Inspection Report

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

Victoria Lodge Residential Care Home

138 Thorne Road, Edenthorpe, Doncaster, DN3 2LU

Tel: 01302884806

Date of Inspection: 01 February 2013

Date of Publication: March 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Enforcement action taken
Cleanliness and infection control	✖ Action needed
Supporting workers	✓ Met this standard
Records	✖ Enforcement action taken

Details about this location

Registered Provider	Mrs Saima Raja
Registered Manager	Mrs. Sara Tamar Bennett
Overview of the service	Victoria Lodge provides care for 24 older people. It is situated on the outskirts of Doncaster in the area of Edenthorpe. It provides accommodation on both the ground and first floor and has parking to the front of the building and a secure accessible garden at the rear.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or 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

We carried out this inspection to check whether Victoria Lodge Residential Care Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Cleanliness and infection control
- Supporting workers
- Records

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 1 February 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

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

What people told us and what we found

We spoke with a number of people during our visit; however most people were unable to communicate with us in a meaningful way due to their medical conditions. People told us that staff looked after them and listened to them. They said they liked to do activities but they were not always arranged. However we spoke with relatives who told us that they were happy with the way the home was run and felt involved. On the day of our visit we saw that people who used the service watched television or listened to music. There were no other activities offered. We observed staff working with people who used the service; however some staff appeared to be task focused.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us. We found that people did not always receive care that met their needs.

People who used the service had a care plan, although not all aspects were in line with their individual needs.

People were not protected from the risk of infection because appropriate guidance had not been followed. We saw that people were not always cared for in a clean, hygienic environment.

Staff received appropriate professional development. A training programme was in place

to provide staff with the training and support they needed.

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 12 March 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Victoria Lodge Residential Care Home to protect the health, safety and welfare of people using this service.

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 ✖ Action needed

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 not meeting this standard.

People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

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 carried out a visit to the service on 29 October 2012 and identified concerns with this outcome; as a result we issued a compliance action. This visit in February 2013 was to determine compliance.

People's diversity, values and human rights were generally respected. We observed people using the hoist. This was carried out by staff in a way that respected people's dignity. We saw that a blanket was given to one person to cover her legs while using the hoist. We also saw that where wheelchairs were used, people were using the foot plates. This showed that staff were preventing injury.

People were able to express some of their views and were sometimes involved in making decisions about their care. The manager told us that residents meetings were held regularly. We saw that these were recorded and usually six to eight residents had attended. They had discussed items such as trips and special occasions such as Christmas. The manager told us that relatives were also invited to attend.

We observed people who used the service over lunch and during the visit. We recorded their experiences at regular intervals. This included people's mood, and how they interacted with staff members, other people who used the service, and the environment. This method of observation is called the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We found that staff were very task orientated, which did not meet individual needs. We saw that the dining room was very small and crowded for the amount of people who used it. We observed one lady trying to leave the table after her main course. This was not possible and staff asked her to sit down as pudding would be served shortly. The lady still

wanted to leave the table, but unfortunately was unable to as she could not get by other people sat at the same table. One person was assisted with their lunch, but there was no room to pull up a chair and sit at the side of the person. The member of staff stood over the person while she was being assisted, which was not conducive to providing a relaxed meal.

We saw people were only given a serviette if they requested one. Neither were they offered a choice of condiments. We saw that the main meal was served on white pot plates, while the desert was served in either yellow or blue plastic bowls. We also saw that people were offered drinks from plastic cups. We spoke to the manager about this and she told us that the coloured plastic bowls were used as the colour was recognisable to people with dementia. This was not a consistent approach as the plates were white. People were not given a choice in having a drink from a plastic cup or a pot one.

We looked at six care plans and found that some had been signed by the person who used the service or their representative. However, we also noted that one care plan had not been signed although the person had capacity to sign it. We spoke to the manager about this and were told that it was not signed as the persons family had not visited. This could have been explained to the person who used the service and they could have signed it themselves. Therefore care plans did not always reflect involvement from people who used the service or their relatives.

On the day of our inspection we saw that no activities took place. The home was waiting for an activity co-ordinator to commence employment as the previous one had left. The manager told us that this person would be starting work on Monday 4 February 2013. The lack of social stimulation did impact on the people who used the service. Throughout the day some people commented that they were bored and others fell asleep.

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We carried out a visit to the service on 29 October 2012 and identified concerns with this outcome; as a result we issued a compliance action. This visit was to determine compliance.

At this visit we found people's needs were assessed, however care and treatment was not always planned or delivered in line with their individual assessed needs.

We looked at six plans of care in detail; we found concerns in each plan. People's needs were not clearly detailed. This did not ensure that staff were able to meet their needs.

People's care and treatment did not always reflect relevant research and guidance about dementia care. The menu displayed was written on a chalk board. People may have related to this better if pictures had been used. We saw that one person had nearly finished their main course, while other people sat at the same table had not been given their lunch. One person asked where her dinner was and was told by a member of staff, "There is a queuing system." This meant that people sat at the same table could not enjoy their meals together.

People's care and treatment was not planned or delivered in a way that protected them from unlawful discrimination. We observed one person having to wait 40 minutes sat in a wheelchair before staff assisted the person into a comfortable chair. We checked this person's care plan and saw they were assessed as being at high risk of developing pressure sores. We also noted that when the person was in bed a specialist pressure relieving mattress was used and when sat in a comfortable chair a specialist cushion was used. However the person had been sat in the wheelchair without a cushion during lunch and for 40 minutes thereafter.

We saw another person sat at the dining table in a wheelchair. When the meal was over

the person attempted to stand up. A staff member said, "I'll get your frame." Unfortunately the staff member was unable to find the walking frame so selected a frame from a person nearby and said, "You'll have to use this for now, I can't find yours. Walking frames are specifically adjusted for each individual person, using another person's walking frame could increase the risk of falling as it may not be the correct size or height.

One person's plan detailed a visit from a district nurse two days previous to our visit on 30 January 2013. They had identified the person had lost a considerable amount of weight. Therefore the district nurse had requested the person was weighed weekly, food and fluid charts commenced and a referral to the dietician was required. Staff told us the GP had prescribed fortified drinks, however we found no evidence these had been obtained by the home or given to the person. Staff we spoke with were not able to tell us if a referral to the dietician had been made. The food and fluid charts had not been commenced and when we asked staff when they would be, they were unable to give us an answer. The person had also not been weighed.

Another plan we looked at showed someone had been assessed as at risk of poor nutritional intake. The care plan stated, 'the person's appetite is very poor at present' and one of the actions was to weigh them monthly. Records showed they had been weighed in November but no other weights had been recorded. The person was also on a food chart to monitor their nutritional intake. We found the charts had commenced on Friday 11 January. However we saw 35 meals had not been recorded up to Thursday 31 January. The weekly charts had not been reviewed or evaluated and it was not clear how much food the person had eaten.

Another person's care plan detailed they could become anxious and agitated and could shout loudly at these times. The care plan said, 'When the person is being verbally loud take them to a quiet area.' The plan did not detail how to do this or what to do if the person refused. There was no guidance for staff on how to deal with the person's behaviour. The care plan also stated the person had been seen by the care liaison team, yet no record was detailed in the professional's visits log. We saw they had lost six kilograms in four months and staff had recorded on the weight record 'observe and report more weight loss' dated 18/12/12. The weight recorded on 16/1/13 showed further weight loss but this had not been reported and they had not been referred to the dietician.

A further plan we looked at identified that the person had sustained an injury to their leg on 27/1/13. This was detailed on the incident form as caused by the person trying to get up out of their wheelchair and trapping their leg between the chair and the footplate. This was clearly documented. The report also stated a dressing was applied and the district nurse contacted. It stated they had assessed the injury the following morning 28/1/13. However, there was no record in the plan of care that this had been carried out. The existing care plan had not been reviewed to reflect the changes and detail appropriate action to take. The moving and handling risk assessment had also not been evaluated or updated. There was no body map completed to document the injury. The manager told us this should always be completed for any injuries or changes to skin integrity. The person had also lost weight over a number of months and the care plan review stated, 'plan continue'. No action had been taken to address the weight loss.

During our visit we spoke with visiting health care professionals who were investigating a safeguarding referral. They told us the person had been admitted to hospital with pressure ulcers to both heels. The staff had said the person was independent. Entries in the care record said 'refused to stand.' Yet the staff had not ascertained why the person was not

standing. They had also not identified the pressure ulcers.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not protected from the risk of infection because appropriate guidance was not available or had not been followed. People were not cared for in a clean, hygienic environment.

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 carried out a visit to the service in 29 October 2012, although we did not cover the outcome in full at our visit in October we identified concerns with this outcome. As a result we issued a compliance action. This visit was to determine compliance.

At this visit we arranged to be accompanied by an infection prevention and control nurse who carried out a full audit of all systems. We found the service did not have effective systems in place to reduce the risk and spread of infection. Although physically the environment was found to be clean there were concerns in that there were inadequate systems for safe decontamination of equipment. For example, commode pans.

During our visit we identified a decommissioned bathroom used as a sluice. This room was used for multi purposes including the hairdresser, cleaning of commode pans (in the bath) and the toilet was still being used by people. Twelve people had commodes in their rooms, which required cleaning. There were no sluicing facilities within the home. From speaking with the manager it was not clear how often the pans were cleaned, what process was used, if it was safe or if it was adequate to enable the pans to be properly cleaned.

We found the laundry room was extremely small. The dirty laundry was transported to the room in waste bags and baskets, no laundry skips were used. We found the laundry stacked on the floor waiting to be washed. No hand washing facilities were available in the laundry room. We also found the ceiling and wall surfaces were damaged exposing untreated plaster which could not be effectively cleaned.

The clean laundry store was not able to be thoroughly cleaned. The walls were wallpapered, which in places was peeling, the floor was untreated plywood and the ceiling had plaster board missing exposing insulation.

We saw the colour coding for mops, buckets and cleaning clothes were different between

the ground and first floor. For example green was used on one floor for toilets and blue on the other floor. We found the colour coding was confusing and could lead to the wrong equipment being used to clean an area. We also found the kitchen mop was stored outside in the garden, which posed a risk of cross contamination.

Cleaning cloths were all one colour, whether they were used in the kitchen or the toilets. We found a number of different cleaning products were available but staff told us they only used disinfectant. Products were not standardised, which could be confusing for staff and lead to areas not being appropriately cleaned.

We found cleaning schedules lacked sufficient detail for staff to fully understand what required cleaning, the frequency of cleaning, how to clean and what products to use.

Liquid soap was available in most areas, although this again was not standardised. We found paper towels stored loose and not in paper towel dispensers which posed a risk of cross contamination from splashes.

When we looked at a number of commodes we found a large number were still dirty and stained on the underside. One was smeared in faeces. This showed they had not always been thoroughly cleaned.

The cleaning audits also lacked detail and had not identified the issues we found. There was also no mattress audit undertaken. Although we found no problems with the mattresses these required regular checks to ensure there was no ingress of strike through of urine or other body fluids.

Records and staff comments indicated that all staff had received training in infection control and hand hygiene. However we found that the lessons learnt during training were not always implemented by staff.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We carried out a visit to the service in 29 October 2012 and identified concerns with this outcome; as a result we issued a compliance action. This visit was to determine compliance.

At this visit we found staff received appropriate professional development. We looked at four staff files. These showed records of regular supervision, to ensure staff were able to carry out their duties and meet people's needs.

We also saw in staff files that they had received yearly appraisals. This ensured staff had achieved their objectives.

We looked at the staff training record. These showed that staff received regular training, including updates. This ensured they were able to meet people's needs. Staff we spoke with told us they did regular training. However we found that the lessons learnt in training were not always followed or implemented by staff. This is detailed in other outcomes.

Records

✖ Enforcement action taken

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's personal records including medical records were not accurate or fit for purpose. Records relevant to the management of the services were also not always accurate or fit for purpose.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We carried out a visit to the service in 29 October 2012 and identified concerns with this outcome; as a result we issued a compliance action. This visit was to determine compliance.

At our last visit we found care plans did not accurately reflect the required care and treatment. At this visit we looked at six people's care plans, again we found similar issues.

At this visit we found people's personal records were not always accurate or fit for purpose. Records relevant to the management of the services were also not always accurate or fit for purpose.

We identified food and fluid charts were not completed, reviewed or evaluated. Weight records were not recorded and body maps were not completed. For example we found one person was on food and fluid charts, in the week commencing 28 January three afternoons were not completed. Week commencing 21 January three afternoons and one morning were not completed and week commencing 14 January one morning and one full day were not completed.

Mental capacity assessments stated family would make any important decisions. This was not in line with legal requirements and accepted practice as best interest decision making should follow a legal and accepted process.

The manager had introduced a daily body checklist, these were ticked if a person's pressure areas had been checked. These were not always completed and did not contain accurate records. One person was identified as having a pressure ulcer and this was not documented in the book.

In each plan of care there was a section called 'Resident's profiles', these would include detail such as people's likes and dislikes and family involvement. In a number of plans we looked at they had not been completed.
The care files included an agreement that was to be signed by the person who received a service and their next of kin. It stated they had read the plan of care and agreed it was correct. These had not all been signed. The manager told us they were waiting for families to visit to be able to sign. However some people had capacity to understand their care needs and did not need family to sign the agreement on their behalf, yet these were still not completed.

We saw weight charts had not been completed with people's weight loss or gain documented each month as indicated in their care records. We also found one person's skin condition assessment had not been scored since 10 November 2012, the homes practice state these should be updated monthly or when any changes occur.

Some care plans we looked at had been reviewed and updated with how to meet the person's needs. However the old information had not been removed so it was not clear on what action was required to meet the person's needs.

One person had a catheter. The plan detailed that the amount of urine passed should be recorded. It also stated "ensure sufficient fluids are drunk". There was no fluid chart in place for this person and no record of this documented in the plan of care.

Care plans had comments on them such as 'not consistent', 'needs to be changed', and 'hoisting now needs to be changed.' These were dated 26 November 2012 yet they had not been changed to reflect an accurate record of care required. This showed that staff were not taking any action and senior staff were not checking issues were being addressed.

We found the cleaning schedules were not detailed and did not contain all the required information for staff to be able to understand how to thoroughly clean the home and equipment. The audit for the cleaning also did not include a mattress audit, which would ensure all mattresses were checked regularly.

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
Accommodation for persons who require nursing or personal care	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not protected from the risk of infection because appropriate guidance was not available or had not been followed. People were not cared for in a clean, hygienic environment.

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 12 March 2013.

This section is primarily information for the provider

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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 01 March 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or 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: People did not experience care, treatment and support that met their needs and protected their rights.
We have served a warning notice to be met by 01 March 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People's personal records including medical records were not accurate or fit for purpose. Records relevant to the management of the services were also not always accurate or fit for purpose.

This section is primarily information for the provider

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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.

✓ **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. 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:

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

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