Inspection Report

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

Brambles Care Home

Bramble Lane, Wye, Ashford, TN25 5EE

Tel: 01233813217

Date of Inspection: 20 August 2014

Date of Publication: September 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
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	K A Parker & A H Parker & Mrs J M Parker
Registered Manager	Mr Kevin Parker
Overview of the service	Brambles Care Home provides accommodation and personal care for up to 28 older people. The premises are a detached building situated in the village of Wye, near to the town of Ashford.
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 20 August 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, received feedback from people using comment cards and reviewed information given to us by the provider.

What people told us and what we found

The inspection was carried out by one Inspector over six hours. During the visit we talked with eleven people who were living in the home, five of these individually, and others in the lounges. We also met other people briefly, and observed staff carrying out care duties. The manager was available during the morning, and the assistant manager was in the home throughout the whole of the inspection. The management included a care supervisor who was absent due to annual leave. We talked with four other staff, and two visiting health professionals.

We looked at the answers to five questions: Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

Is the service safe?

We saw that the premises were visibly clean in all areas and were well maintained. The front and rear gardens were attractively presented.

We inspected medicines management and found that appropriate procedures were in place to ensure that people received the right medicines at the right time, with the support of appropriately trained staff. Some people were able to manage their own medicines, and had been risk assessed as able to carry this out effectively.

We found that the management had suitable procedures in place to ensure that people consented to the care and support provided for them. None of the people in the home were deemed as lacking the mental capacity to make day to day decisions, and most were able to make complex decisions. The manager and assistant manager were currently reviewing the home's responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) for two people, for whom DoLS applications could be needed. This applied to people who might be assessed as needing their liberty restricted for their own safety.

We saw there were reliable systems in place for the safe storage and management of people's own pocket monies. This prevented people from possible financial abuse.

Is the service effective?

We found that people's needs had been discussed and assessed prior to their admission, and were reviewed again as part of the admission procedures. A care plan was implemented from this, and was reviewed monthly, or more frequently if changes were needed. We saw that people or their next of kin (as preferred) had been involved in all aspects of their care planning. The staff liaised appropriately with other health and social care professionals to provide people with additional care or treatment.

The home provided people with a variety of food and drinks to meet their different nutritional needs. People said that the food was good, and they had plenty of choice.

Staff had been trained in required subjects such as health and safety, moving and handling, infection control and fire safety. We saw that this training was kept up to date. Other relevant training courses were provided so that staff could develop their knowledge in line with people's needs.

Is the service caring?

We saw that the home had a relaxed atmosphere, and people were supported to sit where they wanted to, and to take part in the activities that they preferred. Everyone that we talked with made very positive comments about the service, with remarks such as "The staff are very kind, very good. They are always there if I want someone;" and "We are looked after very well, I would recommend this home to anyone."

The home provided a range of activities throughout the week, with a planned activity each morning and afternoon. These were led each day by an allocated member of care staff for each shift, and this enabled staff to be informed about people's interests and hobbies. We saw that the activities were flexible in line with people's preferences.

We saw that staff took time to engage people in conversation, and did not appear rushed. Staff said that they usually chatted with people while assisting them with personal care, but did not have much time for conversation apart from this. All of the people that we talked with spoke highly of the staff's attitude and caring natures.

We viewed responses that people had given to questions in a recent questionnaire. One of the questions was "Are you happy that staff are always polite and respectful?", to which 100% of people who had responded had replied "Yes."

Is the service responsive?

The service had an arrangement with the local GP surgery for routine weekly visits to the home. The staff recognised when people appeared unwell and ensured that they were referred to see the doctor. Other people requested to see the doctor and staff added these to the weekly list.

The service liaised with other health services to maintain people's health needs, such as a

visiting dentist, optician, and chiropodist; and made referrals for services such as dietician, community nurses and occupational therapy.

People were enabled to stay in their rooms, go to the lounges, or go out of the home as they wished. Some people said they would not go out of the home without the support of a staff member.

We saw that there were systems in place to ensure that people's care had been given in accordance with their wishes, and to check that their rooms were clean and tidy. A keyworker system was in place so that staff could get to know a few people in more detail, and could assist them with day to day needs such as obtaining toiletries or shopping, or tidying wardrobes.

People that we talked with said that if they had any worries or concerns they would talk to their keyworker or any of the staff; or would ask to speak to the manager or assistant manager. They were confident that the staff would take appropriate action to deal with their concerns. The manager or assistant manager had a visible presence in the home every day, and usually spoke to each person each day. This enabled them to deal with any minor concerns immediately.

Is the service well-led?

We saw that people in the home knew the manager and assistant manager well, and had confidence in them to deal with any issues.

Staff had individual supervision sessions on a regular basis, and staff meetings. This enabled them to discuss ideas and any matters of concern. Staff said that they could ask the management about anything at any time.

People who lived in the home were encouraged to share their views on a daily basis, and had the opportunity to do this when the manager or assistant manager spoke to them. They were provided with a monthly newsletter which identified any changes taking place in the home, and had a list of the planned activities for the month. People were also invited to share their views at residents and relatives meetings; through a separate forum; and using questionnaires. We saw that their views were collated, and action was taken in response to people's comments.

The home had monitoring procedures in place. This included regular checks for maintenance and safety, such as checking water temperatures, checking the nurse call bell system, and checking fire alarms and fire equipment. Medicines were checked every month to see that they were all in date; and the pharmacist visited twice per year to check medicines management.

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

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

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

People's care needs were discussed with them prior to admission. A care plan was then implemented and was discussed with the person concerned. The assistant manager said that they gave the person a copy of the care plan, so that they could have time to read it, and make sure they agreed with the content. This was then signed by the person or their representative to confirm their agreement.

Most people came in for permanent care, but had a trial period first to ensure that they were happy with the home, and to see that the staff could meet their needs effectively. This was usually about four weeks, but could be extended if people wished. The management met with the person and their next of kin or representative at the end of the trial period, so as to ensure everyone was satisfied with the standards of care, and to discuss any concerns or changes needed.

We saw that people had a formal agreement with the home, with agreed terms and conditions of residency. This included details such as the weekly fees, an overview of the staffing, care planning processes, and arrangements for terminating the agreement. People were given a copy of the complaints procedure, in the event that they wished to make a formal complaint, or wished to contact an authorised independent service.

We saw that staff obtained people's verbal consent for everyday care and treatments. For example, they asked people for their choice of bath, shower or wash in the mornings and evenings; asked people where they wished to go, and if they wanted to join in with activities; and ensured that people had their own choices in regards to food and where they preferred to eat their meals.

All of the people currently living in the home were able to make their own choices about

their day to day activities, and most could make complex decisions. However, the management demonstrated that they understood their responsibilities under the Mental Capacity Act 2005, and Deprivation of Liberty Safeguards (DoLS). This meant that people who lacked the mental capacity to make decisions about where they lived or the care that they needed would be appropriately supported by their family members or advocates, and by health and social care professionals, to make decisions on their behalf and in their best interests.

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.

People experienced care, treatment and support that met their needs and protected their rights.

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 talked with people living in the home, some of these in their own bedrooms and some in the lounges. People said that they liked living in the home and were happy there. The staff showed that they knew people's individual preferences and routines. For example, they told us that most people had breakfast on their trays in their bedrooms, but one person preferred to go to a dining area and sit at a dining-table. Other examples were that staff knew that some people liked to spend time in their own rooms except for main meals; and others preferred to have a bath during the afternoons, and not the mornings or evenings.

We looked at three people's care plans and saw that these reflected people's individual choices and care needs. The care plans included all aspects of care, such as communication, continence, daily life, emotional support, medical needs, mobility, nutrition and personal care. Each care plan included a care needs summary at the front. This enabled staff and visiting health professionals to have a quick overview of a person's care and support. A précis of this was placed inside each person's wardrobe with their permission. This meant that the person, their keyworker, or other care staff, could quickly check any details of their care needs.

The care plans provided a comprehensive plan for each part of the person's care. We saw that these were very detailed, specifically when they related to people's medical needs such as use of oxygen, or pressure relief to prevent pressure sores. The care plans were written from the person's own viewpoint, so that they could relate to them well. For example, "I can mobilise with the aid of a wheeled Zimmer frame; I can be unsteady at times, and may ask a carer to walk with me if I feel unsteady."

Assessments were carried out when people were admitted, and were carried out monthly to check for any changes. Some of these were held as paper records, and some on the computer system. They included a nutritional assessment, moving and handling assessment, falls risk assessment and 'Waterlow' (skin integrity) assessment. We saw that

people's weights were monitored and recorded each month. People with sore areas or wounds were referred to the Community Nurses, who maintained their own records for wound care. We saw that two people were sitting with their feet elevated, and they told us that the nurses had instructed the care staff that this should be done to reduce swelling of their legs and feet.

The senior care staff wrote daily records of care for people, for each shift. We saw that these contained sufficient information about the person's health and wellbeing, their mood and any activities. The records were signed and dated, but the time when the entries had been written was not recorded.

The home provided a wide variety of activities. These included items such as board games and jigsaws; flower arranging; hand massage; taking part in gardening in raised beds; quizzes; a Saturday afternoon film with refreshments; chair exercises to music; sewing group; poetry group, and cooking. Visiting entertainers came in, and a mobile clothing shop. The manager said they were in the process of setting up a small trolley shop, so that people could buy popular items within the home on set days. The home had a hairdressing salon, and some people used the hairdresser booked by the home, and others had their own hairdressers to come in and do their hair.

The home had good links with the local community. A church service was held in the home every month for people who wished to take part in this. Local schools and choirs visited the home, especially at Christmas; and the home held a Summer fete each year in the gardens.

People said they were happy living in the home. Comments included, "It's lovely here. It is very, very good. The staff are all very friendly and caring"; "The staff are very kind, and very good. They always send someone to check my room has been cleaned properly, and everything has been done right"; and "I am very happy and very settled here. I would recommend it to anyone."

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 used the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who used the service were protected from the risk of abuse, because the provider had taken reasonable steps to prevent abuse from happening.

We saw that safeguarding policies and procedures and adult protection were included in the first day's induction. Staff were required to read key policies and procedures and signed to confirm this. The home's policy stated there was a "Zero tolerance to abuse."

The induction was followed up with safeguarding vulnerable adults training, using an e-learning training course. We saw from records that staff had completed this training, and there was a system in place to ensure their training was kept up to date. The training included a test at the end, and results which were delivered to the management. This meant that the management could check when training had been completed, and how well staff had been able to understand and apply it.

The manager and assistant manager demonstrated their understanding of safeguarding procedures and how to report any suspicions or allegations of abuse. We saw that there was a copy of the Kent and Medway multi-agency agreed protocols in the office, so that staff could access this if they needed to.

Some people had pocket monies kept in storage by the home for safe keeping. This was only for small amounts, and was to pay for services such as chiropody, hairdressing, newspapers, and outings. We saw that an individual record was maintained for each person, and all receipts were kept. These records were shared and discussed with the person or their authorised representative on request. This showed that there were robust procedures in place to prevent people from financial abuse.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Medicines were prescribed and given to people appropriately.

Medicines were stored in a locked room, in suitable locked cupboards, and in a medicines trolley. We saw that the trolley was attached to the wall when not in use. The cupboards and trolley were clean and neatly maintained. There were systems in place to check the stock and the dates each month, and included appropriate stock rotation. Most medicines were dispensed using a monitored dosage system, whereby each dose was separately identified for each person.

We saw that controlled drugs were kept in a locked metal cupboard which met legal requirements. A controlled drugs register was accurately maintained, and showed two signatures for all drugs given or returned to the pharmacy.

The room contained a drugs fridge which was kept locked, and which contained only items which needed to be stored at lower temperatures. We saw that the drugs fridge and room temperatures were checked and recorded daily.

We viewed medicine administration records (MAR charts) and found they were correctly completed, using the right codes on the chart to show if any medicines had been refused or not given. A space on the back of the chart was used to identify reasons why medicines had not been given, or if "as necessary" (PRN) medicines had been given. Handwritten entries had been entered and signed by one staff member, but had not been countersigned by a second staff member to confirm the accuracy of transcribing from the label to the MAR chart.

The management discussed people's medicines with them as part of the admission processes. Some people wished to continue to self-administer their medicines. In this case, a self-administration assessment was carried out to ensure that the person was fully able to understand their medicines; had the dexterity to open the packets or bottles; and knew the times and doses of their medicines. Each person had a lockable facility in their bedrooms, and these provided suitable storage for people who self-administered their medicines.

We saw that oxygen cylinders were stored in the medicines room, and oxygen was in use in someone's bedroom. The provider may find it useful to note that there was no hazard warning sign on the doors to show that oxygen was stored or in use in these rooms. The assistant manager was taking action to address this when we finished the inspection. We saw that staff were appropriately trained to administer medicines before they were allowed to do so.

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

Staff received appropriate professional development.

We viewed the home's induction programme. Staff were required to read policies and procedures on the first day, and then received training in topics such as the fire alarm system, call bell system, maintaining confidentiality, answering the phone and front door, and a practical training session in moving and handling. Most newly recruited care staff had already qualified in National Vocational Qualifications (NVQ) or Quality Credit Framework (QCF) levels 2 or 3 in health and social care. However, some new staff had not previously carried out care work, and they were supported in completing the nationally recognised Common Induction Standards.

New staff were required to show training certificates to confirm any previous training and when it had been completed. The home provided an e-learning training programme for required subjects such as health and safety, first aid, infection control and fire safety. The training courses included a test and results, which were sent via the computer system to the assistant manager. She talked through staff's understanding of their training after they had carried out e-learning courses, during individual supervision sessions. Staff were required to achieve a certain percentage for each course to pass the subject. Staff told us that they also had face to face training for some subjects, such as moving and handling. Staff could carry out the training courses at home in their own time, or could use a computer in the home if they wished to do so, or needed computer support.

Staff were given a copy of the staff handbook to read during their first few days, and a copy of this was kept in the duty office and the manager's office for reference. Staff were also given a copy of the General Social Care Council (GSCC) codes of conduct, explaining the expected role of care workers.

New staff were required to carry out shadow shifts with experienced care staff prior to being assessed as able to work on their own.

We saw that staff were encouraged to carry out training courses for additional subjects which were relevant to people in their care. This included subjects such as Parkinson's

disease, diabetes, and understanding dementia.

Staff were supported through individual supervision sessions, and through staff meetings. We saw that individual supervision was usually carried out every two months. Two to three general staff meetings were held each year, and other staff meetings for staff in the same job roles. The management usually met weekly to discuss people's changing needs and any other issues

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

People who used the service, their representatives and staff were asked for their views about their care and treatment and these were acted on appropriately.

The manager and assistant manager had an open door policy and we saw this in practice as they were available to people during our visit. Staff said that the manager was approachable and accessible.

The home had good links with the local community in the village. This included a Summer Fete held each year; and events at other key times such as Christmas, when local school children and church choirs visited. People's families and friends were invited to these events, so that the home was well known locally. This was important to people living in the home, as most of them had been admitted from the local area. Most people had previously attended the local GP surgery, and were pleased that they had been able to retain the same group of doctors for their medical care.

People's views were obtained through direct conversation each day, as the manager, assistant manager, or care supervisor spoke briefly with each person each day. This provided people with the opportunity to share any everyday concerns, and these were then dealt with immediately.

Residents and relatives meeting were held several times per year, so that people could discuss aspects of the home together. We saw that these meetings included topics such as outings and activities, menus and special events.

People were also enabled to share their views using annual questionnaires. We saw that these had been recently completed, and the results were being collated so that any required action could be taken as appropriate. The questionnaires included questions about the environment, the food, laundry care, care planning, activities, and if people felt their privacy and dignity were respected. We saw that the overall responses were very positive. For example, 100% of people who had so far responded stated they were happy with the environment; with the cleanliness of their own rooms; and with how the care staff

assisted them. They said that staff were "Always polite and respectful"; and agreed that their likes and dislikes were known and adhered to. People were able to make additional comments, and these included, "I am very happy with the care staff, you could not choose better"; and "I think you run a very happy care home."

We found that the manager carried out weekly management meetings. General staff meetings were held two or three times per year to update the staff with any changes. A recent change had been to enable senior care staff to attend training in how to run teams, so that they would be confident in their team leadership.

We viewed some of the home's policies and procedures, and saw that these were kept up to date, and were amended in line with changing regulations. Auditing systems were in place, and included checks for items such as medicines management, care plan reviews, and checking people's personal monies.

The home had a complaints procedure which was easily available to people. We viewed the complaints log and saw that there had been no formal complaints during the previous year. We saw evidence to show that people's concerns and complaints were taken seriously, were properly investigated, and action was taken to resolve any complaints as quickly as possible.

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