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

Wokingham Community Hospital

Barkham Road, Wokingham, RG41 2RE

Date of Inspection: 19 February 2013  Date of Publication: March 2013

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

- Respecting and involving people who use services: Met this standard
- Care and welfare of people who use services: Met this standard
- Safeguarding people who use services from abuse: Met this standard
- Management of medicines: Met this standard
- Staffing: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Berkshire Healthcare NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Wokingham Community Hospital has two inpatient wards which provide nursing and therapy care for adults over the age of 18. A variety of services are also located at Wokingham Community Hospital. These include the Out of Hours GP Service, Intermediate Care service to prevent hospital admission and facilitate discharge for adults over the age of 16 years, Diabetic Eye Screening Service and Specialist Continence Service.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Community healthcare service</td>
</tr>
<tr>
<td></td>
<td>Doctors consultation service</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
</tr>
<tr>
<td>Regulated activity</td>
<td>Treatment of disease, disorder or injury</td>
</tr>
</tbody>
</table>
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’.

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of this inspection:</td>
<td></td>
</tr>
<tr>
<td>Why we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
<tr>
<td>Our judgements for each standard inspected:</td>
<td></td>
</tr>
<tr>
<td>Respecting and involving people who use services</td>
<td>6</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>8</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>10</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>11</td>
</tr>
<tr>
<td>Staffing</td>
<td>13</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>15</td>
</tr>
<tr>
<td>About CQC Inspections</td>
<td>17</td>
</tr>
<tr>
<td>How we define our judgements</td>
<td>18</td>
</tr>
<tr>
<td>Glossary of terms we use in this report</td>
<td>20</td>
</tr>
<tr>
<td>Contact us</td>
<td>22</td>
</tr>
</tbody>
</table>
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 19 February 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, reviewed information we asked the provider to send to us and were accompanied by a pharmacist.

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

What people told us and what we found

We inspected the two in patient wards of the hospital. We spoke with ten people who used the service, senior management staff, ward staff and completed a formal observation (SOFI). The observation took place in one of the six bedded bays over a one hour and ten minute period.

We found that people were involved in their treatment and care planning. They told us that no decisions were taken without their involvement and they were consulted "every step of the way". People told us that they had witnessed people with dementia being treated with "great respect and dignity".

We found that people were appropriately cared for. People told us that they were "very, very well looked after" and it "was the best hospital experience" they'd had.

We found that staff were appropriately trained and were knowledgeable about how to keep people safe. People told us that they felt "very safe" in the hospital and never had any concerns about the way they or others were treated.

We found that medicines were managed safely and people were given their medication appropriately.

We found that there were enough appropriately qualified staff on duty. People said that they felt there were "plenty" of staff to meet their needs. They told us that " there's always a nurse there to help you when you need them".

We found that the provider had ways of continually checking the quality of the care they
offered. People were involved in the quality checks.

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.
Respecting and involving people who use services  
Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who use the service understood the care and treatment choices available to them. People told us that they were consulted "every step of the way" with regard to their treatment plan. They said that they understood the treatment that was being given and could discuss issues with the doctor, consultant or nurses as appropriate.

People who use the service were given appropriate information and support regarding their care or treatment. In public areas there were displays of leaflets giving information about various aspects of care, such as Dementia, getting help for carers and information about other support for health costs and mobility.

People expressed their views and were involved in making decisions about their care and treatment. Senior ward staff told us that on the day of admission, a care plan would start to be developed with the person. This took into account their views and expectations for their stay and planning for their discharge home. We were told this plan may change day to day depending on people's needs and their ability to recover. Examples included a person who was ready to go home but had acquired a chest infection. The person described how staff had explained everything to them, called the doctor immediately and then changed their discharge plan. They told us that "staff explained all the changes to them". They said that they agreed to the new discharge plan. We saw four care records which showed that the person or their relative's views had been sought and contributed towards their care planning and discharge arrangements.

People told us that no decisions were taken without their involvement. We observed staff carefully explaining to people what they were going to do and why. They then checked whether the person had understood what they had been told. We saw people negotiating their care with the nurses and we saw that the nurses respected their choices, whilst keeping them safe. Examples included people wanting to dress independently even though they were not physically strong enough to stand unaided. Staff ensured that they
discreetly and sensitively offered enough assistance to keep people safe.

People were supported in promoting their independence. Both wards provided rehabilitation programmes to people, as appropriate. We saw people being encouraged and assisted to be as independent as possible. People told us that staff "let you do as much as you could for yourself, even if it does take a lot longer".

We saw staff treating people with consideration and respect. People's preferred names were noted on the information boards above their beds. We saw that staff sat with people and offered assistance to help them to eat their food, take drinks or medication. We saw staff speaking in quiet confidential tones to ensure that privacy and dignity was maintained at all times. Curtains were drawn around beds whenever individual treatments were given. There was a separate quiet room where people and their families could go to have private conversations. People told us that all staff at whatever level always respected their privacy and treated them with great respect. One person told us that they had witnessed staff treating people with dementia with "great dignity and respect".

People's diversity and human rights were respected. We looked at four care records which contained information about how people's diverse needs were met and how these were reflected in care plans. The information included details of their mobility, medical needs, dietary requirements and communication needs. Examples included staff seen communicating with people in different ways depending on their ability to understand and interact with them. We saw that when staff were assisting people to mobilise staff numbers and equipment varied depending on the individual's identified needs. One person told us that the hospital had been excellent in identifying the special requirements necessary because of their responsibilities as a full time carer. Training records showed that all staff had completed equality and diversity training.
Care and welfare of people who use services

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at four individual care records which were divided into sections for ease of use. Records were detailed and identified people's preferences and personal wishes. They included admission assessments, risk management, care planning and other professionals' input. People's notes were kept in two separate files, with care plans being kept at the person's bedside and other historical information (for example information from a previous hospital) kept in another file.

We saw that confidential computer based records that were kept for each patient. These included information about any treatment received, current and past care plans and medication used. Community nursing could access these records which would provide them with accurate and up to date information about that person's care.

All changes on the ward were communicated in a handover book which was given to each member of staff starting a new shift. We saw a current example of the handover book. Staff told us that it ensured that they knew what was happening, and that people were supported in the right way. At the end of each shift, a care evaluation was written up in the folder at the person's bed which they could read if they wished. People we spoke with told us or indicated that they knew where the notes were.

Two of the medical records we reviewed held the NHS 'Do not attempt cardio-pulmonary resuscitation' form. These had been completed correctly to show that the person or their next of kin had agreed with the medical decision.

Throughout the inspection and during the formal observation we saw that staff were interacting positively with people. Examples included one member of staff sitting with a person and helping them pack their belongings as they were leaving that afternoon. Staff continually checked up on people and asked them if they needed anything. They communicated with people whenever they entered the ward. We saw that some people, in the side rooms, had a copy of an "intentional rounding chart" which was a two hourly record of all the interactions staff had with them. People told us that "staff are always chatty and treat us very well". People said that they were "very, very well looked after". One person told us they had "enjoyed" the hospital experience "in as much as it is better
than any other hospital experience I've had”.

A local GP, who was retained as a medical consultant, visited the wards every morning and a specialist consultant visited twice a week. A full multidisciplinary meeting was held weekly on each ward. We saw this taking place in one of the wards on the day of our inspection. The hospital had advertised for a full time registrar to take up the duties the GP was currently providing.

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare. People were in looked after in either six or four bedded bays or in single rooms. We were told by staff that the single rooms were mainly used for people with specific needs. We saw that the care plan of one person who was being looked after in a side room reflected why this was required. We saw that a range of assessments were being used in order to identify risks to patient’s wellbeing such areas as falls, pressure areas, continence and behaviour. Examples included a risk assessment which had concluded that bed rails were the safest measure to prevent the person falling out of bed. We saw this person had signed an agreement for their use, and there was a daily record completed by staff which indicated when and why these had remained in use. People's weights were monitored and Malnutrition Universal Screening Tool (MUST) assessments were used. We saw that therapy plans were in place for people who needed intervention from a physiotherapist or occupational therapist.

There were arrangements in place to deal with foreseeable emergencies. During our observations we saw resuscitation equipment and trolleys containing items provided for use in an emergency located throughout the service. We saw that the equipment and supplies on the trolley had been checked and signed by staff each week.
Safeguarding people who use services from abuse  ✔  Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

The provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Training records showed that all staff had received raining with regard to the safeguarding of vulnerable adults and children. This training was up-dated approximately, every three years. Staff we spoke to had a good awareness of what constituted abuse and the reporting systems that were in place, should they suspect that abuse had occurred. They told us that they would have no concerns about contacting people outside the organisation, if necessary. People told us that they felt “very safe” in the hospital. They said that they had never had any concerns about how they or others were spoken to or treated.

Staff we spoke with had a good awareness of the rights of the people on the ward and the process they would follow if they thought a person lacked mental capacity. We saw one care record which showed a detailed assessment undertaken by the memory clinic to assess that person's mental state. A nursing sister told us that all qualified staff had completed Mental Capacity Act training and unqualified staff sought advice from colleagues, as necessary.

The provider responded appropriately to any allegation of abuse. One member of staff we spoke with demonstrated their understanding of safeguarding procedures. They described how they had dealt with a potential safeguarding issue.
Management of medicines

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We checked the medicines management arrangements in the two inpatient wards at this location.

We saw that medicines were stored safely and within the temperatures recommended by the manufacturers. The minimum and maximum temperatures of the fridge, which was used to store medicines, was monitored and recorded. This meant that there was a constant check to ensure medicines were kept at the required temperatures. The provider may find it useful to note that the room used to store non fridge medicines was a little warm and the temperature was not monitored. The nurse we spoke with told us that a thermometer would be obtained to address this.

Medicines were handled appropriately. We spoke to the senior nurses on duty on both wards. They both explained and confirmed the process used for pharmaceutical services to the ward.

Appropriate arrangements were in place in relation to obtaining medicine. Medicines were disposed of appropriately. Medicines orders, supplies and disposal were managed by another hospital pharmacy under an agreement. The arrangement allowed a pharmacist and a technician to visit the hospital regularly to check prescribed treatment and ensure supplies of medicines were available for people. All discharges from the hospital were planned well in advance so the required medicines to take home were ordered in time. On the odd unplanned self discharge, the services of the ‘out of hours’ doctors were employed. This meant that robust systems were in place to allow required treatment for the people using the service.

This location provided a rehabilitation service between acute units and moving back to the community setting. The provider may find it useful to note that people were not given the choice to manage their own medicines at this service. This meant that people were not supported to manage their own medicines which might be vital in their progress to independence.

Safe systems were in place to manage medicines. We checked the reports of all incidents and near misses over the last 12 months relating to medicines. We saw that corrective
action was taken by the service and any learning cascaded to ward level. This meant that the service was constantly improving their processes and addressed any gaps appropriately.

The nurses told us that there was very good support from the doctor, the consultant and the out of hours doctors. We saw records which showed that people saw a doctor when required.
Staffing

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

Met this standard

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. We looked at the records of nursing staff numbers on duty on each shift on the wards. There was a minimum of two trained nurses on duty on each day shift and at night. There was a minimum of three health care assistants (HCA) on the early shift, and two on the late and the night shifts. There was a modern matron who worked in a supernumerary capacity. The ward manager role was currently covered for two days a week by a member of staff from another locality. The senior staff members on the wards told us that they applied for additional staff if they admitted people with special needs. They gave an example of one to one staffing being provided for people who needed advanced dementia care. All staff we spoke with agreed that there were sufficient staff to meet the needs of the people using the service.

People told us that nurses were attentive to their needs and call bells were answered quickly. We saw the nurses going to help people without delay whenever a call bell rang. People said "there's always a nurse there to help you when you need them". They told us that call bells were answered as quickly during the night as during the day. People said that they felt there were "plenty" of staff to meet their needs. One person said "the staff here are excellent and they have helped me no end". Another said, "I have come in here before and found the care was fantastic".

Training records showed that staff received appropriate training. This included training in moving and handling, health and safety, dementia, and food hygiene. Staff were also provided with specific training such as conflict resolution and infection control. We saw that the central training department kept a current database of all staff training. When a training session was due for renewal they sent an email reminder to the member of staff and the ward manager. The provider may wish to note that these reminders were not always being coordinated at ward level. This meant that training was not being monitored at ward level and consequently may not be kept up to date to ensure effective patient care. We saw that there was always a qualified staff member overseeing the wards. People told us that staff "appeared to be very knowledgeable and knew what they were doing".

In addition to the nursing staff each ward employed a Physiotherapist, Occupational Therapist, two therapy technicians and a housekeeper. They were also supported by a
Tissue Viability Nurse (TVN) who was based with in the hospital and provided staff with expert advice on the prevention and treatment of pressure ulcers.

Cleaners were employed by a separate organisation but we were told by staff that they were part of the team and provided a valuable service. Nursing staff told us that there had been no issues over their standard of work. We saw that all areas of the hospital looked clean and hygienic. People told us that the wards were "exceptionally clean".

Medical cover was provided by the Community GP’s and the local out of hours GP service.
Assessing and monitoring the quality of service provision

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.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

The hospital had a detailed quality assurance system which operated at organisational and ward level.

The ward staff audited all aspects of treatment and care. Audits included daily skin checks, weekly pressure sores and weight check audits and monthly falls audits. Wards used a monthly chart system in which they placed crosses on the days when there were medication errors, falls, incidents or other issues. Senior ward staff told us that these had been publicly displayed along with the actions taken with regard to the crosses. The provider may find it useful to note that the publicly displayed daily/monthly audits had been removed and the ward staff were not sure why or if they were to be displayed in the future. This meant that patients were no longer able to easily access the day to day quality assurance system.

The organisation audited all ward records and held specific 'Patient safety and Quality Meetings'. These were held every month and were attended by senior management staff and senior nurses. The meeting minutes showed that actions plans were developed as a result of the various audits completed. Examples included how to manage clinical supervision when there was a shortage of experienced staff and increased reporting because of a small rise in the number of infections acquired by patients. The provider may find it useful to note that senior ward staff we spoke with were not always aware of how the information they fed up to senior management was used. They felt that it was not always used in a timely manner and the actions taken as a result of the information were not always fed back down. This meant that ward staff may not have felt fully involved in the decision making processes. They may not have fully understood or been committed to take the actions prescribed by senior management.

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. The hospital had a method of collecting people's views on a weekly basis and prior to discharge. People completed a
simple computerised question and answer survey, with help if necessary. During the inspection one patient was in the process of being discharged and we saw staff completing the questionnaire with them. The results of the surveys were looked at by 'head office' and the results fed back down to the ward via the matron. Ward staff told us that they used to display the results of surveys in the ward but this practice had stopped. The provider may find it useful to note that senior ward staff were unsure of why results were no longer displayed or how survey results would be communicated to them. This meant that ward staff were not aware of any actions they may need to take to improve the quality of service to people in their care. The Patient Safety and Quality Meeting minutes showed that the provider had taken action as a result of people's views. An example was that the organisation had provided 'end of life care' training for all staff. People told us that staff always listened to them and took action if they expressed any needs or had any concerns.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We found that ward staff were supported by consultants and specialist medical staff, as necessary. We saw that doctors and any other specialist staff signed and dated care and treatment plans, as appropriate.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. We saw that accidents and incidents were recorded and were reported using a computerised system. The information from these was gathered by the central governance team who would report on the details and outcomes to the ward manager and at the monthly senior managers meeting. We saw the minutes of the meetings where the incidents were monitored and any further actions agreed.

The provider took account of complaints and comments to improve the service. The hospital had a formal complaints procedure. The record of complaints showed that six complaints had been received since January 2012. Complaints were appropriately investigated, four had been upheld or partially upheld and two were still being dealt with. People told us that they knew how to complain if necessary.

The provider assessed risks to individuals which were included in their care and treatment records. They had generic health and Safety policy and procedures which were available 'on line'. The ward sister and staff followed all health and safety instructions examples included locking cupboards that contained substances hazardous to health and following lifting and handling guidelines.
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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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.

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ <strong>Met this standard</strong></td>
<td>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.</td>
</tr>
<tr>
<td>✗ <strong>Action needed</strong></td>
<td>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.</td>
</tr>
<tr>
<td>✗ <strong>Enforcement action taken</strong></td>
<td>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.</td>
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</tbody>
</table>
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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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:

<table>
<thead>
<tr>
<th>Standard Description</th>
<th>Regulation No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>17</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>18</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>9</td>
</tr>
<tr>
<td>Meeting Nutritional Needs</td>
<td>14</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>24</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>11</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>12</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>13</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>15</td>
</tr>
<tr>
<td>Safety, availability and suitability of equipment</td>
<td>16</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>21</td>
</tr>
<tr>
<td>Staffing</td>
<td>22</td>
</tr>
<tr>
<td>Supporting Staff</td>
<td>23</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>10</td>
</tr>
<tr>
<td>Complaints</td>
<td>19</td>
</tr>
<tr>
<td>Records</td>
<td>20</td>
</tr>
</tbody>
</table>

**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.