Care Quality Commission

Inspection Report

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

Bluebird Care (Bath & North East Somerset)

Kingston House, Pierrepont, Bath, BA1 1LA

Tel: 01225445225

Date of Inspections: 14 August 2013
13 August 2013

Date of Publication: October 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	✗ Action needed
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	TimRowlandJones Limited
Registered Manager	Mrs. Louise Clare Taylor
Overview of the service	Bluebird Care is a domiciliary care agency who provide personal care to people in their own homes aged over 18 years with a range of needs.
Type of service	Domiciliary care service
Regulated activity	Personal care

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'.

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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 13 August 2013 and 14 August 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We carried out a visit on 13th and 14th August 2013. We talked to people who used the service. We talked with carers and relatives. We looked at the personal care records of people who use the service and checked how people were cared for at each stage of their treatment and care. We looked at other records to see how carers were being supported and how the quality of the service was being monitored.

We noted the provider had contacted us during April 2013 regarding problems with aspects of the service management. The provider told us they had subsequently made action plans and were progressing these to resolve the issues they had identified.

We visited four people in their own homes who told us they were happy with the care they received and liked the carers. We met relatives of two people using the service who told us care was given in a respectful and dignified manner.

We spoke by telephone with other people who used the service and relatives who told us that occasionally carers did not arrive on time, and they were not always told by the provider when or why people were going to be late.

People told us they felt safe with carers. We spoke with staff who demonstrated an understanding of policies and procedures to safeguard people from abuse. Records showed the provider had responded appropriately with allegations and disclosures of abuse.

Bluebird Care had a new manager of care who told us policies and processes were being reviewed. We saw the provider did not have complete systems in place to be able to assess and monitor the quality of the service. Records showed not all carers had the supervision, training and support policies stated they should to enable safe care for people.

We saw assessments and care plans were personalised. We saw some information was missing from care plans that would protect people against the risks of receiving care that

was inappropriate or unsafe.

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 21 September 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 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

The four people we visited and people who used the service we spoke with by telephone all told us staff were respectful. We were told that dignity and privacy were respected as much as possible by carers when personal care was provided to people. One person told us: "they treat me with real respect, like I was a relative." Another person said: "they (carers) don't talk down to you or are silly. They are respectful of me and my home." All the people we spoke with said carers always knocked on the door and called out their names before entering their homes.

All four people we visited had a care plan in their home. All the people we spoke with told us they had been involved in the planning of their care. We were told agency staff visited people in their homes to discuss needs and how people wanted care to be provided. This information was written into a care plan. One relative of a person using the service told us changes were needed as the care plan did not meet the person's needs. They said they went to the office to discuss this and staff listened and respected the person's wishes. The relative told us the care plan was amended and re-printed while they were at the office.

We spoke with four care staff. They all told us they talked with people about their care so the person was involved and with how care was delivered. One care worker told us they asked people how they would like their care to be given every time they visited, rather than assume they would like it the same way every time.

We were told by care workers the provider tried to match people with specific staff based on what people said they liked or disliked. For example if they wanted care workers to be particularly talkative.

On both days we visited we heard people being spoken to on the phone by office staff in a way that was respectful and responsive to individual needs. For example, we heard a person call staff in the office to discuss a change in their care. We heard the office staff be polite and helpful, asking the person's preferences for a male or female care worker, what time they would like care and reassuring the person that their needs could be met.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Individual care needs were assessed and delivered in a way that did not always ensure people's safety and welfare. This is a breach of Regulation (9) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

The four people we met in their homes and other people we spoke with told us their personal care was good and care was delivered in their preferred manner. The nine care records we looked at included environmental and mobility risk assessments. Individual needs of people had been assessed and included in care plans. For example, we saw assessments and plans for using hoisting equipment. Care workers told us needs were assessed based on what people said and what carers observed. Family were consulted by care workers when the person was unable to do this for themselves.

Care plans recorded likes and dislikes of people and what was important to them. The people we met and others we spoke with by telephone told us carers read their care plans when they arrived and before they began work.

We looked at nine care records and saw health conditions were listed for people. We saw there was no information in care or risk management plans that explained these health conditions. We spoke with care workers who told us they did not understand what some of the health conditions meant and how they impacted on people. This meant care workers were not able to effectively assess and monitor care, plan how to best meet needs and ensure the welfare and safety of people. The manager told us they were beginning to develop a resource file for care workers to refer to.

In the records we looked at, we found people's needs were not fully assessed. Care assessments lacked information that promoted the care and welfare of people. For example, one recently reviewed care assessment recorded a person had a specific health condition. One carer told us they knew this health condition had progressed, affecting the person's mobility. This information was not written in the care record. This meant staff unfamiliar with this person would not know how to provide the most effective and safe care. In another care record it stated it was important for carers to 'take particular care' observing the person's facial expressions. We asked a care supervisor to explain this and they told us the person's facial expressions were linked to their pain levels. This was not

documented in the person's care plan. This meant the person was not protected against the risks of receiving care or treatment that was inappropriate or unsafe.

Care workers and the manager told us about situations with people that made it challenging for staff to provide care. Clear guidance and care plans for staff to follow in challenging situations had not been produced. This meant staff may have been consistent in their approach to dealing with challenging situations and were not supported to provide safe and effective care to people.

The manager showed us a plan used for dealing with situations that might affect the provision of the service. This included emergency contact details for people and care staff, the type of care provided and where care staff lived in relation to people who used the service. We were told this plan had been effective in enabling care workers to get to people's homes when travel had been difficult due to adverse weather conditions.

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

We talked with four people in their own homes and others by telephone who used the service. We talked with five care workers, the manager and relatives. We looked at nine personal care records of people.

People said: "I feel safe with the carers" and "yes, I feel safe. They (carers) listen to me and are kind people."

The five care workers we spoke with and the manager were able to demonstrate they knew how to recognise the signs of abuse and the various forms it could take. Care workers told us about the safeguarding policy, where it was, how to access it and how to use it. One care worker told us that they used their knowledge of people to recognise when someone appeared different. The care worker said they would think about what why that might be and discuss any concerns immediately with a manager.

Records showed care workers worked with other professionals to safeguard people from abuse and harm. For example, records showed care workers recognised and documented when one person's mental health deteriorated. Records showed care workers referred this person to a mental health team and called the persons GP and community matron. Records showed staff continued to contact the mental health team to ensure this person had a new assessment.

Other records showed the provider had responded appropriately to one person who reported money missing from their home. Records showed the provider followed the 'safeguarding people from abuse' policy resulting in internal and external investigations by other services. Other care records documented information a person gave about abuse in their home, unrelated to the care agency. Records documented staff explained to this person they had a duty and responsibility for reporting this information to the local council's safeguarding team. Records showed this was done promptly.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were cared for by staff who were not fully supported to deliver care safely or to an appropriate standard. This is a breach of Regulation (23) (1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2010.

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

We spoke with five staff who all felt supported by the new manager. We looked at records and we spoke with the manager.

All five care workers told us the new manager was supportive and approachable. Senior staff told us they met every week with the new manager and other office managers to discuss staff and care worker issues and found this process supportive. We saw records that confirmed these meetings took place as described.

The manager told us all new care workers completed an induction programme. The induction programme was designed to ensure all care workers completed statutory training and learned the provider's policies and procedures. New care workers learned how to provide care to people by 'shadowing' experienced care staff. The manager told us this process continued until senior staff supervised and assessed new staff as competent.

When the manager was talking with us, they became aware they could not confirm if some staff working with people had completed their induction training programme. The manager also could not confirm if some staff had been 'signed off' by supervisors as competent to provide care. This meant people may have been at risk of unsafe or inappropriate care by staff. During our visit, the manager told us care staff would be contacted immediately and not be permitted to work with people until the providers required training and assessment had been completed.

The provider assured us that a personal development plan had been completed for all staff. Howver, staff told us they were not aware what post induction individual training had been identified for them. Some staff training was inconsistent. For example, care workers told us some had completed additional medicine training but others had not. This meant staff may not have had all the skills required to support people appropriately or safely.

Care workers' on-going performance was monitored by annual appraisals, supervisions

and unannounced 'spot checks'. The manager told us all staff annual appraisals were in date as there was no records available to show this. Records showed supervision and spot checks were not up to date for all care staff in accordance with the provider's policy. This may have meant staff were not appropriately supported to enable them to deliver care safely and to an appropriate standard.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. This is a breach of Regulation (10) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

We visited four people in their homes and spoke by telephone with other people. We talked to five care staff and the manager. We looked at records and the provider's policies. The provider told us in April 2013 that the registered manager had left their employment. The provider also told us in April 2013 they had identified some concerns with regard to the management of the service The provider told us they had developed action plans to address the shortfalls they had identified. A new manager had been employed to work at Bluebird Care in Bath at the beginning of June 2013. At the time of this inspection we saw some of the action plans were in progress but work was still to be completed. The new manager confirmed with us the improvements that had been implemented.

We found that the provider had processes and policies in place to record and monitor the quality of the service but found there was not a complete system in place to effectively assess and analyse the quality of the service provision. This meant that people who used the service may not have been protected against the risks of unsafe or inappropriate care.

The views of people who used the agency were sought annually through surveys. We were shown the April 2013 analysis. Seventy-three responses were received from the 116 surveys sent to people who used the agency. Of the people who responded, 75% were satisfied with the service received. Comments had also been made about improvements needed. This included improving the continuity of care people received. The provider had documented an action plan to address this. The manager showed us plans of how the agency was considering improving continuity of care for people by allocating care staff specific geographic areas to work. The manager told us this would improve consistency to people as they would be supported the same group of care staff.

The four people we visited and others we spoke with by telephone said they knew the contact details of the agency office and felt confident to complain. We saw records of

complaints received which the manager told us had been investigated. There was no documentation to show how complaints had been resolved or how complaints had been audited to make improvements to the service.

The manager told us the agency had recently begun to audit medicine errors. The audit records showed a substantial number of medicine errors had been reported by care staff. The manager had not analysed or reflected on the medicine errors and the potential harm to people. There was no action plan recorded to manage the risks to people and improve the quality of the service.

The provider did not have a system in place to check induction training had been completed or to audit new staff about their views of the induction training. Some care staff had not completed their induction training or been signed off as competent by supervisors. This meant the provider did not know what care was being provided to people by staff who may not have had the required knowledge and training. The manager did not know who or how many care workers this involved. This may have meant people were not being protected against the risks of inappropriate or unsafe care. During our visit, the manager identified the care staff and assured us they would not be permitted to work with people until the required training and assessment had been completed.

The provider had a system to monitor staff performance through supervision and observation checks. We saw that this system had not been audited as the records did not accurately show when staff had completed supervision or an observational check, if this was overdue or if this had been booked with supervisors.

We saw the provider had an incident, accident and events policy and the manager showed us records that were being dealt with in line with this policy. We saw the complaints policy and records to show how complaints were being documented. The manager told us all complaints had been dealt in accordance with the time scale stated in the provider's policy.There were no records to show this had been done or what the outcome of complaints had been. This meant the provider may not have been able to audit complaints, identify trends and make improvements to the service.

The manager told us they had started to send the providers policies to all care staff and would be expected care staff to sign to confirm they had read the policies.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not maintained. This in breech of Regulation (23) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

We saw the four people we visited had care plans in their homes. We talked with five care workers and the manager. We looked at nine personal care records of people. We found people were not protected from the risks of unsafe or inappropriate care by means of the maintenance of their records. This was because information was unclear and was not following the provider's record keeping policies.

We found that some information in the care records we saw was vague. This meant care staff could misinterpret how care should be provided to people. For example, we saw in care records the words 'prompt' and 'support' were used to inform care staff how to support people with their care. In the care records we saw there was no other information to go with these words to explain exactly how care staff should provide care. For example, care records did not state if 'prompt' should be verbal, physical or both. This may have meant the delivery of care to people was inconsistent, unsafe or not appropriate.

In one person's home we visited we were given permission to look at their care plan. We saw the care plan had not been audited in line with the provider's record keeping policy and staff performance monitoring. For example, we observed some daily care records written by care staff were illegible. We saw the medicine administration record (MAR) had been incorrectly completed. Additionally, other medicine errors recorded by the manager concerned care staff not completing the MAR charts correctly. This meant as different care staff came to support people they might not have been able to understand what care had been provided or if there were new issues that needed to be reported.

For two of the four people we visited, we saw their care records were not secure. This meant information could be missed that other carer staff or the provider needed to know in order to assess and plan how to meet the person's needs.

We saw that people's archived records were stored securely in the office and were easily accessible.

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.

Regulated activity	Regulation
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Individual care needs were assessed and delivered in a way that did not always ensure people's safety and welfare. This is a breach of Regulation (9) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The registered person must have suitable arrangements in place to ensure staff are appropriately supported to deliver care safely and appropriately. Some staff working with people had not completed their induction training programme. Training needs had not been identified or planned for all staff. Staff supervision was not in date for all staff. This meant people were not fully supported to provide safe and appropriate care. This is a breech of Regulation (23) (1) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2010.
Regulated activity	Regulation

This section is primarily information for the provider

Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have a complete system in place to effectively assess and analyse the quality of the service provision. There was no documentation to show how complaints had been resolved or how complaints had been audited to make improvements to the service. The provider had not analysed or reflected on the significant number of medicine errors and the potential harm to people. The provider did not have a system in place to audit induction training with new staff and some staff were found not to have completed the induction training or been assessed as competent. The staff supervision records had not been auditied.This meant that people who used the service may not have been protected against the risks of unsafe or inappropriate care. This is a breech of Regulation (10) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not fully protected from the risks of unsafe or inappropriate care because accurate and appropriate records were not maintained. This is a breach of Regulation (23) (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 21 September 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 other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk

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