Inspection Report

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

Kent & Canterbury Hospital

Trust Offices, Ethelbert Road, Canterbury, CT1 3NG

Tel: 01227866308

Date of Inspection: 13 March 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	East Kent Hospitals University NHS Foundation Trust
Overview of the service	Kent and Canterbury hospital is one of five hospital sites managed by East Kent Hospitals University NHS Foundation Trust. This is an acute hospital providing services to the general population of around 720,500 people in the South East Kent area.
Type of services	Acute services with overnight beds Ambulance service Blood and Transplant service Community healthcare service Community based services for people with mental health needs
Regulated activities	Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an 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 13 March 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

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.

What people told us and what we found

This inspection included visits to the following wards: Mount/McMaster, Harbledown, Invicta and Marlowe. We observed and talked with 30 patients and 11 relatives on the wards and spoke to 14 staff, including ward managers and junior doctors. Around half the patients we spoke with had reduced mental capacity, for example dementia or confusion, and needed additional support to understand their treatments and care in the hospital.

People told us the staff explained their treatment to them and gave them enough time to make a decision. One patient on Invicta ward told us "Doctors explain what they are about to do with my treatment, so I always know what's going on". All the staff we spoke to were aware of their responsibilities to support people to make decisions about their care and treatment. Some of the relatives told us that discharge planning was an area that needed some improvement as there was confusion about whether patients were ready to be discharged and what arrangements had been made for post discharge support.

The wards were very busy and active. Harbledown and Mount/McMaster had extra beds because of winter pressures such as seasonal infections. Staff, patients and visitors commented on how busy the staff were and some said they were short staffed but all the comments about the staff and the care were positive. Patients and relatives said the staff were friendly. One patient commented, "We have a laugh together which makes it more friendly."

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

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Before people had an operation or any invasive procedure their consent was always obtained. People said that they were given enough information to make a decision about their treatment. People said they were always asked for their consent before staff carried out treatments. A patient on Mount and McMaster ward said, "They talked to me before I signed the paper", and "They explained everything and spoke about the best options for me." Another patient said they understood what doctors and nurses were saying, "… because they put it in plain English." A patient on Marlowe ward told us "The staff are really good, they even draw pictures to explain things if you don't understand".

Records showed that where a patient had undergone a procedure this included completed consent forms signed by the patient and the doctor. The consent forms included information about the risks and benefits of the proposed procedure. This meant that patients were given information to enable them to make an informed choice about their treatment.

When treatment was urgently required consultants made the decision about what intervention and treatment was necessary in the person's best interest.

The nurses we spoke with on all the wards we inspected were aware of the Mental Capacity Act and how they could assess a patient's capacity to make decisions. Nurses told us that they monitored patients on a day to day basis to determine if they had capacity for less complex decisions. This would include the care they provided each day. Staff demonstrated an understanding that people's capacity sometimes fluctuated and that

capacity was determined for each specific decision. There was an abbreviated mental test (AMT) recommended for use by staff to determine the mental and cognitive ability of each patient. The AMT was completed by doctors, at the point of admission. Nurses said they often used the AMT completed by medical staff to help determine whether or not a further behavioural assessment was required. We found that these were used as the basis for mental capacity assessments. The nurses said that the documentation was sometimes missed out if they were short of time as they prioritised the patient care. This meant that staff were aware of their responsibilities to assess capacity but were relying on verbal reports between each other rather than the documentation available.

The trust carries out annual audits of implementation of the consent procedures which includes checking that people who do not have capacity have had the appropriate support to make a decision. Due to inconsistencies across the trust with the implementation of MCA, the trust increased the frequency of the audits to 6 monthly and increased the focus on the monitoring of MCA. The most recent audit was in November 2012 and the next one is planned for May 2013. The audit found that MCAs and best interest meetings were being carried out but not all the documentation was completed. The trust action plan included further monitoring and a review of the documentation with regard to MCA and best interest meetings.

There was a safeguarding practice nurse and a dementia specialist nurse who were available to offer staff advice where they had concerns about patients' wellbeing or their mental capacity. The safeguarding practice team had produced a new training package that focused on safeguarding vulnerable adults, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The type and depth of the training and how often it needed to be refreshed, was tailored to the different levels of staff. There was a programme of external training for clinical staff. A pocket sized card booklet of flow charts and guidance had been produced as a quick reference guide to safeguarding adults. This included guidance around Mental Capacity and Deprivation of Liberty Safeguards.

Records showed that there was a clear procedure for decisions about whether resuscitation was in a patient's interests or not. We looked at ten patients' records with DNAR (Do Not Attempt Resuscitation) forms in across all four wards. The notes for five of the patients included a DNAR form completed by a doctor, with the reason given for the decision clearly documented, as well as some discussions held with the patient's family about the need for the decision. The remaining notes showed some records of decisions being made and communicated to families but there were some gaps. Relatives we spoke to said that nursing staff and Doctors had spoken to them but we noted that this had not always been recorded. This meant that consultations were taking place but were not always written in the notes, so they could lead to inconsistencies in communication between hospital staff and families. The trust were aware of this from their audit and were addressing it through their action plan.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

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

Peoples' needs were assessed on admission to meet the individual needs of each patient. Assessments, treatment and observations were carried out routinely to make sure that any change in need was detected and acted upon.
Staff used a combination of paper records and an electronic system using a handset to record observations and updates on care and treatments. When observations were recorded using the electronic handset it automatically alerted staff if there was cause for concern. This meant that if the observations indicated that a patient needed medical attention staff would be able to respond quickly, as the information could be relayed immediately to doctors via their own handsets on the wards. The trust directors said that they were moving towards an electronic record system across the whole of the trust as it would allow staff to spend more time with patients.

People's care and treatment was planned with their involvement. People spoke very positively about the care and treatment they had received. A patient on Harbledown said, "…they have been absolutely brilliant to me."
Patients said they were given enough time to make decisions. "My condition and treatment has been explained to me both in medical terms and lay terms… My family were all with me…it was very sympathetic when I was told [about my condition]". Relatives on Harbledown told us that they discussed treatment options and acted in the best interests of patients who were frail and unable to fully understand what was happening. One patient on Marlowe ward said, "The nurses and doctors keep me informed", and another patient on Invicta ward said "The doctors and nurses are pretty good; they tell you if your treatment has changed".

We saw that the medical notes were comprehensive, and included safety checklists for specific procedures, such as endoscopy. This meant that staff would be able to provide consistent and safe care at all points of the patient's care provision. All of the nurses we spoke with were knowledgeable about the assessments they used to ascertain the physical and mental ability and needs of each patient.

Physiotherapists, dieticians, occupational therapists and speech and language therapists were involved with people's care. We were able to talk with a physiotherapist on Mount/McMaster and observed people being supported to maintain their mobility and independence. The physiotherapist told us how the multi-disciplinary team worked together to ensure that people were appropriately supported. We reviewed four sets of patient notes on this ward which documented the regular assessments completed by members of the multi-disciplinary team. These were used to determine the patient's suitability or fitness for discharge.

Staff said that discharge planning started as soon as the patient was admitted. The discharge date was estimated and then reviewed daily. People told us that staff explained how long they were expected to stay in hospital and talked to them about plans to go home. There was evidence of discharge planning or an expected discharge date in 16 of the 21 notes we reviewed, and we noted that other members of the multi-disciplinary team such as physiotherapists and occupational therapists updated the notes regularly with details of their assessments and treatments. We saw evidence of home assessments by occupational therapists (OT) in the notes of all the patients we reviewed. In one set of notes, we saw that the OT had arranged for a stair rail to be installed prior to discharge, to ensure the patient would have a safer environment at home. We found that in some of these notes, the information was discussed with the patients and relatives regularly, and in others, there were long gaps between discussions. We discussed this inconsistency in communication with the trust chief executive and senior managers. They told us that they had recognised this as an issue of concern for patients, and had started a pilot programme 'Tick it Home' on two wards to provide clearer and more precise information for patients about their discharge plan. We found evidence of this pilot on both of the wards, and patients and relatives we spoke with were aware of the information. This meant that the trust was aware that this was an area that needed improvement and had taken action to address it.

People who had chronic conditions had access to specialists from the community services (outreach services) whilst in hospital. There was an outreach nurse on the ward who told us that part of the outreach team's role was to educate people in managing their medical conditions at home or in a care setting. There was a clear referral process from the nursing staff to the outreach team and they routinely visited the ward to pick these referrals up. This meant that people were reassured and given the support they needed to maintain their health with the aim that they did not need to be readmitted to hospital unnecessarily.

A specialist dementia nurse, called a 'dementia champion', was based in the hospital. She offered training, advice and support to enable the staff to meet the diverse needs of people with dementia and confusion. A programme of more in depth training in dementia and delirium had been implemented and was ongoing for all staff. Staff on Harbledown ward said they found the training helpful in understanding how to talk to and support people with dementia. The provider may like to note that we saw two incidents where a doctor and nursing staff were not considerate to two patients with dementia on Harbledown. However, overall we observed an increased awareness in the staff of the needs of people with dementia across all the wards. This meant that people coming into hospital with dementia and confusion were receiving an improved quality of care to meet their needs.

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 people's needs.

Reasons for our judgement

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

One patient on Marlowe told us "The staff here are great, I have absolute confidence in all of them". A relative said "The staff take the time to talk to you and explain what is going on". All staff always introduce themselves.

We spoke with two nurses and a physiotherapist on Harbledown ward, and two nurses on McMaster/Mount ward, and they told us that they enjoyed working on the wards, but that staffing levels could sometimes be a concern. The nurses on all wards we inspected said that there were usually vacancies on each shift, but these were mostly filled by staff who had worked on the wards before. Relatives on Harbledown said that the staff are really good but there are not enough of them. They seemed to be pulled in all directions. One relative said we help where we can, for instance, they supervise the patient taking their pills because they need more time than the nurses have available. On Mount/McMaster ward, patients said they did not feel they had to wait long for a nurse to come.

Patients said that staff were friendly and helpful. A patient on Mount/McMaster ward commented, "The girls are lovely and have a laugh with the patients." Another patient commented, "I'm feeling well cared for if I ask for something" Patients told us they did not have to wait long if they used the call buzzer. One said "They come quickly and explain if they are with a patient."

Staffing levels were assessed and agreed using recognised assessment tools and national guidance. We discussed the rotas with the ward managers who explained how their staffing levels were managed. There had been some sickness amongst some of the staff teams in the last few weeks and the wards were also unusually busy with the increased cold weather and the impact of other external situations. Some of the wards had been closed due to the norovirus so there were extra beds on Harbledown and Mount/ McMaster and some staff were off work due to the norovirus. The ward managers had been able to cover the sickness with agency staff or ward staff working additional hours. Ward managers had allocated time each week when they were supernumerary to carry out management tasks but when needed they worked on the wards to cover. This meant that despite the increased demand and sickness the impact of shortages were minimised. A

patient on this ward said, "Yes they do not rush it and are very patient." The provider may like to note that on Mount/McMaster and Harbledown wards we observed that the staff were busy and some of the call buzzers sounded for some time before being answered. This meant that patients were not always receiving care in a timely way but there was no evidence to indicate that patients were at risk.

We observed care being given on all the wards we visited, and found that on Marlowe and Invicta wards the call buzzers were answered promptly, and that nurses responded quickly when patients requested help. We spoke with a nurse on Marlowe ward, and two nurses on Invicta ward, and they all told us that although the wards could be busy at times, there were usually enough staff to ensure that all the needs of the patient were met.

We reviewed the nursing assessments, and found that there were some gaps in the two-hourly checklists used by nurses to document their checks on each patient. The provider might find it useful to note that the nurses we spoke with all told us that sometimes they were unable to complete all of their paperwork during a busy shift. This meant that the most up to date information about a patient's condition was not always available. The trust directors said that it was their intention to resolve this by moving to electronic recording, which would take less time. They have also found in other services in the trust that using electronic records means that communication between departments is faster and more efficient.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

We spoke with eight patients and four relatives across three wards, and observed care being given to patients in two wards. One patient told us "The nurses are good listeners; I've been able to tell them what I think of my stay here". Another patient said "The staff always ask me how I've been treated each day". One patient told us she had filled in a survey about her stay at the hospital.

We spoke with two nurses on both Invicta and Marlowe wards, who told us that they asked patients daily what they thought of the care they had received, and if they had any complaints. All the nurses we spoke with were aware of the mechanisms by which patients and relatives could feedback to the hospital, including surveys, patient representatives, and comment cards. This meant that patients were given the opportunity to raise any concerns.

The trust has been working on the 'We Care' programme that was launched last summer. This is a project that includes all staff, visitors and patients. There were posters and a variety of methods and opportunities to give feedback on people's experiences that included completing surveys and writing comments on noticeboards. People's experiences have been collated and there have been a series of meetings for patients and staff, to enable people to have discussions and give further feedback. We saw the documented outcomes of the meetings which included the main themes of what people thought the hospitals did well and what the priorities for improvement were. This, and the general feedback from compliments and complaints were being analysed and an action plan was being designed to address all the issues raised. Further meetings were scheduled in this ongoing process. For example, recent patient complaints about discharge planning were being addressed via the Tick it Home pilot on two wards, with plans to roll out the programme across the trust. This meant that the trust was getting a clear picture of strengths to build on as well as areas that needed improvement.

We requested and received specific information on clinical incidents logged at the hospital, and how the senior management responded to these incidents. We reviewed minutes from the most recent risk management and governance group meetings, which met monthly to discuss clinical incidents, health and safety and the corporate risk register. We found that incidents were reported appropriately. The trust senior management team told us that there were a variety of methods through which staff could learn from incidents and complaints, including patient videos (with the patient's consent), team meetings, and the hospital online information system. We spoke with ward nurses who confirmed that they discussed incidents in team meetings, as well as any identified actions to take to ensure the incident was not repeated. For example, the trust recently introduced a new procedure for identifying the safe positioning of naso-gastric tubes, which nurses told us was relayed to staff via the online information system.

We spoke with ward managers who told us that they had started using a new system of recording a number of criteria, including complaints, falls, infection rates and staff roster efficiency. They could also compare their ward's performance with other wards across the whole of the trust. This helped them to identify areas where performance was not up to standard, and to target measures for improvement, for example, monitoring and amending the electronic roster to ensure appropriate skill mix and staff complement to meet the needs of the patients. We saw evidence of this data displayed on ward noticeboards. This meant that the standards of care and treatment in the hospital were being monitored at ward level and overseen by the directors so that they had a clear picture of what was working well and what needed to be improved.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs.

We saw that information leaflets about complaints were available on every ward we inspected. The leaflets provided a variety of information for patients and relatives, including an explanation of the complaints process, how to contact the relevant organisations including the Patient Experience Team (PET), expected timescales for response to a complaint, and how to access independent organisations for mediation and advocacy services. The leaflets were available in a variety of languages and formats, including large print and Braille. This meant that patients and visitors were provided with sufficient information on how to make a complaint and what to expect when they did so. Some complaints were made directly to the ward managers or through the PET. This team was based in the hospital and offered confidential advice, support and information on health-related matters to both patients and families. Complaints were monitored for trends and for areas where improvements were needed.

All of the patients we spoke with did not have any complaints about the service they received as in-patients, but some told us that they were concerned about the communication of discharge arrangements. This was largely with regard to after care arrangements once they had left hospital, as some patients and relatives told us that they did not know what to expect when they got home. We noted that the trust had started the Tick it Home pilot scheme, to provide clearer and more precise information about discharge arrangements to patients and relatives. We saw evidence of the pilot by each patient's bed, and spoke with patients who understood what the pilot aims were.

Staff told us that it was part of the admission process to inform people that if they had any concerns they should speak to a member of staff or the ward manager. Some patients and relatives we spoke to were not aware of a formal complaints procedure, although we found folders containing useful information for patients including how to complain, by the beds. Some patients knew about the patient experience team, and all the patients told us that if they had a complaint they were happy to speak to a nurse or the ward manager. People said the staff were open and friendly. Staff said if patients were admitted when they were very ill then they did not always have the discussion about making complaints.

Relatives confirmed that this had happened but they had been given the information they needed at a later time. This meant that although some relatives did not know the complaints procedure they had been able to express their views and be listened to.

The ward managers said that they encouraged people to make complaints directly on the ward because it could be investigated and resolved more quickly and efficiently.

We spoke with three patients and one relative from two wards about complaints, and they all told us that they were happy with the service they had received from the hospital, and had no reason to make a complaint. One patient said "I've never had to complain here as the care is very good, but I know about the patient experience team". Another patient told us "I have no reason to complain; I couldn't have been better treated".

If a complaint was received the PET would request an investigation by the most appropriate staff and if a complaint was complex they supported staff on the ward by providing training and guidance. All complaints were responded to and followed up to see if something could be learned to prevent similar occurrences.

People who had made complaints were offered a meeting and could make a video which could be used in training. This meant that staff were able to understand a situation from the patient's point of view. The senior management team told us that fewer complaints now require the second stage of mediation, as a result.

We reviewed information about complaints received by the hospital, and found that 95 complaints were received in total over the previous six months. The areas most complained about were staff attitudes, delays to treatment and discharge arrangements. The chief executive and senior managers told us changes had been made as a result of the complaints, including the pilot to provide more information about discharge for patients, training programmes for staff in relation to customer service, and an increase in staffing and bed numbers to address the increased pressure on services. The trust also provided information on how complaints received were investigated, with audit findings which demonstrated that complaints received were mostly investigated appropriately, although some issues with communication of progress of the complaint investigation were highlighted. The trust's senior management team told us that the complaint process was being reviewed, to ensure that all complaints continued to be handled according to the trust's policy.

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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