told us, "I am aware of the side effects of my medication".

In the wards, we spoke to the nurses about how the staffing was organised. We spoke to five nurses in the wards, all of whom felt there were sufficient levels of staff at all times. All of the nurses we spoke with told us they were never short staffed and only on rare occasions were agency nurses required. The nurses told us staffing was based on dependency and acuity of patient's needs.

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

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 patient's safety and welfare.

Reasons for our judgement

Patients we spoke with during the inspection confirmed they had individual treatment and care plans. One person we spoke with commented, "I had detailed discussions about my care with my consultant and I have found this very reassuring". The second patient we spoke with said, "My doctor explained the operation I was going to have before surgery, came to see me after and we discussed the care I would need after the operation". Patients we spoke with were confident about their care and their stay. One patient said, "I have a named nurse and we have had discussions about my care". Another told us, "I have been in the hospital for three days and the doctors and nurses review my care each day ". We looked at four care plans and saw these were individualised, comprehensive and related to the reason for the patients' admissions. We saw nurses had recorded detailed daily progress notes for each patient.

The care and welfare of patients during examinations and investigations in the medical imaging department at BMI The Princess Margaret Hospital was in line with statutory requirements on patient safety and relevant professional and other guidance. We saw there was a framework for patient safety in place including a radiation safety policy, annual radiation protection committee, risk and governance committee and clear lines of accountability from executive director to front line staff. Roles and responsibilities were defined and included contracted provision of an expert radiation protection adviser (RPA) and medical physics expert (MPE). Referral, authorisation and optimisation of imaging exposures were subject to written procedures and were reflected in day to day practice. Patient doses of radiation were subject to set diagnostic reference levels and equipment commissioning, critical examination and maintenance were also satisfactory. All imaging examinations were reported to other consultants or GPs and it was confirmed there was no backlog of 'unreported' images. We observed that practices and procedures ensured patients and staff were exposed to safe limits of radiation.

Care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare. We saw patients undergoing day procedures were cared for using a clinical pathway for ambulatory care where possible. For patients who had

endoscopy procedures, a separate specified care pathway was used. The care plans included pre-admission checks by nursing and anaesthetic staff, risk analysis of pre-existing medical conditions and admission and pre-operative checklists. This ensured people's safety, especially after they had received sedation which affected their level of consciousness and ability to respond.

Patients care and treatment reflected relevant research and guidance. We observed the use of the World Health Organisation's surgical safety checklist (WHO Checklist) and the application of the National Patient Safety Agency (NPSA) 5 steps to safer surgery in the operating theatres. All operating theatres use these patient safety tools to ensure that patients receive the correct surgery to the correct part of their body. Before the operating list started the whole team had a team brief or 'huddle' designed to enhance team-work and safety to the patient by being fully prepared for all elements of surgery and anaesthetics. We saw the surgical team discussed the list order, patient details, confirmed surgical and anaesthetic procedures, patient positioning, instrumentation and whether company representative surgical assistant would be required. This ensured the whole surgical team was informed about the necessary information for each theatre case and helped prevent errors.

At each stage of a patient's operation, checks were completed to ensure patient safety. Before the operation started the anaesthetic and surgical teams went through a series of core safety checks which for example included patient identification, correct surgical site, whether the patient had any allergies, estimated blood loss, and deep vein thrombosis prophylaxis. During the operating list we saw evidence of effective coordinated team-work whilst positioning the patient for surgery and transferring the patient to and from the operating table.

There were arrangements in place to deal with foreseeable emergencies. We inspected the provider's arrangements for dealing with emergencies in the surgical wards and in the operating theatres. We observed that the resuscitation equipment was present, easily accessible and had been checked on the morning of the inspection in all areas. We saw a documented log of daily checks which showed that checks at least every 24 hours was routine practice. We inspected minutes of a recent staff meeting in the operating theatre which documented that the requirement for checking the equipment was once per week, but the provider decided to continue with daily checks in order for staff to maintain familiarity with the equipment. In the event of a resuscitation attempt, this could potentially reduce delays.

We saw on the resuscitation and defibrillator trolley there were laminated copies of the resuscitation council algorithms for adult and paediatric emergencies. The emergency drugs were in line with resuscitation guidelines and within their expiry dates. We were told by staff that the emergency call bell in the post-anaesthetic care unit (recovery) had been checked on the morning of the inspection and we were shown a log that indicated it was checked on a daily basis. The provider may find it useful to note that the Department of Health, Health Building Note (HBN) 26 recommends a wall-mounted push-button emergency call with re-set and indicator lamp should also be located in each anaesthetic and operating room, linked to the recovery unit and the staff rest area.

In the wards, we saw nurses recorded patients' vital signs following surgery against the national early warning score (NEWS) observation chart. The tool prompted the nurses to increase the frequency of observations or seek medical review if a patient's scores were outside the expected range indicated by different staged colour coding. This ensured that the early deterioration of a patient's condition was more likely to be detected by the nursing

staff or health care assistants and prevented emergencies on the surgical ward.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Prior to surgery, patients were fasted to ensure that the risk of vomiting or regurgitation during or after their anaesthetic was reduced. Staff told us patients were asked not to eat solid food for six hours or more before their operation. We saw patients were however permitted to drink clear fluids, such as plain water up to two hours prior to their surgery in order to limit the effects of dehydration. Patients undergoing long or complex procedures had an intravenous cannula inserted and IV fluids ordered, administered and monitored by operating theatre and ward staff until they were able to commence drinking and then eating.

Patients' safety was considered when patients were fasted for surgery. Surgical staff told us that it was standard operating procedure to schedule surgery on patients with diabetes first on the list, in order to help control blood glucose in patients when they were nil by mouth. The operating theatre staff also communicated with the ward where there were delays in operating lists, so that patients could be offered sips of water to help prevent dehydration. We saw the fasting procedure was dependent on individual surgeons' and anaesthetists' preferences. The provider may find it useful to note that there was not a consistent fasting policy or procedure in place across the various wards of the location. We spoke to the registered manager about this, who told us the location was about to commence a trial of an enhanced recovery programme in the near future. The manager told us this involved patients taking high carbohydrate drinks prior to surgery in order to assist with their post-anaesthetic recovery.

Staff we spoke with in the operating theatre and ward were knowledgeable about the fasting procedure and we saw this was adequately explained to patients who underwent surgery on the day of the inspection. Nursing staff on the wards followed the surgeons' and anaesthetists' instructions about when patients could re-commence oral intake. Sufficient assessment was completed by nursing staff to determine that patients could take food and fluid once again. Once patients had started eating and drinking again following surgery, patients were supported to be able to eat and drink sufficient amounts to meet their needs. For patients who experience nausea or vomiting following surgery, nursing staff administered medications (as ordered) to alleviate these symptoms and to enable patients to feel they could take food and drink. Patients were not discharged home if they were day patients unless they had successfully had something to eat and drink prior to discharge.

Patients were provided with a choice of suitable and nutritious food and drink. Patients we

spoke with were complimentary about the food provided during their inpatient stay. One patient told us, "The meals are very good and we have many choices". Another person we spoke with commented, "I was surprised by the good standard of the meals, as you hear so many bad things about hospital food". One person we talked with told us about the range of choices available, "A three course meal is on offer every day which includes soup as a starter". A fourth person we spoke with told us they were able to pick and choose from the available menu, depending on how they felt. They said, "The meals are enjoyable, hot and portion sizes are commendable. I chose sandwiches for lunch one day and that was not a problem".

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.

Patients 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

Patients 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. One person we spoke with told us they were given a welcome pack by the hospital prior to or upon admission and this included information about the hospital complaints procedure and what action to take if they were concerned in any way. Other patients we spoke with confirmed that they were also given welcome packs and had information about how to raise concerns. One person we spoke with raised concerns with us and we passed these onto the registered manager, who was already aware. The manager advised us that the provider had already commenced an investigation into the person's concerns.

The provider responded appropriately to any allegation of abuse. In the surgical wards, we observed there was signage available in staff stations about how to raise safeguarding matters. This included signs and symptoms to be aware of regarding abuse in adults and children, and who to contact both internally and externally in the event that abuse was suspected. The provider had named nurses, midwives and doctors available on site or via bleeper in the event that a safeguarding case needed to be raised. One nurse we spoke with was familiar with the internal procedures and explained that patients' safety was the first priority for the team that delivered care. They told us they would have no hesitation raising an alert and could show us the referral pathways available on the staff noticeboard. They told us they rarely had to use the referral mechanisms, but that all staff knew where they were and how to make referrals if needed.

Staff we spoke with in the operating theatres told us that amongst other policies, the safeguarding policy was available in hard copy and via the 'BMI learn' online training portal. We saw there were separate policies for children's and adults safeguarding available which were regularly reviewed for content and updated where needed. We inspected minutes of a recent staff meeting where the policy had been discussed with staff. We interviewed two staff that had recently joined the provider. They said they had both received mandatory training in safeguarding vulnerable adults and children.

The staff demonstrated they were knowledgeable about recognising signs of abuse, both

physical and psychological. They described how they would gather further information by speaking with colleagues and via 'BMI learn' and how to escalate concerns through the organisation. The provider showed us training statistics which demonstrated that at the date of the inspection, 87% of all staff were up to date with safeguarding adults training and 88% of staff were up to date with safeguarding children training. The provider also showed us a mandatory training matrix which demonstrated all staff were subject to adult and children's safeguarding training at a minimum of every two years.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

Patients were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We spoke to patients about medications in the surgical wards and patients had positive comments. One person told us they had their medications explained to them by the doctor. They said, "My consultant told me about the risk and benefits of taking the medicines". Another person we spoke with said they understand potential effects that the medication may have had. They told us, "I am aware of the side effects of my medication". Another person was complimentary about the way staff had informed them about their medication. The person said, "I am pleased with the explanation I was given about my medicines and this has made me feel comfortable about taking them". We observed a pharmacist discussing medications with a person who was to take them home following their discharge. When we spoke with the person later, they commented, "I am being discharged today and the pharmacist has explained how I should take my tablets".

Medicines were kept safely. In the operating theatres we inspected the anaesthetic rooms and recovery area. We saw the drug cupboards were adequate and lockable. Syringes and medicines prepared for use were labelled to reduce the risk of maladministration. We inspected the cupboards for expired drugs and found none. Whilst inspecting controlled drugs cupboards we found that the provider was reducing the risk of harm to patients by storing and using only low strength midazolam (a medicine used for conscious sedation), and this was in line with the recommendations of a National Patient Safety Agency (NPSA) alert. We found all of the prescription only medicine medical gas cylinders on the anaesthetic machines were within their expiry dates and the anaesthetic practitioners had an effective system of checking and recording the expiry dates. We saw the resuscitation drugs on the resuscitation trolley had tamper-evident seals.

Medicines were prescribed and given to patients appropriately. On the surgical wards, we saw surgeons and anaesthetists used the drug charts to order medications they wanted patients to have. We found nursing staff carefully followed the doctors' orders. On one ward, we observed two nurses preparing an intravenous infusion of antibiotics for one patient. When it was safe to do so, we asked the nurses what checks they had undertaken prior to preparing the medication. They advised they checked the order matched what they had prepared, they were administering the drug at the right time and they had prepared the medication according to manufacturer instructions. The nurses showed us the sources of information in the medication room they could refer to for advice if necessary. The

medication was checked independently by two staff and they also checked the patient did not have an allergy to the medicine before administering it.

Appropriate arrangements were in place in relation to obtaining medicines. The provider had an on-site pharmacy run by pharmacists at all times with the assistance of pharmacy technicians. We inspected the pharmacy and spoke with the staff. They had robust procedures in place to make sure that medications were appropriately obtained, stored and disposed of as necessary. Patients who were admitted to the hospital for surgery were encouraged to bring their own medications with them. Where they had forgotten to bring them, or were in short supply, the hospital pharmacy had the necessary stock to ensure that patients did not run out. The pharmacy also supplied controlled drugs, like morphine and fentanyl to the operating theatre and surgical wards. Adequate checks were completed to account for the high risk medicines. This included regular stock takes and audits to ensure the medicines were always accounted for. We saw the pharmacist provide instructions to a person who was dispensed medication, and the pharmacist ensured the person's safety by providing literature and advice for the person to take with them.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet patients' needs. We spoke to patients about the level of staffing at the location and they all gave us positive feedback. One patient said, "Staff are always available if you need assistance day or night". Another patient told us, "Following my operation I was very ill and the nurses had me under observation day and night for two full days". Patients we spoke felt there were sufficient staff available for their care in the surgical ward. For example, one patient commented, "I am of the opinion that the ward is well staffed, as they appeared not be rushed". The fourth patient we spoke with stated, "The care given by staff is excellent".

Staffing in radiology was observed to be satisfactory. We saw the department was well-led and had adequate staffing to ensure, at all times, patients were safe. The eight radiographers were satisfactorily trained and all registered with the Health and Care Professions Council (HCPC). We noted there was a competency framework in place and this was led by radiographer leads, for example, in mammography, CT and MRI, where those involved had a post-graduate diploma or other qualification. This ensured the safety of patients and others. We also saw records were kept of training and radiographers maintained their own continuing professional development portfolio.

In the wards, we spoke to the nurses about how the staffing was organised. We spoke to five nurses in the wards, all of whom felt there were sufficient levels of staff at all times. All of the nurses we spoke with told us they were never short staffed and only on rare occasions were agency nurses required. The nurses told us staffing was based on dependency and acuity of patient's needs. On one ward, a nurse we spoke with told us there was a "predictable" pattern for the staffing, and that on Thursdays each week a meeting was held to review the required staffing for the following week. Another nurse we spoke with indicated the staffing was always proactively managed by the staff. They said "This is an elective, acute surgical unit. We control what comes through the door. There are no unplanned admissions unless an agreement is reached between the operating theatres, there is bed space and nursing coverage".

We also spoke with the registered manager about how clinical staffing at the location was organised and managed. We were told that at any time, about 70% of the staff working directly with patients comprised registered nurses and the remaining staff were trained health care assistants. The registered manager also told us that when each clinical staff

member left their post, the director of nursing performed a position review prior to re-appointing the same type of staff member. This ensured that the skill mix was always kept in review prior to recruitment activity taking place. We saw clinical staff were supported by various other ancillary staff such as administration workers, domestics, catering workers, receptionists and porters. In the wards, we observed nurses and health care assistants spent the majority of their time assisting patients with their direct care needs, and the other workers performed tasks that complemented the nursing and care assistants to safely and effectively care for patients. When patients used their call bells, they were answered promptly without patients having to wait.

In the operating theatres, we found that the provider made a significant effort in recruiting and retaining the staff. Many of the staff we spoke to explained they had worked for BMI The Princess Margaret Hospital in excess of ten years. Some staff we talked with had been recruited from overseas and given the option of which area to work in; either anaesthetics, scrub or recovery. They told us they were then trained either in post or by external providers to be appropriately specialist skilled in their area. We inspected the policy for induction, health and safety induction checklist, new starter checklists and a comprehensive practical assessment log book. We saw evidence that mandatory training was being monitored by the organisation and there was an online learning system for staff called 'BMI learn'.

The Association for Perioperative Practice (AfPP) recommends that for each theatre, there should be one anaesthetic practitioner, two scrub staff, one circulating assistant and a minimum of one recovery practitioner. We found the recommended levels of staff in each theatre were being met. We were told that in the event of unexpected absence caused by staff sickness, the theatre management would risk assess the planned operating lists in terms of staff required, phone staffing agencies and check with other BMI providers that may be able to reallocate staff. Staff told us safety was paramount and a list would be cancelled if there wasn't enough staff to safely run the theatre session. The provider may find it useful to note that when four operating theatres were occupied, there were only three dedicated recovery practitioners. However, we saw that the operating department practitioner or anaesthetist could stay in the recovery area if needed to ensure patient safety. We raised this issue with the management team and they told us that they would review the staffing levels in recovery. They also told us a new staff member had recently been recruited to commence work in recovery.

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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