Inspection Report

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

Brandon House Nursing Home

140 Old Church Road, Bell Green, Coventry, CV6 7ED

Tel: 02476638602

Date of Inspection: 12 August 2013

Date of Publication: September 2013

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

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✖ Action needed
Cleanliness and infection control	✖ Action needed
Staffing	✖ Action needed
Supporting workers	✖ Action needed

Details about this location

Registered Provider	HC-One Limited
Registered Manager	Mrs. Zoe King
Overview of the service	Brandon House is registered to provide accommodation and nursing care for a maximum of 35 people. It provides a service for older people with dementia care needs.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 12 August 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 staff and talked with commissioners of services.

What people told us and what we found

Two inspectors visited Brandon House Nursing Home on 12 August 2013. The inspection was part of our annual inspection programme as well as to check concerns we had received about the service. The manager and deputy manager had left their positions in the three weeks prior to our visit. A manager from another home in the provider group had taken up the role of manager until a new manager had been appointed. They were being supported by the group's Quality Assurance Manager.

People at the home had very complex needs and were unable to tell us about their experiences. We closely observed the care provided to people and looked at associated records. We found there were improvements needed in all five of the standards we reviewed.

Care records were not always accurate and did not demonstrate that people's care and treatment needs were being effectively and safely managed. Action was not taken when it had been identified people had lost significant amounts of weight.

The service had to use a high level of agency staff as they did not have sufficient numbers of staff to cover all the shifts on the rota. We were concerned there were insufficient nursing staff to meet the needs of people at night.

Arrangements to minimise the risk of infection in the home were not always being followed by staff.

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

taken.

We have referred our findings to Local Authority: Commissioning. We will check to make sure that action is taken to meet the essential standards.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

When we visited Brandon House Nursing Home we spoke with the Acting Home Manager who had been in position for three weeks. They explained they were going to undertake an audit of all care plans for people living in the home as they had identified that care plans were not up to date. Care plans should provide staff with information about how to meet people's needs effectively and safely in a way people prefer. During our visit we looked at six people's care plans.

We saw people had an assessment of their needs and abilities prior to moving to Brandon House. The information obtained in these assessments informed the plan of care. For one person we saw the pre-admission assessment form detailed that they were allergic to eight different types of medication. The care plan stated that they had "no known allergies". This meant there was conflicting evidence which could result in that person being given medicines to which they were allergic.

We saw the evidence of risk assessment tools to identify any risks in areas such as falls, nutrition, mobility and pressure sores. We saw that where a risk had been identified the actions put in place to manage the risk were not up to date. One person's care plan stated they were able to walk small distances independently from their bed to their chair. A member of care staff told us, "X does not walk on their own – they would fall over. They need two staff to stand them and two staff to get them walking and stay with them."

Many people living at Brandon House had been identified as having poor skin integrity. They were at risk of developing pressure ulcers. Pressure ulcers are graded from one to four depending on the level of skin loss. Grade four pressure ulcers can be life threatening. At the time of our visit nursing and care staff we spoke with informed us there were eight people living in the home with pressure ulcers. The information provided by staff about the number of people with pressure ulcers did not tally with that held by managers. We asked

both nurses on duty about one person's pressure ulcer. Neither were aware of the condition of that person's pressure ulcer and whether it had deteriorated or improved. There was a lack of clarity around pressure area management within the home.

We saw the wound management plan for one person with a pressure ulcer stated that their dressing was to be changed every three days and documented. There were no records of any dressing changes to confirm they had been carried out in accordance with the plan. There were no records of the ulcer being assessed or monitored. The wound management plan said that staff were to ensure the person was sitting on a pro-pad high profile cushion. During our visit the person spent the majority of their time sitting in a chair in the lounge. There was no pro-pad cushion in place.

The risk assessment tool had identified another person as being at very high risk of developing pressure ulcers. We saw they slept on an alternating mattress at night to reduce the risk. On the day of our visit we observed this person was seated in a chair in their room for over five hours. There was no pressure relieving cushion in place.

We identified eight people who had lost between 2kg and 6 kg in weight within the last two months. There was minimal information in care plans to support what actions had been put in place when people had been identified as losing weight. For example there was no information about fortified drinks, food supplements or increasing calorie intake. There was no audit tool in place to monitor or analyse people's weights in the home. People's health and wellbeing can be compromised if weight loss is not swiftly identified and acted upon.

Topical medicines are those that are applied directly to the skin. We looked at the topical medication records for people to ensure they were being applied by care staff as directed. There were gaps in the records so we could not be sure topical medications were being applied to people's skin to prevent breakdown.

During our visit we observed three members of care staff attempt to assist one person to stand. They initially tried to pull the person up by their arms. One member of staff then grabbed the person by the waistband at the back of their trousers, and assisted by another staff member, they pulled the person to a standing position. We observed two staff pull another person up from their chair by using an "underarm" technique. Both these manual handling manoeuvres are not good practice and could result in injury to the health and wellbeing of the person being assisted to move.

We observed a person being transferred by a wheelchair which had only one footrest. The carer placed both feet on the one footrest. They then held the person's feet in place whilst trying to steer the wheelchair up the corridor. This practice was not safe to either the person being moved or the member of staff involved.

Meeting nutritional needs ✖ Action needed

Food and drink should meet people's individual dietary needs

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration.

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

Reasons for our judgement

During our visit we observed the lunch service on both floors.

On the first floor lunch was served in the lounge area. Three people sat at a table at the end of the lounge. Other people sat around the edges of the room. The area was cramped with people having to move around the food trolley and mobility aids. Six people required assistance to eat their lunch. This assistance was provided by three care staff and the nurse on duty. We saw that due to the lack of space, staff struggled to seat themselves in a comfortable position when supporting people. One staff member sat on a foot stool and was therefore on a level lower than the person they were assisting. After a while they stood up and continued to assist the person to eat from a standing position. This was not respectful to that person.

We later saw there was a pleasantly furnished dining room available on the first floor where tables could be laid. Staff we spoke with told us they did not use the dining room as there were not enough staff to cover the dining room, lounge and support people who chose to eat in their bedroom.

We observed people eating their lunch in the dining room on the ground floor. Three people were assisted to eat. People did not receive the full attention of staff. Staff talked to each other rather than the person they were supporting.

We saw that people were offered a choice of liver and onions, cheese and onion pastie or an omelette for lunch. The servings looked generous and people were offered second helpings. At 3.00pm we saw people were offered hot drinks with a selection of sandwiches, pastries and cakes.

We identified eight people living in the home who had lost a significant amount of weight in the previous eight weeks. The cook confirmed they were not informed of people who were losing weight, but fortified all meals prepared.

One person who had lost weight had spent most of the night before our visit awake. During our visit they were asleep in bed for much of the time. At lunch time their lunch of a cheese

sandwich and a packet of crisps was put by their bed. At 3.30pm it was still there. We looked at their fluid and food intake charts for that day. We saw they had not eaten any food and only taken 60 mls of fluids. We asked the cook if food was available during the night. They told us they were not asked to prepare anything, but food was available in the kitchen for care staff to prepare.

Everybody in the home was on food and fluid charts. One member of staff raised concerns with us about the accuracy of the charts. Another confirmed the charts were not completed immediately the food or fluid was taken. This meant we could not be sure the charts accurately reflected people's food and fluid intake.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance had not always been followed.

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

When we visited Brandon House we saw the communal areas were generally clean and there were no unpleasant odours. New washable flooring was being put down in the communal corridors on the day of our visit.

We looked at direct care areas such as bathrooms and communal toilets. In one bathroom we saw that whilst the fabric of the bathroom was clean, the hoist was stained on the side and required wiping. Dirty laundry was being stored in the bathroom. This meant people were being provided with personal care in proximity to dirty laundry.

In many bathrooms and toilets we saw the paper towel dispensers were empty. This did not support people in maintaining good hand hygiene. The acting manager sourced some paper towels from another home within the provider group during our visit.

We looked at the sluice room. The key to the sluice room was in the door which made it accessible to anybody in the home. This did not keep people safe. The sluice room was tidy and uncluttered, but there was no facility available to store and dry clean commode pots or urinals after they had been washed and disinfected. We were told nobody used this equipment in the home. However, in one person's care plan it was recorded they did use it. We noted there was a leak under the hand wash sink with a bucket underneath to catch the drips. Water was leaking under the door. We spoke with the maintenance person who told us they were not aware of the leak. They later confirmed to us the leak had been repaired.

We looked at people's bedrooms. We saw they were clean and there were no odours. We saw new linen on people's beds. Pillows and mattresses we looked at were clean.

People had en suite toilets and wash basins in their bedrooms. In one person's bathroom we saw a bag of dirty pads on the floor by their bin. In another person's room we saw a bucket half full of stale water under the wash basin. We were later informed this had been left by some decorators who had been working in the bathroom the previous week. Some

bathrooms contained mobility items such as walking frames and wheelchairs which made access difficult.

In one person's room we saw a jug of juice with a note to use by 11 August 2013. The juice was still available on 12 August 2013. In another person's room we saw a bottle of diluted juice on the top of their wardrobe. We could not be sure how long it had been there or whether it was still safe to drink.

We checked two slings and two slide sheets in the presence of a senior carer. All four were clean, stitching and seams were intact and manufacturer's instructions were legible for cleaning. They had all had been serviced within the last six months.

We saw there was a plentiful supply of personal protective equipment for staff such as plastic gloves and aprons. When our inspectors arrived at the home the door was opened by a member of staff wearing white plastic gloves and apron. This meant they had been delivering personal care to a person at the time of our arrival. Failing to remove their apron and gloves before leaving that person could lead to the spread of infection throughout the home.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a major 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

When we visited Brandon House Nursing Home we looked to see whether there were sufficient staff with the right knowledge, experience, qualifications and skills to support people. Care was provided over two floors in the home. At the time of our visit there were 31 people living at the home, two of which were in hospital. 18 people were cared for on the ground floor and 13 people on the first floor. We saw that people living there had high dependency needs. Three people who used the service required "one to one" support from staff. Funding for this was provided by local health services which provided extra staff to those employed directly by the service. This meant they were additional to the home's own staff complement.

The registered manager had resigned their position and left the service three weeks prior to our visit. The deputy manager had also left their position in that period. A manager from another home within the provider group had stepped in as Acting Home Manager. They had been in position for three weeks. The Quality Assurance Manager from the provider group was providing managerial support on a daily basis.

Prior to our visit we were aware a number of staff had recently left the home. At our visit we were told there were currently four nurses employed permanently, one of whom had recently tendered their resignation. There were 32 permanent care staff on full and part time hours. There were not enough permanent nursing or care staff to cover all the shifts. In the week before our visit the service had relied on agency staff to cover 200 hours on the rota. Rotas seen confirmed this level of agency cover.

We were told that during the day there was one nurse and four care staff on each floor from 8.00am to 8.00pm. From 8.00pm to 8.00am there were two carers on each floor and one nurse to cover both floors. We were concerned that due to the dependency levels of people within the home, there was insufficient nursing cover at night. One member of staff told us, "They used to have two nurses now they only have one for both floors. I don't think the care is safe, especially if there is an emergency such as a fall and everyone needs to assist." Another told us, "The situation has got worse. They want us to work alone sometimes but I cannot put my residents at risk. We've asked the agency but they are

struggling to find nurses to backfill." The Acting Home Manager told us the provider had given authority the previous week for an extra nurse to be put on the night rota. This had not yet been implemented.

We arrived for our visit at 7.30am. The nurse on night duty with responsibility for all 29 people in the home was an agency nurse. During the day there was one nurse on duty who was employed by the service. Agencies approached had been unable to provide a nurse to cover the day shift. The employed nurse had managed to secure another nurse to cover the day shift at 9.00pm the night before.

During our visit we saw there was one nurse and four to five care staff on the ground floor. We observed that people's needs were being met in an unrushed manner.

We saw there were three care staff on the first floor. One of those staff was only on the rota to work until 2.00pm. This meant that from 2.00pm until 8.00pm there were only two staff on the floor. There was an agency care worker who moved between floors to provide extra cover when needed during the day.

During the afternoon we observed a member of agency staff and a member of care staff from the ground floor were the only staff on the first floor. Each nursing and care staff were allowed a thirty minute break during the afternoon. The care staff on the first floor had taken their break at the same time. Staff from the ground floor had been moved up to cover their break. The nurse was not on the floor. One person became agitated because the agency worker was an unfamiliar face. The other member of care staff shouted across the room in an attempt to calm that person down. They were not able to physically approach the person as they were in the middle of providing support to another person at the time.

We were told four people on the first floor required the assistance of two members of staff when receiving personal care. If one of those people required personal care at a time when there were only two members of staff on the floor, there was nobody to observe the care needs of the other people or to respond to emergencies. There was a lack of leadership to organise staffing on the shift.

Most staff we spoke with expressed concerns about the level of staffing within the home. Comments we received included:

"There have been a lot of occasions when we haven't had four staff on the floor."

"It has only been the last couple of weeks we have had regular agency staff coming in."

"We have enough staff during the day. I feel we give good care."

"If you have good staff you can do it. There is not much interaction with people. There is no time anymore."

One member of staff we spoke with told us they did not feel there were enough staff to meet people's needs saying, "And that is in every aspect of the home. There are no domestic or laundry staff at weekends. Care staff are having to do laundry."

We spoke with the Acting Home Manager and the Quality Assurance Manager. They told us they were aware of staffing needs and had interviewed to fill the vacant nursing positions the previous week. Two nurses had been offered employment following those

interviews. An assessment of staffing levels was being completed to inform any further staff recruitment.

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.

The provider was not making suitable arrangements to ensure that staff were appropriately supported in relation to their responsibilities.

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

Reasons for our judgement

Staff we spoke with told us that new staff were starting to work in the home without an induction. One staff member told us, "When I first started we had a week's worth of shifts as induction and you weren't counted in the numbers on the floors. I haven't seen any new starters with any sort of induction. Some of them don't even have manual handling training. They would be used in the numbers but if they haven't got manual handling they would just be lounge watching. You would feel uneasy working with them because you weren't very confident in their abilities." Another member of staff we spoke with confirmed they had not received an induction despite requesting one. They had completed their manual handling training three weeks after commencing work at the home. Staff files we looked at for staff who had been employed in the last six months did not have any information about an induction period. New staff were not being supported with an induction into their new roles within the home.

Staff were being supported to gain further qualifications. Two staff we spoke with confirmed they were currently working towards National Vocational Qualifications in care at level 3. This would support staff in delivering effective care.

Staff we spoke with confirmed they had completed their mandatory training, most of which was completed on e-learning. We looked at an analysis of training completed by staff. We saw that in areas such as safeguarding, equality and diversity, infection control and emergency procedures over 80% of staff were up to date in their training. 65% of staff were up to date with 'safer people handling', 82% with manual handling, 65% with fire drills and 85% with emergency procedures.

Many people living at Brandon House had dementia, some with associated challenging behaviours. We saw e-learning training on dementia was available to staff in four parts. This training supported staff in developing their skills in interacting and communicating with people who had advanced dementia. Records demonstrated that 73% of staff had completed the introduction to dementia, and 53% had completed the part relating to understanding and resolving behaviours that challenge. Not all staff had completed the

training to provide them with the skills to meet the needs of those living in the home with dementia.

Staff told us they were not receiving regular supervision. One staff member told us, "I haven't for a long time. Not for about six months." Staff files did not evidence any supervision or clinical observations. Staff were not being provided with an opportunity to talk through any issues about their role, or about the people they provided care and support for.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010** **Meeting nutritional needs**
	How the regulation was not being met: People were not protected from the risks of inadequate nutrition and dehydration. Regulation 14 (1)(a)(b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Systems in place to maintain standards of cleanliness and prevent the spread of infection were not sufficient to protect people. Regulation 12 (1)(2)(c)(i)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met:

This section is primarily information for the provider

disease, disorder or injury	People's safety and welfare were at risk because the provider was not taking appropriate steps to ensure that there were sufficient numbers of staff at all times. Regulation 22
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers** **How the regulation was not being met:** Suitable arrangements were not in place to ensure that staff were appropriately supported to deliver care safely to an appropriate standard. Regulation 23(1)(2)

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 28 September 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.

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