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

Burnley General Hospital

Burnley General Hospital, Casterton Avenue, Burnley, BB10 2PQ

Tel: 01254263555

Date of Inspection: 26 September 2012

Date of Publication: October 2012

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

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<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>✓</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>✓</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>East Lancashire Hospitals NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overview of the service</strong></td>
<td>Burnley General Hospital provides a range of hospital services for adults and children. This includes general and specialist medical and surgical services along with diagnostic and support services. The hospital includes an urgent care centre and the Lancashire Women's and Newborn Centre. The latter has facilities for the urgent care of new born babies and a full range of maternity services.</td>
</tr>
</tbody>
</table>
| **Type of services**       | Acute services with overnight beds  
Blood and Transplant service  
Community healthcare service  
Diagnostic and/or screening service  
Long term conditions services  
Community based services for people with mental health needs  
Rehabilitation services  
Urgent care services |
| **Regulated activities**   | Diagnostic and screening procedures  
Family planning  
Management of supply of blood and blood derived products  
Maternity and midwifery services  
Nursing care  
Surgical procedures  
Termination of pregnancies  
Treatment of disease, disorder or injury |
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’.

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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 26 September 2012, 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 and talked with staff.

What people told us and what we found

We spoke with five patients on ward 10 of the Lancashire Women's and Newborn Centre, all had recently given birth in the birthing suite. We also spoke with midwives and senior managers and looked at a sample of records and policies and procedures.

All patients spoken with made positive comments about their care and support throughout their pregnancy and in particular during the birth of their baby. One patient told us, "The consultant and midwife were both brilliant and very supportive". Patients were closely involved in decisions about their care and that of their baby. Each person had an individual midwifery care plan which was reviewed following any change of need or circumstance.

Midwives had a thorough understanding of safeguarding procedures for the protection of children and vulnerable adults. We saw evidence to demonstrate that midwives worked in collaboration with other agencies such as the Police and Social Services to ensure a coordinated response to safeguarding issues.

Midwives had access to appropriate supervision and were given opportunities to update and extend their training in line with their roles. We saw records of staff training during our visit.

There were established and effective systems in place to monitor the quality and safety of the service which included the analysis of patient feedback. We saw examples of how these systems worked together to monitor the performance of the Trust.

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

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.

Patients’ views and experiences were taken into account in the way service was provided and delivered and they were fully involved in decisions about their care.

Reasons for our judgement

All patients spoken with told us they had been involved in decisions about their care throughout their pregnancy. They also confirmed the results of scans and tests had been fully explained by doctors and midwives and they had been able to make a choice about where to deliver their baby. Patients told us they had developed birth plans in consultation with a midwife. We saw a sample of completed antenatal records during our visit.

Patients expressed a high level of satisfaction with the support they received during the delivery of their baby. One patient said “I was involved in everything, everyone was so supportive, it really couldn't have been better” and another patient commented, “It couldn't have been more perfect, every question was answered straight away. They were unbelievably good”. Patients confirmed they continued to be consulted about their care and that of their baby during the postnatal period. We saw evidence of discussions with patients in their daily progress notes, which were known as hand held notes on the ward.

Partners spoken with during the inspection told us they had been actively involved in the birth of their baby and they had received support from the midwives. One person told us, “They have been brilliant, I really couldn't fault them in anyway and they still continue to explain everything now the baby is born”. This meant the patient and her partner were able to make informed decisions about the care of their baby.

Patients confirmed their rights to privacy and dignity were respected and upheld at all times. Patients described examples of midwives lowering their voice in the shared bays and knocking on the door of single bedrooms before entering. Midwives spoken with also told us rooms were available to discuss any personal aspects of care with patients in private. A chaperone was provided during examinations by a male doctor. We observed sensitive and kind interactions between the staff and patients during our visit and noted all records were written in respectful terms. The postnatal records were returned to patients on leaving the ward to ensure they received coordinated care in the community. This also meant patients were able to read records of their care.

Patients were offered information throughout their pregnancy. Patients were given the
opportunity to visit the birthing centre and the birthing suite before they gave birth. This meant they were able to make an informed choice about where to have their baby and knew what to expect from the service. We noted comprehensive information including useful contact numbers was given to patients on discharge from the ward. Patients whose first language was not English were offered the services of an interpreter. A midwife spoken with explained this need was assessed before the patient was admitted to the ward so appropriate arrangements could be made via link workers or language line.

Staff were aware of equality and diversity issues such as religious beliefs and cultural background. Staff told us that wherever possible they recognised and respected different child birth customs and practices and were able to give examples of how this benefitted patients. We noted patients’ religion and culture were recorded within their personal records to ensure staff were aware of any pertinent issues.
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.

Patients experienced effective, safe and appropriate care, treatment and support which met their needs and preferences.

Reasons for our judgement

Patients spoken with made complimentary comments about their experiences of the care and support provided by the hospital. Patients told us they received one to one support of a midwife once their labour was established, one patient said, "The midwife never left my side, she was so supportive, I could really rely on her throughout". This was confirmed by another patient who said she had not been left at any point during active labour. She said, "I received all the support I could possibly have". The patient also confirmed she had had skin-to-skin contact with her newborn immediately after delivery to help with the bonding process with the baby.

Partners were involved in the delivery process and made welcome on the wards. We spoke to a patient and her partner who said that staff were supportive to the birthing partner.

Patients told us they were offered pain relief both during labour and after their baby was born. One patient said, "The midwives come round often to ask if I need anything for pain". Another patient explained she had been debriefed by a doctor following the birth of her baby, which enabled her to ask questions about any areas of anxiety. A midwife also told us patients were encouraged to write down a list of questions to discuss during postnatal appointments to ensure there were no residual concerns. The patient said the debriefing had been very helpful and useful in helping her understand the birth and ongoing care of her baby. We saw evidence of the debriefing in the patient's notes.

With their permission, we reviewed three patients' records in detail. From this we could see detailed records had been maintained throughout the patients' pregnancy. These were divided into three books: book one antenatal care, which women carried with them during their antenatal appointments, book two intrapartum care (delivery of baby) and book three postnatal care. We were informed electronic records were also made during delivery. A social needs risk assessment was carried out when the patient was first referred to maternity services and this was updated at 28 weeks into the pregnancy. This meant women received appropriate support for all their identified needs. A "caseload team" of midwives worked in the community with vulnerable groups with either a history of traumatic births or social issues.

All the patients on ward 10 were receiving postnatal care and we therefore focused
particularly on book three and associated records. We noted each patient had a midwifery care plan, which was developed using a SBAR (situation, background, assessment and recommendation) framework. This approach is designed to create a standardised and structured communication format between staff.

One file we looked at provided clear information and recommendations for the patient's care. However, we found two of the patient's care plans known as SBARs were amalgamated in their daily notes which made them difficult to pick out. However, a matron told us this aspect of record keeping had recently been discussed at a meeting and new ways of setting out patients' midwifery care plans were being considered. Midwives explained that SBARs were reviewed following any change in need or circumstance. Whilst we found it difficult to determine the patients' involvement in their care plans from looking at their records, all patients spoken with told us they felt involved in decisions about their care.

Midwives carried out a daily assessment of needs with each patient as part of routine care. This included the use of risk assessments in order to monitor any risks associated with the patient or their baby. An obstetrician was available in the centre until 10 pm and then on call arrangements were in place. An anaesthetist was available 24 hours a day. Patients received ongoing support from doctors during their stay in hospital. We observed consultants visiting patients and discussing care with the midwives during our inspection. We also noted midwives had a detailed handover meeting at the start of each shift. All staff presented as relaxed, friendly and calm and we saw that they responded efficiently to patients as and when they were needed.

Arrangements were in place to respond to medical emergencies and staff received regular obstetric skills and drills training. This type of training involved multi professional staff working together to practise their clinical skills in a carefully constructed simulated environment, to ensure they were fully trained to recognise and deal with real life emergency situations.
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.

Suitable arrangements were in place to recognise and respond to any concerns relating to the safeguarding of vulnerable adults and children.

Reasons for our judgement

Patients spoken with told us they were able to voice any concerns about the service and they felt confident appropriate action would be taken. All patients told us they felt comfortable and safe in the hospital environment.

We discussed safeguarding procedures with members of staff in the hospital. (These procedures are designed to protect children and vulnerable adults from abuse and the risk of harm). We found staff had a high level of understanding of the signs and indicators of possible abuse and knew what action to take if they had concerns. This included liaison with the local authority and police and the use of internal systems of communication, for instance incident reporting procedures.

There was a named midwife for safeguarding children. Midwives spoken with knew who the safeguarding midwife was and told us she was easy to contact for support and advice. The named midwife explained the systems in place to protect women and their babies from harm. A significant emphasis had been placed on working collaboratively with other agencies to ensure a coordinated approach to any concerns and the smooth flow of information. For instance, the named midwife attended the MARAC (Multi Agency Risk Assessment Conference) which focused on increasing the safety of high risk victims of domestic abuse. We saw examples of completed assessments, which outlined the arrangements put in place with the community midwife teams. All such cases were carefully monitored and any children involved were "flagged and tagged" on the electronic records systems. This meant staff would be aware of the children's circumstances if they presented in other departments such as accident and emergency.

Arrangements were in place to draw up pre birth agreements with social services for babies identified "at risk". We saw examples of these agreements during the inspection. Multi disciplinary discharge meetings were held with the involvement of the mother to ensure there was coordinated support and care across all agencies and professional staff.

The named midwife reported every three months to the internal safeguarding board which reported directly to the trust board. This meant there was an effective system in place to ensure communication between all levels of management and staff.
Staff completed specific coloured "special circumstances forms" to alert other staff to any potential concerns relating to safeguarding issues. A midwife explained that she had contacted social services on the day of our visit, after being alerted of potential issues on the form. This contact had been discussed with the patient concerned so they were aware of the checks being made.

Staff completed annual mandatory training on safeguarding children and vulnerable adults and midwives undertook more complex safeguarding training every three years. We saw records during the inspection to demonstrate this training had taken place. The named midwife told us "spot check" audits were carried out to ensure staff understood the safeguarding procedures and they were able to apply and use them as part of their work.

Policies and procedures were available on safeguarding vulnerable adults and children, which incorporated a flow chart for reporting concerns. We saw this documentation was freely available to all staff on the Trust's intranet (internal website). The named midwife explained a booklet entitled, "What to do if you're worried a child is being abused" had been placed in all areas of the hospital which were regularly accessed by children. Staff also had access to whistle blowing procedures, which provided them with information about how to disclose any concerns about individuals or the organisation through appropriate channels.
Supporting workers

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

Met this standard

Our judgement

The provider was meeting this standard.

Patients were supported by staff who had received appropriate training and support for their role.

Reasons for our judgement

All patients spoken with made complimentary comments about the staff team including the midwives and doctors. One patient said, “The consultant and midwife have both been so supportive” and another patient commented, “They have all been very friendly and approachable”. Patients felt confident they and their babies were receiving appropriate care and told us staff were competent and well trained. All staff spoken with articulated a strong commitment to patient care and providing people with a positive experience of the service. Wherever possible new mothers and their babies were kept together and the ward had been configured to provide a separate zone for babies receiving transitional care.

Patients were assisted to recognise midwives and other staff roles by the colour of their epaulettes on their uniform. A key to each colour was displayed on the ward.

Midwives told us there was always a supervisor of midwives available to them if they had any concerns. (It is a statutory function that each midwife has a named supervisor of midwives and meets with them as a minimum of once a year to review practice and identify training needs and keep a record of supervisory activities). The head of midwifery confirmed there was continuous supervisory support available at all times by the provision of a rostered on call system with contact numbers, which was displayed in each area. She also explained this service was available for patients if issues could not be dealt with via their own midwife. Midwives spoken with told us they felt very well supported by their supervisor and confirmed they could contact them at anytime for support and advice.

An annual report was published on the supervision of midwives and we were sent a copy of the report following the inspection. This presented evidence of supervisory activity at the Lancashire Women’s and Newborn Centre and how supervision is provided, managed, and monitored.

Midwives also received management supervision and an annual appraisal of their work performance, this included the identification of training and development needs. Records seen confirmed staff appraisal records known as PDRs (Performance Development Reviews) had been carried out and updated on an annual basis.

Midwives had been provided with training in a range of topics pertinent to their role. Midwives spoken with explained they had completed annual mandatory training which
included moving and handling, safeguarding vulnerable adults and children and health safety as well as role specific training. The latter included PROMPT training (Practical Obstetric Multi-Professional Training) which incorporated clinical skill drills to ensure all emergency procedures and responses were well coordinated and all participants were fully trained in their role. We were given a copy of the PROMPT update training during the inspection and midwives confirmed they had taken part, along with other clinicians such as the Obstetricians and Anaesthetists. The staff training was monitored and managed by a maternity practice development officer. We saw records of staff training during the inspection, which were maintained on a database on the computer. This meant future update training could be readily identified and planned.

New staff completed an induction programme, which included a corporate day, mandatory training and a training pack to orientate the person in the hospital and ensure they were aware of the policies and procedures. Newly qualified midwives were supported through a perceptorship programme. During the programme new appointees were supervised by a qualified and experienced midwife (their preceptor) in a clinical setting to allow practical experience with patients and build their competencies and skills.

Staff had access to a staff forum which was division wide. (There are five clinical divisions across the Trust). The head of midwifery told us she sent emails to staff to remind them when these meetings were taking place and we saw forum information was also accessible on the Trust’s computer intranet. Staff were also invited to attend ward meetings. This meant there were a variety of ways for staff to discuss the operation of the hospital and any issues affecting their role.
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 quality and safety of the service was regularly assessed and monitored, as a means to protect patients against the risks of inappropriate or unsafe care and treatment.

Reasons for our judgement

Patients spoken with on ward 10 expressed a high level of satisfaction with the care and support received during their time accessing maternity services. One patient said, "I've been happy with everything" and another patient commented, "The hospital has met all my expectations, I feel everything is in hand". Patients were aware of who to speak to in the event of a concern and felt confident appropriate action would be taken as necessary.

Patients were asked for feedback about the service on a continuous basis. We looked at the results from questionnaires which had been completed by patients in August and September 2012 and noted the vast majority of respondents were either satisfied or very satisfied with their maternity care. Patients could access the maternity questionnaire on the Trust's website and answer "pop up" questions on their bedside television. Senior managers also told us patients were asked for their views and opinions about the service before they were discharged from the Centre.

The results from patient surveys were analysed and discussed by all levels of staff and management. Feedback was given back to patients relating to comments and suggestions made on questionnaires in "You Said, We Did" notices. These notices were displayed on patient information boards.

We were informed about the various ways patients and their community were involved in their service provision. For example the Maternity Services Liaison Committee was chaired by a person using the service and included patient representatives. Any information leaflets designed for patients were checked by this committee to ensure they were written and presented in a way people could understand.

Patients had established a social media site to enable women to discuss their birth experience across East Lancashire Maternity Services. Patients could also express their views on the NHS Choices website. The Trust monitored this site and responded to any concerns. They made people aware of the PALS (Patient Advice and Liaison Service) if they wished to discuss their concerns further. This service is designed to listen to patients views, answer their questions and resolve their concerns as quickly as possible.

Midwives told us they knew how to report untoward incidents on the electronic system.
The Trust disseminated learning from incidents and near misses to all staff through a "blue light" alert, which was displayed in staff areas, meeting rooms and was available on the Trust's intranet.

Staff were given the opportunity to provide the Trust with feedback about the quality of services, by means of a questionnaire, supervision, staff forums and staff meetings. As a result from feedback from staff increased clerical support had been provided on the birthing suite.

We spent time with senior managers to gain an overview of how the trust was organised and governed. We were shown how the quality assurance systems known as "governance" worked to ensure the service was monitored and managed. (Governance is a term used to describe the systems, processes and behaviours that support an organisation to achieve its objectives and safeguard high standards of care for patients).

The governance systems used at the trust facilitated the exchange of information from "ward to board and from board to ward". This meant there was 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. The Trust was divided into five clinical divisions. Each clinical division was divided into directorates with each division and directorate having a quality and safety board. Each quality and safety board fed back information to the next level and then to the overall quality and safety board which reported to the trust's board of directors.

Quality monitoring mechanisms were used in all divisions and directorates to provide information on the performance of the trust. These included a variety of auditing and reporting systems. We were shown a copy of the programme of audits which covered different aspects of the service. The audits, subsequent reports and action plans were designed to demonstrate practices were being monitored with the aim of driving improvements. A quality account which set out the outcomes of the quality monitoring systems and the trust's objectives for service improvement was published on an annual basis and was available for the public on the trust's external website.

Senior managers informed us that the Trust was participating in the NHS Safety Express that specifically monitored five known harms to patients, such as falls and pressure ulcers. Information was gathered on one day a month known as census day and the outcomes were visually displayed on notice boards around the hospital. The Trust won a national award in the measurement for improvement category for their work to help reduce avoidable harm to patients.
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, 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, primary medical services 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>✔ Met this standard</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Action needed</td>
<td>This means that the standard was not being met in that the provider was non-compliant with the regulation. We 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.</td>
</tr>
<tr>
<td>✗ Enforcement action taken</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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</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:

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<td>Consent to care and treatment - Outcome 2</td>
<td>Regulation 18</td>
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<td>Care and welfare of people who use services - Outcome 4</td>
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<td>Meeting Nutritional Needs - Outcome 5</td>
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<td>Cooperating with other providers - Outcome 6</td>
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<td>Safeguarding people who use services from abuse - Outcome 7</td>
<td>Regulation 11</td>
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<td>Cleanliness and infection control - Outcome 8</td>
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<td>Management of medicines - Outcome 9</td>
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<td>Safety and suitability of premises - Outcome 10</td>
<td>Regulation 15</td>
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<td>Safety, availability and suitability of equipment - Outcome 11</td>
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<td>Requirements relating to workers - Outcome 12</td>
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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.