Inspection Report

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

Ribbleton Hospital

Miller Road, Ribbleton, Preston, PR2 6LS

Tel: 01772695300

Date of Inspection: 26 November 2013

Date of Publication: December 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Lancashire Care NHS Foundation Trust
Overview of the service	Ribbleton hospital provides 32 mental health inpatient beds for adults and older adults within two wards, Grasmere and Wordsworth. The hospital is situated on the outskirts of Preston in Lancashire.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 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

We carried out this inspection to check whether Ribbleton Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Meeting nutritional needs
- Supporting workers
- Assessing and monitoring the quality of service provision

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

What people told us and what we found

We conducted this follow up inspection because we found improvements were needed following our inspection visit in February 2013. The trust had sent us an action plan, which told us the improvements they would make. Following the initial visit in February 2013 the trust closed (Coniston now Wordsworth ward) to make the improvements needed. We went back to Ribbleton hospital during this inspection to check on the improvements they said they would make. At this inspection we were accompanied by a specialist advisor (consultant psychiatrist) and an expert by experience.

All the people we spoke with said they were happy with the care provided. The expert by experience spoke with three family members who told us, "Her care has been excellent, I have been involved with the care plan and attended meetings. The doctor explains everything. We are both treated with great dignity", "We have little experience as my aunt was only admitted just over a week ago. They have been quite informative and phoned me a couple of times about her care. We are here for a CPA meeting" and "Staff could be more informative, but they have phoned up when there have been problems. His discharge arrangements have been discussed and I have been invited to meetings, but transport problems make this impractical. The service is quite good as a whole". Relatives were kept up to date with the care and support of their family member cared for on this ward.

We found staff were supported in their responsibilities to be able to deliver care and treatment to the patients. We spoke with three staff about being supported in their work. All of the staff we spoke with said they felt supported by the ward managers, modern matron and each other.

There were systems in place to monitor the quality and safety of the service. We found the trust had implemented improvements to the ward.

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 people's safety and welfare.

Reasons for our judgement

On our previous inspection in February 2013 of Ribbleton Hospital (Coniston ward) now re named Wordsworth unit, we found the provider had not taken proper steps to ensure that people using the service were protected against the risks of receiving inappropriate care and treatment. This was because the plans of care did not reflect the needs of people who used the service and the care plans and risk management plans we reviewed did not provide staff with any guidance on how individual assessed needs and identified risks should be managed or addressed. Following the inspection, the provider wrote to us and told us what action they were going to take.

All the people we spoke with and who could respond said they were happy with the care they were getting. One person told us, "I want to stay here. I don't want to go anywhere else".

We found that plans of care had improved significantly in detail. There was a clear pathway of how people were admitted, where they had been admitted from and any investigations completed prior to admission to the ward. This helped staff identify each person's needs and develop a care plan during the first 72 hours.

The plans of care contained significantly more details for staff to identify a person's needs and the action staff needed to take to help people reach a desired outcome. However, the provider may wish to note that the system remained cumbersome and details about a person's care or any risk assessments were held in different places. We identified three areas where a person's care may be recorded including the computer system, on paper care plans and in the dormitory records. This meant there was the potential for staff to record a problem on one system, which was not readily available for all staff to view and therefore people may be at risk their care is not up to date or suitable action taken to remedy the problem. For example - the recording of people's vital signs such as their blood pressure was recorded on the dormitory sheets. We saw that people had refused to have this done. We did not see how this was then transferred onto the main computer plan

and/or the arrangements made for any follow up action.

There were family care plans although it was recorded on one of the five plans we looked at that the family member had declined the offer of involvement. On the day of the inspection there was a meeting at which a family member attended where care and support was discussed. We also heard nurses talking to family members by telephone to update them on care and for one new admission the support that could be provided to them if they wished.

All the people admitted to the ward were on a mental health section and detained for treatment. We saw that, where possible, people had signed some of their documents including those indicating they had been told of their rights. Care plans and treatments were discussed at meetings where family members and people who used the service were invited to attend. The meetings were also attended by various grades of staff such as psychiatrists, doctors and nurses. This meant people who used the service and family members (where appropriate) were kept up to date with care issues and could make their wishes known.

Plans of care showed that people were able to access the advocacy service or be provided with an Independent Mental Health Advocate (IMHA). On the day of the inspection an advocate was on the ward to attend a meeting. This helped protect the rights and wishes of people who had limited mental understanding of their care.

There was a record of what mental health section each person was currently admitted on and paperwork had been completed following legal guidelines. During our visit we saw that the level of observation people were undergoing was dependent upon their condition and observed staff undertaking the observations. At all times during our inspection we saw that staff treated people with respect and compassion. There was a good rapport between staff and people who used the service.

There was a record of each persons mental capacity (their ability to make reasonable decisions) in the plans we looked at. There were records of where staff had made best interest decisions for people. This told staff what decisions people could make and help protect people's rights.

At the last inspection we found that bank staff did not have access to the computer based care plans and risk assessments. We observed bank staff using the system at this inspection. This meant all staff were able to access vital information.

There were daily records held on the computer system. The daily records showed staff recorded any incidents or positive aspects of people's care. We did not see how any problems highlighted were flagged to other members of staff but were told this would be at staff handover meetings or the multi-disciplinary team meetings.

Staff we spoke with said the care plan system was better but remained difficult to navigate.

There was a form for staff to complete for discharge planning. An occupational therapist told us, "I work on this ward from Monday to Friday. We liaise with local occupational teams for discharge planning to get everything in place before they leave here". Although we did not see a completed discharge record we did find evidence that suitable places were being sought for people on the ward. Staff from other organisations had visited to complete assessments but at the time of the inspection no discharge was planned.

We saw that doctors, dieticians, physiotherapists and occupational therapists assisted nursing staff to meet people's physical health needs. Evidence we saw included health checks, assistance with mobility problems and tests such as heart monitoring. However, not all staff seemed able to access the records due to the system.

We also found an examination room had been identified on the ward. However, this room had not been properly equipped to allow for the monitoring of complete physical health checks of patients.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We conducted this follow up inspection because we found improvements were needed following our scheduled inspection in February 2013. The trust had sent us an action plan informing us how they would make improvements. At the last inspection we found the majority of staff had not received any training in using the Malnutrition Universal Screening Tool (MUST). This a system used to highlight patient's nutritional needs. This meant that patients were not always protected from the risk of inadequate nutrition and dehydration if staff had not been trained in how to use this tool.

At this inspection some staff told us they had been trained to use the nutritional tool and other staff we spoke with said they were enrolled on a course. Bank staff told us they had the option to go on a course. The modern matron told us that if a person was scored (using the nutritional tool) as at risk of poor nutritional intake they were automatically provided with the services of a dietician. This helped ensure people took sufficient food and fluids.

All the people we spoke with said the food was good and that there was a good choice on offer. We saw that people had access to water or fruit juice to help keep them hydrated. Staff told us people could have a snack at any time if they wished, which helped keep people nourished if they had refused a meal. We saw that people had been weighed and nobody had lost weight whilst they were on the ward. Four of the five plans we examined showed people had gained weight. We observed two meals and saw staff bring people to the dining area in a calm manner. One person could not settle and was given food and drink suitable for a person 'on the go' to help them take sufficient nourishment. People were supported to be able to eat and drink sufficient amounts to meet their needs.

We reviewed an audit completed for each patient on the ward at the time. This told us that checks were in place to ensure information contained on the MUST and in relation to nutrition had been fully completed. It included checks on diet intake charts, nutritional care plan checks and it also checked that peoples weights had been recorded. This meant that that some checks were in place to ensure the MUST tool had been completed and nutritional intake was being monitored.

Plans of care highlighted any special dietary needs such as if patient's required a diabetic diet. This information was forwarded to the kitchen and suitable food was then provided for

people.

During mealtimes people sat in a suitable dining area. There was sufficient good quality furniture to enable all the people on the ward to sit as a group if they wished. One person chose to sit in another area and his choice was respected. We observed two meals being served and found there were two hot choices and other foods such as sandwiches. Although none of the people we observed needed assistance with feeding staff encouraged people individually and helped create a social atmosphere where the meal could be enjoyed.

The expert by experience sat in the dining area during lunch time. He told us, "Tables of four were set and each place setting had a napkin. There was a choice of two main courses and these were explained to each patient. The meals looked appetising, were hot and the day's choices were displayed and explained by staff. Each patient was offered a choice of soft drinks, tea or coffee. All patients were able to feed themselves although staff circulated checking that patients were eating and talked reassuringly. Patients all spoke positively about the food". People were provided with a choice of suitable and nutritious food and drink.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

On our previous inspection of Ribbleton Hospital on 4 February 2013, on Coniston ward now re named Wordsworth ward, we found the provider had not taken proper steps to ensure that staff had received the support they needed to enable them to deliver safe and effective care for people using the service.

Following the inspection, the provider wrote to us and told us what action they were going to take to ensure staff were appropriately supported in relation to their responsibilities to deliver care and treatment to people who accessed the hospital.

During this inspection we found the trust had introduced a formal supervision structure for all staff with an identified supervisor. We saw all staff had completed a portfolio before their selection interview, which meant the trust had selected staff on their suitability, experience, trust values and knowledge to meet the needs of people accessing this ward. We also found a competency framework was in place for staff.

We found staff had access to a ward based induction where staff signed to confirm they had received particular information about the ward. Staff were also required to further sign that they would notify the person in charge of any policies and procedures they were not aware of including equipment they were not familiar with. This meant staff had access to the ward induction and were provided with specific information about the wards expectations and the philosophy of care for people on the ward.

We also found staff had been provided with written, 'general instructions' which included the trust's expectations of staff whist they were on shift. We also found healthcare support workers and assistant practitioners had been informed of the new code of conduct and the minimum training standards. They had been given the opportunity to discuss how this would impact on their future roles.

The ward had introduced a 'team plan'; this was reviewed weekly and addressed vacant positions, staff support and training. It also told us that issues in relation to staff were being addressed and monitored with identified staff who were responsible for the monitoring of actions taken. We found that weekly team meetings were held on the ward. These meant

systems were in place to support staff and these were constantly being monitored by the trust.

We found staff had access to a training plan throughout the ward (toolbox training) where specific training topics had been delivered in hourly sessions for staff. We reviewed the training schedule (toolbox training) and some examples included introductory sessions about dementia, patient and carer experiences, mobility in dementia, and reducing some behaviour in dementia as well as meaningful activities and developing effective communication.

We found training dates had been planned to start in January 2014, where qualified staff and health care support workers had been identified for attendance. They would commence tailored training in relation to people who have a dementia type illness. The trust had planned to deliver training throughout 2014/2015 to forty identified staff. We also found evidence that staff had access to de briefing, drop in sessions where they could discuss issues relating to the management of violence and aggression as well as ward specific meetings to discuss management of violence and aggression and behaviours.

We reviewed the wards training record. Although most of the mandatory training had been completed by staff, the information governance and control and restraint or breakaway training had not been completed with any staff names recorded. The record also told us that there were gaps in other training we looked at. However, the ward had only been reopened since September 2013. We found the ward manager had identified staff who had been tasked with updating the ward staff training matrix and this had not been fully completed when we visited.

We found the trust had an inpatient ward improvement plan to monitor staff training and a quality assurance plan specific to the ward. This meant that staff were kept up to date about the ward governance and were aware of what was expected of them.

We spoke with a healthcare support worker and two qualified nurses as well as the modern matron in relation to this regulation. The nurses and healthcare support worker told us they felt supported and knew who provided their supervision. One staff member told us, "There are support systems in place for staff" and "Staffing has improved because the trust has reduced the patient numbers admitted on the ward". Other comments included, "It is now a pleasure getting up in the morning and coming to work", "We are still in the early stages of the ward reopening and the changes and support are good, we all help each other" and "I feel supported by the management on the ward and by other team members".

One staff member told us what their thoughts were about what they did well as a staff team. They told us, "Staff are welcoming, friendly and compassionate toward patients and we help each other out".

One staff member told us they had recently been identified to hold a key role on the ward so that they could develop their job role and disseminate information to staff and people who use the service as well as relatives. We saw staff had been identified as a responsible link person for events on the ward being organised, a walking aid assessor/falls link organiser, a student nurse link and a staff member who had been identified to oversee the preceptorship of new nursing staff. We also saw two staff members had been identified as family support nurses (patient and carer liaison).

Staff were provided with the opportunity to give feedback about the quality of services, by means of access to the NHS staff surveys, individual and group supervision and appraisal as well as team meetings. Staff also had access to a whistle blowing procedure should they wish to raise any concerns about the organisation anonymously or outside of their line management arrangements.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with two patients and three relatives on Wordsworth ward during our inspection; we also spoke with an advocate who visited the ward regularly. We asked their opinion of the overall quality of the care and service provided.

We found the trust had an internal complaints team (customer care team) which was responsible for managing any complaints received. We found that when a complaint was made the trust acknowledged the complaint and allocated a person to review and investigate the complaint. We were told during our engagement meetings with the trust that the chair of governors and the interim director of nursing had recently introduced a system of sampling complaints responded to by the trust. This was to ensure lessons could be learnt and improvements made when dealing with patient complaints.

We had also previously looked at the trust's quality account for 2012 to 2013 which documented the quality of their services delivered from April 2012 to March 2013 and sets out their priority areas for improvement for 2013 to 2014. This plan is available to the public, providing an overview of the services the trust provide and their performance for the previous year. It also provided an overview of systems being used to monitor and improve the services provided by the trust.

Information, also reviewed previously, told us that the process for overseeing the management of incidents and risks within the trust were fed into the clinical business unit risk management group and to the executive risk management committee who were also informed. Serious incidents were recorded on the datix system with associated action plans and lessons learnt fields completed. The information we reviewed told us that any serious incident investigations, where necessary, were escalated onto the trusts risk register which was monitored by the executive team.

We saw evidence that the trust had a clinical governance structure in place for all services provided by Lancashire Care NHS Foundation Trust. The governance systems used at this trust facilitated a continuous flow of information, from patients and frontline staff to managers and then senior managers and vice versa to ensure quality and safety was

monitored at all levels within the organisation. This structure was used to monitor, review and improve risk management as well as to review service development, performance management, workforce performance, development and policy implementation as well as service user experience. We found systems had been implemented to improve older adult mental health inpatient and community services. The trust were responding to emerging themes and trends by analysis of data collected as well as monitoring any action plans produced throughout the trust.

We saw minutes from the inpatient older adult mental health service improvement planning meetings. These told us that services were being reviewed by the trust to improve services for older adults who accessed inpatient services. We also reviewed the inpatient practice development group meetings specific to Ribbleton hospital. This meant that the trust had systems in place to oversee the management of this hospital and any actions required were monitored.

We saw pharmacist input had been provided on the ward we visited and incident reporting had been completed in relation to any drug errors and medicines management issues. The provider may find it useful to note that regular multidisciplinary audits of the use of psychotropic agents used on the wards had not been implemented. This would help to identify the indications of use, identifications of risk and benefits for patients and the capacity of patients to consent to their use as well as identifying side effects and management of these drugs. Also pharmacist input and their presence at the multidisciplinary team meetings (MDT) on the ward when reviewing patients could minimise potential risks associated with patients care and treatment.

We also found the trust had conducted an analysis of violence and aggression on Wordsworth unit, following an increase in reported incidents and safeguarding alerts. This meant that systems had been implemented to review the incident data and solutions had been made to minimise and reduce the incidents on this ward. One example of this was, the trust had reduced the number of admission beds to Wordsworth. We also found an environmental assessment/mapping based around dementia care had been completed. This identified areas on the ward where overall activity and meaningful engagement with patients had been reviewed. This meant the trust had taken action to review, monitor and change the service provision by identifying, assessing and managing the risks to protect patients who were admitted to this ward.

It was reported that audits were routine on the ward and undertaken at least on a weekly basis where this was overseen by the modern matron and monitored by the network governance and inpatient development group. Records we looked at told us the audits/checks completed included checks on patient safety profiles, health and social care needs, care plans, safeguarding, one to one time and family contact and support care plans. Also, checks were made to ensure arrangements had been made for the Care Programme Approach meetings (CPA) and for informing people of their rights under the Mental Health Act. We found following these checks the matron developed an action plan for ward staff to implement.

We found the ward manager had completed daily checks and weekly checks. These included checks on the incident reporting (datix), environmental checks, staffing checks including staff sickness and safe staffing issues, activities monitoring and service user and carer views. Other weekly checks included the monitoring of staff supervision, auditing records, Mental Health Act audits and ward meeting checks to meet agreed actions. These checks were used to monitor and improve services.

We saw evidence that incidents that happened on the ward and throughout the trust were reported through their incident reporting systems (datix). Information was provided and cascaded to teams and staff in relation to any lessons learnt from these incident reviews.

We previously looked at improvement plans developed to improve the electronic patient record systems being used (eCPA). Staff used the record to capture information about the patients and individuals to whom they provided a service to within older adult mental health services. We found that the trust had established a 'task and finish' group and plans were in place to improve the functionality of the system used. The provider may wish to note that although improvements were in place, the system used on this ward meant that pertinent information was difficult to access and find which posed a risk toward patients if information could not be easily accessed and found by staff.

We found patient and carers involvement initiatives had been implemented on the ward we visited. These included daily activities for patients and feedback sessions arranged for carers to access. These provided an opportunity for carers to speak with the modern matron and the 'carers' experience and involvement coordinator' with the aim of seeking feedback to improve care and treatment for patients and carers. We also found an introduction booklet had been produced, although still in draft, to provide information to patients and carers about their stay at Ribbleton hospital.

We asked patients and family members, had they been asked about their care and treatment. One patient told us, "I have not had any survey, they used to ask about how I was when I first came, but now they know how I feel". One relative we spoke with had completed a survey. We spoke with the modern matron on the ward about this and they told us they were reviewing the way they collect information and feedback from patients and families.

We found a weekly community/ inpatient meeting had been attended by ward managers and community managers to develop effective pathways for patients being discharged. This meant that patients being discharged from hospital and also their families should experience a more robust and effective discharge from hospital with community input arranged where needed before they leave hospital.

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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