Inspection Report

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

Ardgowan House Residential Care Home (Mrs Annie Jobson)

4 Middle Street, Newsham, Blyth, NE24 4AB

Tel: 01670367072

Date of Inspection: 04 July 2014

Date of Publication: August 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safety and suitability of premises	✗ Action needed
Staffing	✗ Action needed
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mrs A Jobson
Overview of the service	Ardgowan House provides accommodation for up to ten people with enduring mental health conditions. Ardgowan does not provide nursing care.
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'.

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 4 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information sent to us by other authorities and reviewed information sent to us by local groups of people in the community or voluntary sector.

What people told us and what we found

We considered all the evidence we gathered under the outcomes we inspected. We used the information to answer the five questions we always ask;

- Is the service caring?
- Is the service responsive?
- Is the service safe?
- Is the service effective?
- Is the service well led?

Below is a summary of what we found:

Is the service caring?

We saw that people's needs were assessed and care delivered in line with their assessed needs. We saw that people had access to outside professionals such as doctors, dentists and opticians.

We observed that staff responded in a caring and compassionate way to people's needs and had a good understanding of people's individual likes and dislikes.

People we spoke with told us they were happy with the care they received. One person told us, "I like this place very much, you get well looked after." Another person told us, "I have no concerns about living here. It is okay."

Is the service responsive?

People's needs were assessed and their care plans reviewed and revised in line with the changing needs. One person told us, "(Key worker) sits down and goes through the plan so I always know what's in it." Another person told us, "(Key worker) sits down with us once a week and checks that everything is still ok."

People we spoke with told us that they generally liked to do things for themselves but that there were activities, if they wished to join in. One person told us about trips to the theatre and how they had been to a local church to participate in an event. One person told us, "There are trips out, if you want to go; but I'm not a group person, I'm a bit of a loner."

Is the service safe?

Audits of safety systems were in place and the building was clean and tidy.

We found that windows on the upper floor of the building did not have restrictors in place or the window restrictors had been disconnected. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

We saw that night shifts were covered, on some occasions, by only one member of staff. The manager told us that no risk assessment had been undertaken in relation to this, to ensure people could be effectively cared for or supported in the event of an emergency. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

The CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager told us that no applications have needed to be submitted and people's care plans reflected that the issue of capacity had been assessed and considered. All people using the service were assessed as having the capacity to make decisions about their life in line with the Mental Capacity Act 2005.

Is the service effective?

People we spoke with told us they were happy with the care they received. They told us that staff were always available if they had any concerns. People told us, "I do chat to (care worker) if I am worried. She is a nice understanding person" and "If I am worried about anything then I would chat to someone."

We saw that care issues were discussed at staff meeting and changes to care implemented on the back of discussions. We saw one person was being helped to manage their smoking through changes suggested by staff.

Is the service well led?

The home had a range of quality assurance systems in place to monitor the quality and consistency of care and the environment of the home. We saw copies of documents regarding checks on medication, fixtures and furnishings, smoke alarms, water temperatures and electrical systems.

People who used the service confirmed that there were regular residents' meetings and we saw copies of notes from these meeting.

Staff confirmed that staff meetings took place and we saw minutes from these meetings. Staff we spoke with told us there had been no recent supervision sessions and that they had not been given an annual appraisal within the last twelve months. The manager confirmed that these had not taken place. A compliance action has been set in relation to this and the provider must tell us how they plan to improve.

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 30 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Fire Safety Assessor. We will check to make sure that action is taken to meet the essential standards.

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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We looked at three people's care plans. We saw that people had signed each individual care plans developed to meet their assessed needs to say they agreed to the care that was to be delivered. This meant people had given their consent to staff providing the support they needed.

People we spoke with told us that they knew about their care plans and had been asked if they agreed with them. One person told us, "(Key worker) sits down and goes through the plan so I always know what's in it." Another person told us, "(Key worker) sits down with us once a week and checks that everything is still ok."

Staff we spoke with told us that they always sought permission before doing anything. They told us that they made sure that people were happy with their actions. We saw that staff knocked before they entered people's rooms. We asked the deputy manager if we could look around people's rooms as part of our inspection. She checked that people were happy with this before we entered. One person told us, "They always knock. They never come in without knocking." Another person who had just commenced living at the home told us, "They asked me what I did and didn't like and whether I was happy with things." This meant that people's consent was sought before staff acted.

We observed staff throughout the period of our inspection. We saw that they were pleasant and courteous to people and sought permission before acting. For example, we witnessed that they asked people if they wanted some lunch and inquired if two people wished to play a board game in the afternoon.

We saw copies of minutes from monthly residents' meetings. We saw that people were regularly asked if they wished to raise any concerns. We also saw that people were asked if arrangements met their needs. For example, people were asked if a shopping trip to the Metro Centre would allow them to buy Christmas gifts.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We examined three care records and spoke with three people who used the service. We noted that care plans covered a range of areas including, mobility, emotional health and wellbeing and social activity. We also noted a range of health care professionals were involved with people's care. We found copies of yearly dental checks, notes regarding optician appointments and letters from professionals regarding care relating to specific matters, such as smear tests. One person told us, "Dr X comes to the home to see me every few months."

We saw from care plans that people's needs were assessed and specific care plans were in place to support each individual's requirements. For example, we saw that one person was being encouraged to eat a healthy diet and to take more exercise by joining a walking group.

Another person was required to have regular podiatry appointments to improve the condition of their feet. We saw copies of letters and notes to indicate that the person had been helped to attend these.

In another person's care records we saw that there was concern that the person was not drinking enough. We saw that there were notes in the daily records, and in the weekly review notes, that the issue had been discussed with the person and that they had been encouraged to drink more. Staff we spoke with were aware of the issue and told us that whilst the person was able to make their own decisions, they maintained a check on the situation and reminded the person about taking more fluids throughout the day. We observed that the person was offered regular drinks throughout the day. This meant that people's care needs were assessed and addressed.

Staff we spoke with had a good understanding of people's needs and were able to tell us about people's particular likes and dislikes and how they could be best supported. One staff member told us, "It's almost like a second family, working here." We spoke to one

person's care manager who told us that they had not recently visited the home but had never had any issues or concerns about the care raised with them.

People we spoke with told us they were happy with the care they received. One person told us, "I like this place very much, you get well looked after." Another person told us, "I have no concerns about living here. It is okay." They told us that staff were always available if they had any concerns. People told us, "I do chat to (care worker) if I am worried. She is a nice understanding person" and "If I am worried about anything then I would chat to someone."

The provider had in place procedures to deal with foreseeable emergencies. We saw that there was a fire evacuation folder with details of the people living at the home and key contact details. We also noted that for one person there was a procedure regarding action to take if they did not come back to the home within an agreed timescale.

People we spoke with told us that they generally liked to do things for themselves but that there were activities, if they wished to join in. One person told us about trips to the theatre and how they had been to a local church to participate in an event. They also told us that there were trips out and walks. One person told us, "There are trips out, if you want to go; but I'm not a group person, I'm a bit of a loner." During our inspection we observed one member of staff playing a board game with two of the people who used the service. This meant there were activities available to help stimulate people and keep them physically and mentally active.

The deputy manager told us that all the people living at the home had been assessed as having the capacity to make their own decisions in line with the Mental Capacity Act 2005. She said that people were free to come and go and that no one was currently prevented from freely leaving the home and subject to Deprivation of Liberty Safeguards (DoLS). DoLS is a legal process used to ensure that no one has their freedom restricted, without good cause or assessment, through a formal legal process. The deputy manager told us that she was aware that there had been recent changes to DoLS and would be reassessing the situation to ensure that the new Supreme Court ruling did not affect people at the home.

Safety and suitability of premises ✖ Action needed

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

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

We had not intended to look at this outcome, but information and observations during our inspection made us want to look more closely into this matter.

During our inspection we looked around the premises. We found that overall the home was pleasantly decorated, clean, tidy and generally well maintained. We looked in people's rooms and found these were pleasantly decorated, furnished to a good standard and were equipped with en suite toilet and shower facilities. People had personalised their rooms with ornaments and photographs. The deputy manager told us that there had recently been some decorating and maintenance of the home undertaken. There were no malodours around the building.

In addition to the en suite facilities the home had separate bathrooms and shower facilities which were well maintained. A conservatory area looked out on to a large garden. The home did not have a lift but had individual bedrooms on the ground floor.

We checked the premises and found that fire doors and fire exits were clear and functioned appropriately. We saw that regular checks on fire systems were undertaken by the provider. We also witnessed that an engineer was attending the home, on the day of our inspection, to check the fire systems and emergency lighting. He confirmed with us that a contract was in place and the home was subject to regular fire system checks by the company.

We saw that the home had an electrical safety certificate for fixed electrical systems. The manager was aware that this was due to expire in August of this year and told us a re-inspection was already booked.

During our inspection we found that, on the landing area of the stairs, one window which

opened directly on to an immediate drop did not have a restrictor device fitted. We also noted that a window in one person's en suite facility did not have a permanent restrictor device. We saw that other windows on the upper floor did have restrictors, but that these had been disconnected and hung loose from the frame, meaning the windows could be opened fully. This meant that proper safety measures were not in place to ensure that people were protected from potential risk associated with fully opening windows on upper floors.

We spoke to the manager about this. She told us that the restrictors had been disconnected because of decorating and was not aware the other windows opened onto immediate drops. She told us she would look to address this as soon as possible.

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 always enough qualified, skilled and experienced staff to meet people's needs.

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

On the day of our inspection there were seven people using the service. The deputy manager told us that she and a senior care worker were covering the morning shift, which ran from 8.00 am until 4.00pm.

The deputy manager told us that the home currently employed eleven care workers or senior care workers to cover the home over a three shift pattern, seven days a week, although one person was currently on long term sick. We saw from the home's duty rotas that there were regularly two staff on the morning shift and two on the afternoon/ evening shift. Staff we spoke with told us that they felt there were enough staff on duty to deal with people's needs. People we spoke with told us there were always staff around if they needed help.

We saw from the duty rotas that a number of the shifts at the home were covered by the registered manager. We saw that for some days the registered manager was working a full day shift (8.00am until 10.00pm) and then also down to cover the night shift. On other days we saw the manager was detailed to work a night shift and then programmed to also work the following morning shift.

Staff told us that night shifts there had previously been covered by a waking night worker and a worker who was awake for part of the shift, but then slept at the home and could be roused, if extra help was required. From the duty rotas we saw that recently only two or three night shifts had a sleep over staff member. Most night shifts were only covered by one staff member. The deputy manager told us that someone was available on call, but was not physically in the building.

We spoke to the manager about this. She told us that the reduction in staffing was because there were only six or seven people living at the home. She also told us that she covered a lot of the night shifts because it was sometimes difficult to get staff to work at night. One staff member we spoke with told us that they would be happy to work additional hours, but these were not always available.

We saw from care records that one person who lived at the home was noted to be confused at times and could sometimes display behaviour that could be described as challenging and required support from staff to help deal with this behaviour. We asked the manager if she had spoken to the local fire officer about the reduction of staff or undertaken a risk assessment regarding one member of staff supporting people at night and if there was an emergency. The manager agreed that she had not. This meant that no proper needs assessment had been undertaken in relation to staffing levels and it was unclear if one staff member could safely and effectively deliver care and ensure the welfare of people at night.

We have referred this matter to the local fire service.

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 not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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 had not intended to look at this outcome, but information and observations during our inspection made us want to look more closely into this matter.

Staff we spoke with told us there had been no recent supervision sessions and that they had not been given an annual appraisal within the last twelve months. Supervision and appraisal are processes that allow staff and managers, or senior workers, to come together to discuss their current work and identify any issues or future training needs.

We examined the records of three staff members. We saw that appraisals had been carried out just over twelve months previously, although one dated back to March 2013. We could find no record of any supervision sessions having taken place. We spoke to the manager about this. She agreed that no supervision sessions had recently taken place and that it was about the time when appraisal meetings should be undertaken. She told us that she would look to arrange these as soon as possible.

This meant there was no formal system for staff to discuss with managers, on an individual basis, any concerns they had about the work environment, or identify future training needs.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

The provider had in place a range of systems to monitor the quality of the service.

We looked at three care plans and found that people's care plans were reviewed six monthly or updated as people's needs changed. Where major changes had occurred the care plan was re written and the changes agreed with the individual. The provider may find it useful to note that some of the reviews contained limited information.

The deputy manager showed us weekly audits carried out on the fabric and environment of the home. We saw from this document that checks were made on furniture and fixtures, curtains, the overall decoration of the building and the flooring and carpets. The deputy manager also showed us that regular checks of individual rooms were undertaken, along with checks on the shower heads in the en suite facilities. This meant there were regular checks on the home environment.

We saw that there were regular checks on water temperature systems, fire systems, gas safety, smoke alarms and that the home had been assessed in relation to legionella. The provider might find it useful to note that portable appliance testing (PAT) certificates had expired a couple of days prior to the inspection. The manager told she would address this straight away.

The home undertook weekly audits of medication to ensure that stock numbers matched with the number of tablets given and to ensure that replacement medicines were ordered in a timely fashion.

The provider told us there had been no complaints, safeguarding incidents or accidents within the last twelve months. The deputy manager confirmed that she was not aware of any such incidents whilst she had been on duty.

The manager told us that they did not regularly undertake questionnaires with the people who used the service. She said that each person's key worker sat down with them, on a weekly basis to review their care and discuss any problems or issues that they might have.

We saw that each person had a key worker meeting book and that these were up to date. We saw that people were given the opportunity to raise any issues or discuss any problems. People we spoke with confirmed that staff spoke with them weekly and they could raise any issues they had about living at the home.

We saw records from monthly residents' meetings. We saw from the minutes that people were regularly asked if they had any concerns and that a range of issues were discussed. For example, we saw that there had been discussions on trips out and on the activities for the Christmas period. This meant that systems were in place to ascertain the views of people who lived at the home.

Staff told us that staff meeting were not held as regularly as they had previously been, but did take place. Records we looked at in the staff meeting book indicated that there had been two meetings in 2014, although the manager said more had taken place. She told us these had been recorded in the wrong book and showed us minutes kept in another note book. We saw that a range of issues were discussed, including care matters. For example, we saw there had been a discussion in the meeting about how to assist one person with their smoking. We saw from other records that this had been discussed with the individual and the process implemented. Records suggested the change was helping the person.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People were not protected against the risks associated with unsafe premises. Regulation 15.(1)(c)(i)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: People's safety and welfare was not always safeguarded because there were not always sufficient numbers of staff available. Regulation 22.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met:

This section is primarily information for the provider

	Staff were not always supported to enable them to deliver care safely and to an appropriate standard. Regulation 23. (1)(a).

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 30 August 2014.

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

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