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

Hinchingbrooke Hospital

Hinchingbrooke Park, Huntingdon, PE29 6NT

Tel: 01480308222

Date of Inspections: 06 February 2013
05 February 2013

Date of Publication: April 2013

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

<table>
<thead>
<tr>
<th>Standard</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respecting and involving people who use services</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>Action needed</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>Action needed</td>
</tr>
<tr>
<td>Staffing</td>
<td>Action needed</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>Met this standard</td>
</tr>
</tbody>
</table>
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>Cambridgeshire Community Services NHS Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>Holly Ward is a 25 bedded paediatric unit open to 0-16 year olds (or up to 17 years of age if in full-time education). Part of Holly Ward includes the assessment unit where children are first seen and assessed when coming from either their GP or the accident and emergency department.</td>
</tr>
</tbody>
</table>
| Type of services | Acute services with overnight beds  
Dental service  
Diagnostic and/or screening service  
Rehabilitation services |
| Regulated activities | Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury |
### Contents

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

<table>
<thead>
<tr>
<th>Summary of this inspection:</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<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>What we have told the provider to do</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

| Our judgements for each standard inspected:                                               |      |
| Respecting and involving people who use services                                          | 6    |
| Care and welfare of people who use services                                               | 8    |
| Safeguarding people who use services from abuse                                           | 10   |
| Safety and suitability of premises                                                       | 12   |
| Staffing                                                                                  | 14   |
| Assessing and monitoring the quality of service provision                                | 16   |

| Information primarily for the provider:                                                  |      |
| Action we have told the provider to take                                                  | 17   |

| About CQC Inspections                                                                     | 19   |
| How we define our judgements                                                             | 20   |
| Glossary of terms we use in this report                                                   | 22   |
| Contact us                                                                                | 24   |
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 5 February 2013 and 6 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 carers and/or family members, talked with staff, reviewed information sent to us by local groups of people in the community or voluntary sector and talked with local groups of people in the community or voluntary sector.

What people told us and what we found

We saw staff treating people using services at Holly Ward with dignity and respect. People we spoke with told us they could approach staff with questions about their children's care and treatment and they would be listened to.

We reviewed the care plans of children and young people located on Holly Ward. Although people we spoke with told us they were happy with the care and treatment provided to their children, we saw that the care plans we reviewed did not contain sufficient and detailed advice to staff about how to meet people's care needs.

Staff we spoke with demonstrated to us an understanding of safeguarding vulnerable children from abuse guidance and procedures.

At the time of our inspection we saw that people were not protected against the risks associated with unsafe or unsuitable premises.

There were not always enough qualified, skilled and experienced staff on the ward to meet people's needs and ensure their safety and welfare.

There were effective systems in place to regularly assess and monitor the quality of services provided to people on Holly Ward. People were asked for their views and they would be acted on.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 01 May 2013, setting out the action
they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

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 independance were respected.

Reasons for our judgement

People who use the service were given appropriate information and support regarding their care or treatment.

During our inspection of 5 and 6 February 2013 we spoke with families of children and young people receiving care on Holly Ward, Hinchingbrooke Hospital. One parent we spoke with told us they felt they could approach staff members at any time to discuss their child's care and support needs.

We observed staff members providing care and support to children and young people on the ward. We saw that children and their families were treated with dignity and respect, with staff members being polite and spending time listening to people's questions and comments. Staff were mindful of other patients and people on the ward, and they spoke to people in a quiet way so that other people would not easily hear their conversations. Staff members we spoke with told us that there were other 'quiet' areas on the ward where people's care needs could be discussed if necessary.

Facilities on Holly ward were seen to be both child and parent friendly. Specially designed fold away beds were provided next to children's beds and cots on the ward. This meant that parents or family of children receiving care on the ward could sleep next to the child or young person. This also meant that the visiting adult could provide support to the child or young person during the night as well as during the day.

Family members and relatives of children and young people located on Holly Ward told us that they felt involved in the care of the children there. During our inspection we saw that there was a relaxed and friendly atmosphere on the ward.

Information about the ward was provided in leaflet form, and we also saw that this was easily found using the internet. The information was written in a 'child friendly' way and it gave clear and appropriately detailed information about the ward's facilities and what children and young people could expect when they arrive on the ward. This meant that children and young people would be better informed prior to attending the ward for care...
and treatment. The leaflet also provided information to parents and families about visiting the ward, including parking facilities and the availability of refreshments.

We saw that the ward provides a 'Saturday Club' on the first Saturday of each month. This provided the opportunity for children and young people who were due to attend the ward for a planned stay to visit the ward and meet staff first. This meant that they would have a better understanding of what to expect when they attended for their planned stay for care and treatment on the ward.

During our inspection we saw that there were facilities available to both entertain and educate children and young people during their stay on Holly Ward. We spoke with the ward manager and they told us that a play leader/nursery nurse attended the ward to involve people in various activities, such as drawing and other craft activities. Children and young people could be involved in these activities as much or as little as they liked.
Our judgement

The provider was not meeting this standard.

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

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

Reasons for our judgement

People's needs were not always assessed and care and treatment was not planned and delivered in line with their individual care plan.

During our inspection of 5 and 6 February 2013 we spoke with the relatives of children and young people currently receiving treatment on Holly Ward. They told us that they were happy with the standards of care and treatment provided to their children. However, we examined evidence which demonstrated to us that people's care was not always planned in line with their current care requirements.

An open access file was kept on the ward, which detailed children and young people who were regularly admitted to the ward. We examined records in the open access file for ten patient's, including those for two admitted to Holly Ward during our inspection. We found that records contained details of patient's medical conditions and some records also contained details of treatment regimes. These were generally copies of initial outpatient or first admission summaries. However, many patient records were old, some information seen to be up to seven years old, and they did not contain any information of the patient's current health status or needs. One record provided conflicting information about a young person's resuscitation status from some years ago, with no information provided about any recent decisions made about their status.

A staff member we spoke with confirmed that patient's who had open access to the ward (fast access to Holly ward that bypassed usual admission routes, such as Accident and Emergency) had their care records stored close by. There was no clear information for all of the open access records we examined regarding where patient's records were stored. This meant that staff without knowledge of where the records were stored may not have information available when patients’ arrived on the ward to be seen.

We examined one patient's care record on the ward at the time of our inspection. The patient had been regularly admitted to the ward and was well known to staff members. We saw that an admission assessment had been completed, but that this only documented
their immediate health needs. An identification of needs form had also been completed but the patient's activities of daily living requirements were not written in adequate detail and included references such as 'all care as required'. We saw that the patient's care needs were unclear. For example, there was no information about their communication ability, what assistance they required to move or how they how they received adequate nutrition. The records did not offer guidance to staff about how to provide safe care and treatment to the patient.

Further examination of the patient's care record showed that no risk assessments had been undertaken about their specific care needs, such as their risk of developing pressure ulcers. We also saw that a risk assessment had not been undertaken about their moving and handling needs or nutritional and fluid intake requirements. Records associated with care that had been provided, such as turn charts, were also not maintained. We saw that nursing notes did not provide adequate commentary to ascertain whether the patient's skin integrity was maintained.

We spoke with the staff member caring for the patient and they were able to provide us with a detailed explanation of the patient's care needs. They stated they knew the patient and their family well and confirmed that experienced staff members usually cared for the patient, due to their complex care needs. However, this meant that staff members who did not know the patient's care requirements from personal experience would not know how to support them appropriately.
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

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.

All of the staff members we spoke with knew that they could raise a safeguarding issue or concern with their management team and other organisations such as the local authority and the police. They demonstrated to us an adequate understanding of safeguarding vulnerable children procedures and how they should report any concerns they might have.

We spoke with the relatives and families of children and young people currently resident on the ward. They told us that they felt their children were in a safe environment, even when they were not present on the ward themselves.

During our inspection we spoke with staff members who told us that routine safeguarding supervision is not provided to staff working on the ward. The provider may find it useful to note that guidance for the safeguarding supervision for all staff members who work with children and young people is contained in the 'Intercollegiate Safeguarding Guidelines for Children and Young People 2010' publication. This guidance outlines the roles and responsibilities for healthcare staff who work with children and young people. The 'Department for Health Working Together to Safeguard Children 2010' publication also outlines staff safeguarding training and supervision expectations.

We spoke to the ward manager during our inspection and they told us that safeguarding supervision tends to be reactive once a safeguarding incident or concern has been recognised, rather than a proactive approach of being able to discuss potential concerns, such as when working with children and young people who were not considered 'at risk' at the time.

Staff members we spoke with told us that they were aware of regular attendees to the ward who were known to other safeguarding agencies. They also demonstrated an appropriate knowledge of how to inform the other agencies of the child's or young person's current status on the ward. This would ensure that appropriate action could be taken to
ensure the safety and welfare of the child or young person.
Safety and suitability of premises

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

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

Reasons for our judgement

The provider had not taken steps to provide care in an environment that was suitably designed and adequately maintained.

During our inspection on the evening of 5 February 2013 we saw that the clean utility and medication room door on Holly Ward was held in the open position with a wedge. We entered the room and found that although the cupboards used for the storage of medication were locked, under work surface cupboards were not. We saw that these cupboards were not lockable and inside we found various medical solutions, needles, syringes and other medical, cleaning and nursing equipment.

We observed that the clean utility and medication room also contained a yellow bin used for the safe disposal of used needles and other sharp objects. We saw that the lid to the bin was open and that it was approximately two thirds full of used needles and other sharp objects. The opening to this bin was large enough for a child to put their hand into and potentially cause themselves injury. The bin was stored on the waist high work surface, within easy reach of children and young people.

We spoke with the ward manager who told us that children were not allowed to enter the clean utility and medication room, and that the door was left open so that staff inside could hear if a child was calling for assistance. We were also advised that no risk assessment had been undertaken in relation to the room door being wedged open. We pointed out the potential hazards to the ward manager at the time of our inspection that evening.

During our inspection during 6 February we found that the clean utility and medication room door was ajar. We spoke with staff members who confirmed that vulnerable children are often resident on Holly Ward, some of them who might self harm. We noted that children and young people currently located on Holly ward could potentially gain access to the room unnoticed.

We also noted that the kitchen door and door to the 'milk room' on the ward was not
locked, and although both doors closed fully when left to shut without force, they were easily opened with little effort. There was a notice at adult head height advising that children were not permitted in the kitchen. This meant that children and young people might not see the notice. It was also possible that children and young people might not understand the notice and enter the area unattended.

We saw that there was unlimited access to lower level cupboards and drawers, one of which contained a bread knife and another which we saw contained various cutlery. We spoke with staff members who confirmed that the ward had no use for the bread knife.

People visiting Holly Ward had to ring a door buzzer before being allowed access to the ward so that staff members could check their identity. We spoke with staff members who confirmed that they would routinely check the identity of people visiting the ward if they were not aware who they were. We saw that the ward was monitored using CCTV recording equipment.
## Staffing

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

### Our judgement

The provider was not meeting this standard.

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

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

### Reasons for our judgement

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

During our inspection of 6 February 2013 we were advised that Holly Ward consists of 13 inpatient beds, an assessment unit and a day unit. We were told that staff support the running of all three areas and that they are assigned to a specific area on a daily basis.

We spoke with staff members who told us that to operate all three areas effectively and safely requires a minimum number of qualified staff to work in all of the three areas when children and young people were receiving care or treatment there. A minimum number of qualified staff members were also required for night duty on the ward. The assessment unit and day unit were closed during this time. However, we were told that due to staff sickness and annual leave it was often the case that the assessment unit was closed so that staff members could continue to provide care and support to patients resident on the ward and day unit.

We were also told that when the assessment unit was closed, patients would attend the ward for their assessment instead. This was not in the best interests of those attending for assessment or to those already established as patient's on the ward. Children and young people attending for assessment were placed at risk of infection from those resident on the ward and likewise, those already resident on the ward were placed at risk from those patients' who would normally attend the assessment unit.

Children and young people would regularly be expected to attend Holly ward for assessment by staff members who were already providing care and support to patients on a full ward. Staff members were then under pressure to provide appropriate care and support to those already on the ward, as well as providing appropriate care and support to those patient’s attending for assessment.

Staff members we spoke with told us that it was considered normal for the assessment unit to close on a regular basis, meaning that patient's would attend the ward for their assessment. They also told us that they felt pressured and sometimes significantly under
resourced to meet the care and support demands of children, young people and their families across the unit.

Staff members also told us that clinical supervision is provided to them in a group every six to eight weeks. If they required specific one-to-one supervision this had to be requested by them. Staff members also explained that they had not received any supervision since before Christmas 2012 due to the holiday period and staffing issues.

We spoke with the ward manager who told us that they would regularly undertake clinical duties on Holly Ward to cover for staff shortages. This meant the ward manager could not undertake their own role effectively on a regular basis.
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 identify, assess and manage risks to health, safety and welfare of people using the service and others.

Reasons for our judgement

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

During our inspection we saw that information was provided to patients and their families about how and where to complain if they felt they needed to.

Staff members we spoke with told us that they received a weekly 'cascade' letter which updated them about important issues from within the Trust. They also told us that their manager would also highlight important points from the letter which they thought were particularly relevant to their role. These points would also be discussed at staff meetings. Staff members felt able to comment during staff meetings and that their thoughts and ideas would be passed on to senior management and board members for their consideration, although they sometimes did not get any feedback that this had actually occurred.

Staff members told us that their concerns about staffing numbers had been raised with the ward manager and this in turn had been raised with the business manager. However, the provider may find it useful to note that staff members also told us that they felt unclear about what action was being taken to address their concerns about the lack of staff as no clear information had been fed back to them.

We spoke with the families of children and young people resident on Holly ward at the time of our inspection. They told us that they felt confident that if they made a complaint or commented about the quality of the services provided on the ward, that they would be listened to and their views would be acted on.
This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Care plans seen did not contain sufficient information to help staff provide adequate and safe care and support to people resident on the ward. Risk assessments had not always been completed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Safety and suitability of premises</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The wards treatment room door was not locked shut. Children could potentially access medical equipment including needles, medical solutions and used sharp medical equipment.</td>
</tr>
<tr>
<td></td>
<td>The wards kitchen was not locked shut. Children could potentially access knives and other kitchen equipment stored in the kitchen.</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>Staffing</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
</tbody>
</table>

Holly Ward has a clear shortfall of qualified members of nursing staff to sustain the delivery of all three units on a daily basis. This presented a risk to people using services as assessments were regularly completed on the in-patient ward.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 01 May 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.
About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of 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>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 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>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>
</tr>
</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>Outcome</th>
<th>Regulation</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>16</td>
</tr>
<tr>
<td>Complaints</td>
<td>19</td>
</tr>
<tr>
<td>Records</td>
<td>20</td>
</tr>
</tbody>
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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.
### (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.