

Navigating the CQC Regulations: Building confidence in what you will need to evidence

Fundamental Standards - Practical tips

Providing high-quality, safe, and person-centred care is at the heart of every adult social care service. To achieve this, providers must comply with the CQC Fundamental Standards, which outline the minimum expectations for safe, effective, caring, responsive, and well-led care.

Drawing on hundreds of practical examples from adult social care providers, Skills for Care and The Outstanding Society outline engaging and sustainable ways to meet CQC regulatory requirements. This is to complement our [Navigating the CQC Regulations](#) webinar.

Person-centred care (Regulation 9)

Care must reflect each person's unique needs, preferences and goals.

What good looks like

- Coproduced care plans centred on what matters to the person.
- Accessible formats for communication and planning.
- Daily routines shaped by individual wishes.

Practical examples

- Use visual prompts or easy read plans.
- Add “what matters today” notes to handovers.
- Build activity plans around interests, not convenience.

Visiting and accompanying in care homes, hospitals and hospices (Regulation 9A)

People must be supported to maintain meaningful contact with those important to them through safe, consistent and minimally restrictive visiting and accompaniment arrangements across all care settings.

What good looks like

- Flexible, person led visiting arrangements.
- Individual risk assessments rather than blanket restrictions.
- Clear communication with families about visiting options.

Practical examples

- Create personalised visiting plans based on the person's wishes.
- Support relatives to accompany people to appointments or activities.
- Hold reflective sessions on balancing safety with connection and wellbeing.

Dignity and respect (Regulation 10)

People must be treated with dignity, compassion and respect at all times.

What good looks like

- Privacy upheld during all care tasks.
- Staff speak respectfully and offer choices.
- Care plans use person first, noninstitutional language.

Practical examples

- Conduct dignity walkarounds with feedback.
- Remove negative or clinical labels from documentation.
- Train staff in respectful, consent seeking communication.

Need for consent (Regulation 11)

People must give informed consent for all aspects of care.

What good looks like

- Clear, decision specific capacity assessments.
- Best interest decisions recorded and inclusive.
- Staff adapt communication to support understanding.

Practical examples

- Maintain a Mental Capacity Act and DoLS tracker.
- Use case-based supervision to build staff confidence.
- Encourage daily verbal consent checks and explanations.

Safe care and treatment (Regulation 12)

People must receive safe, well-planned and evidence-based care.

What good looks like

- Personalised risk assessments guiding practice.
- Medicines administered safely by competent staff.
- Incidents reviewed and learning shared.

Practical examples

- Hold daily safety huddles to review risks.
- Keep a single incident and learning log.
- Run thorough medication audits with follow up actions.

Safeguarding service users from abuse and improper treatment (Regulation 13)

People must be protected from abuse, neglect and degrading treatment.

What good looks like

- Staff confident in recognising and reporting concerns.
- Timely investigations and appropriate referrals.
- Restrictive practices minimal, justified and reviewed.

Practical examples

- Maintain a safeguarding register and monthly review.
- Use anonymised case scenarios in supervision.

- Train staff in deescalation and positive behaviour support.

Meeting nutritional and hydration needs (Regulation 14)

People must have adequate, appropriate food and fluid tailored to their needs.

What good looks like

- Clear documentation of dietary requirements.
- Dignified, unhurried support at mealtimes.
- Monitoring intake and acting on concerns.

Practical examples

- Use detailed food/fluid charts with follow-up notes.
- Observe mealtime support during walkarounds.
- Offer alternatives when preferences change.

Premises and equipment (Regulation 15)

Care environments must be safe, clean and well maintained.

What good looks like

- Regular safety checks and timely repairs.
- Accessible, supportive design features.
- Safe equipment used by trained staff.

Practical examples

- Include daily environment checks in leadership walkarounds.
- Keep a defect to completion log.
- Provide refresher training on safe equipment use.

Receiving and acting on complaints (Regulation 16)

Concerns must be listened to and responded to transparently and promptly.

What good looks like

- Easy-to-use complaints process.
- Clear records of investigations and outcomes.
- Learning shared with staff and people using the service.

Practical examples

- Electronic complaints log with action tracking.
- Publish “you said, we did” updates.

Good governance (Regulation 17)

Providers must have effective systems to monitor and improve quality.

What good looks like

- A structured audit calendar that informs improvement.
- Accurate, up-to-date records.
- A live Quality Improvement Plan with measurable actions.

Practical examples

- Use a risk board and daily leadership walkarounds.
- Turn audit findings into trackable improvement tasks.
- Review progress in monthly governance meetings.

Staffing (Regulation 18)

There must be enough skilled staff to meet people’s needs reliably.

What good looks like

- Staffing levels based on dependency and layout.
- Competency based training and supervision.

- Wellbeing and retention actively supported.

Practical examples

- Adjust deployment daily based on changing needs.
- Buddy new and agency staff before lone working.
- Use reflective supervision to build competence.

Fit and proper persons employed (Regulation 19)

Recruitment must ensure only suitable individuals provide care.

What good looks like

- Full employment checks before unsupervised work.
- Clear induction and competency signoff.
- Ongoing monitoring of suitability

Practical examples

- Conduct monthly file audits.
- Delay independent shifts until all checks are complete.
- Use supervision to address performance concerns promptly.

Duty of candour (Regulation 20)

Providers must be open and honest when things go wrong.

What good looks like

- Timely apologies and clear explanations.
- Documented communication with people and families.
- Learning translated into improvement actions.

Practical examples

- Add Duty of Candour prompts to incident forms.
- Review all DoC cases at governance meetings.

Display of CQC ratings (Regulation 20A)

Ratings must be clearly displayed and easy to find online and onsite.

What good looks like

- Visible posters at entrances and reception.
- Website updated promptly after inspection.
- Staff able to discuss ratings and improvement work.

Practical examples

- Use an “Our rating and improvement journey” display board.
- Update signage within 24 hours of publication.

Evidencing compliance with the CQC Fundamental Standards

Compliance isn't achieved through checklists or isolated tasks. It grows from continuous reflection, skilled leadership, and everyday good practice embedded across the whole service.

Demonstrating compliance relies on turning everyday practice into clear, consistent evidence that shows people are safe, supported and listened to, while systems, staff and leadership continuously monitor quality and respond effectively to emerging risks or feedback.

Our overarching recommendations include;

- Strong compliance begins with consistent, visible oversight, using daily walkarounds, safety huddles and real time monitoring systems that allow leaders to spot risks early, reinforce good practice, and capture evidence naturally through routine, observable day-to-day activity.
- Trend analysis strengthens assurance by showing how incidents, complaints, health concerns or medication patterns change over time, enabling managers to demonstrate not only that issues are identified, but that clear actions, responsible leads and meaningful follow up steps are consistently applied.
- Evidence is strengthened when care plans, risk assessments and records remain current, decision specific and reflective of people's changing needs,

ensuring inspectors can see a clear, logical link between assessed risks, planned support, staff actions and the outcomes people experience.

- Workforce evidence should include full recruitment trails, character-based interview notes, DBS and reference verification, induction competencies and regular supervision records, demonstrating that staff are safe, skilled and supported to deliver consistently high-quality care aligned with regulatory expectations.
- Learning and feedback processes provide rich evidence when services gather people's views, hold reflective discussions, and use incidents or complaints to drive improvement, with clear documentation that shows what was learned, what changed and how improvements were sustained over time.
- Mock inspections, peer reviews and external quality checks provide additional layers of assurance, demonstrating that the service welcomes scrutiny, tests its systems regularly and uses insights from outside perspectives to challenge assumptions and support continuous improvement across all regulatory areas.
- Evidence of people's rights in action includes personalised visiting plans, clear communication with families, and responsive arrangements that respect individual preferences, showing that decisions are person led and restrictions are used only when necessary, proportionate and transparently justified.
- A strong leadership narrative ties all evidence together by showing how managers communicate standards, explain performance, share learning, track improvements and model openness, creating a culture where regulatory compliance is embedded, understood and actively upheld across the service.