Inspection Report

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

Fisher Close

1-3 Fisher Close, Grangewood, Chesterfield, S40 2UN

Tel: 01246202667

Date of Inspection: 06 June 2014

Date of Publication: July 2014

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

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

Details about this location

Registered Provider	Enable Care & Home Support Limited
Registered Manager	Mrs Tanya Mostol Smith
Overview of the service	Fisher Close is located in Chesterfield, Derbyshire. Accommodation nursing and personal care is provided at Fisher Close for up to 15 adults with learning disabilities within three bungalows.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 6 June 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 carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by commissioners of services and reviewed information sent to us by other authorities.

What people told us and what we found

There were 14 people living at Fisher Close. Most people were not able to tell us about their care and experiences because of their medical conditions. We spoke with some people's relatives, spent time observing how staff interacted and supported people, spoke with staff about people's care and looked at some of their care records. Below is a summary of what we found the service.

Was it safe?

We saw that staff supported people safely and mostly followed the Mental Capacity Act 2005. One person was able to consent to their care and their records showed that the provider asked them for their consent before they received care and acted in accordance with their wishes.

Two people's care records did not properly account for their best interests. This was because they did not show the necessary arrangements, where important decisions about their care and welfare had been made by others on their behalf. This meant that where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.

People were protected against the risks of unsafe or unsuitable premises because the provider had taken steps to ensure the home was adequately maintained and equipped and mostly suitably designed.

Arrangements were in place for dealing with foreseeable emergencies, such as in the event of a fire or accidents or serious accidents and incidents. The local fire authority had inspected the home in March 2014 and found the provider fire safety arrangements were broadly compliant with their fire safety requirement.

The manager had undertaken checks of people's care and safety and the records required for this were mostly kept up to date. They were also introducing checking systems in for medicines and infection prevention and control. This helped to ensure that people were not being placed at unnecessary risk because the provider had systems to assess and manage risks to people's health and welfare.

Was it effective?

Staff understood people's needs and any known risks to their safety, which helped to ensure that people experienced care, treatment and support that met their needs.

Two people's relatives told us they (people), received the care they needed. This was independently described by both as 'excellent.' One person's relative said, "He's been in a few homes and has been much better here."

The provider had external management monitoring arrangements, which included a recorded annual audit. This audit was used to check the quality and safety of people's care at Fisher Close. This was completed to show the provider's systems that should be operating to ensure people's safe and effective care. However, the record did not show whether these were met or whether any improvements were needed This meant it was not wholly effective in assuring the quality and safety of people's care.

Was it caring?

Two people's relatives told us that staff, were "brilliant" and "caring."

We saw that staff communicated well with people, in a caring manner. Staff supported people with sensitivity, for example supporting them to move and to eat and drink. They promoted people's privacy and dignity and helped them to make simple daily living choices. For example choice of meals and drinks.

Was it responsive?

We found there was usually enough qualified, skilled and experienced staff to meet people's needs. We saw that staff communicated well with people, in a caring manner. They supported people at their own pace and in a way that recognised their individuality.

Work was in progress to develop approaches to people's care. This included assessing and responding to people's behavioural needs and developing a more person centred approach to meet people's changing and complex care needs.

Some information was provided for people about their care in formats that were easier for them to understand. This included the use of pictures and symbols. A meals toolkit was being developed to further to assist people in choosing their meals. People's care plans showed how they communicated their needs and instructed staff about this.

The home was comfortable, homely and equipped to meet people's mobility and sensory needs. This included personal mobility equipment and sensory quiet rooms and equipment. All people's own rooms were highly personalised. However, the design of the garden in Bungalow 1 restricted people's use. This was because it was too difficult for staff to move people in their adapted wheelchairs on the soft grass and the patio area provided limited space.

We found that the provider properly responded to complaints and concerns they received. This included investigating, acting and responding to the complainant.

Was it well led?

The manager and senior staff involved people's families, advocates and relevant health and social care professionals in people's care when required. This helped to ensure that people's health and social care needs were met, including for their routine health screening.

We found that the manager was consulting with staff and facilitating a review of their skills and deployment arrangements. Their stated aim was to develop proactive approaches to people's care and to secure more flexible staff working across the three bungalows at Fisher Close for benefit the people living there.

The manager monitored accidents and incidents and errors and near misses to check whether improvements were needed to people's care. Improvements being made included, developing care plan approaches for managing people's behaviours that challenged others. This included the commencement of a programme of related accredited staff training.

We found that staff, were asked for their views about people's care and treatment, and consulted about any changes. However, people's views about their care and treatment; or their representatives where required, were not always obtained or accounted for.

One person's care records did not fully account for their safety and welfare needs. This was because some of their personal care needs, relating to risks from their medical condition, were not being regularly reviewed. However, records showed that the manager had identified this and had instructed staff about the action to be taken and by when to rectify this.

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

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases

we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Where people were able to consent to their care, the provider asked them for their consent before they provided care and acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with the manager and two staff and asked them about the arrangements for determining and agreeing people's care and looked at four of people's care records. We were advised that the majority of people were not able to make important decisions about their care and treatment because of their mental capacity.

One person was able to consent to their care and their care plan records showed that they were consulted with and had agreed their care plan, which was also regularly reviewed with them. This meant that before they received any care and treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where most people did not have the capacity to consent, we found the provider did not always act in accordance with legal requirements.

Three people's recorded needs assessments showed they were not able to consent to their care and treatment. Care plans detailed how some decisions about people's care and treatment were being made in their best interests. For example, their nutrition and medicines. They also showed the sorts of choices some people were able to make about their daily living routines and lifestyle preferences and how they communicated their wishes and needs.

Two people's care records showed that they had a legally appointed person to make decisions for them. Information was held about the sort of decisions they were authorised to make. This meant that the right person would be contacted if a decision needed to be

made on behalf of someone receiving care at Fisher Close.

However, one person's care records showed that a family member managed their finances for them on their behalf. Their record did not show whether the person was legally authorised to do this. Another persons' care plan showed that an advanced decision about their care and treatment had been made by family members. However, there were no records to show, either they were legally authorised to make this type of decision; or the decision was made in their best interests in consultation with relevant health or social care professionals where required.

We found that staff responsible for gaining and reviewing consent from people about their care and treatment had a basic understanding of the Mental Capacity Act 2005 (MCA). The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. Staff also told us they had completed training in the MCA and training records reflected this.

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.

Reasons for our judgement

At our last inspection on 11 November 2013, we found that people mainly experienced care and support that met their needs and protected their rights. However, the planning and delivery of people's care did not always ensure their welfare and safety. This was because people' care plan records did not always identify risks to people's safety or show how they should be managed and reviewed. Following our visit the provider told us about the action they were taking to improve this.

At this inspection most people were not able to tell us about their care and experiences of living at Fisher Close because of their medical conditions. We spoke with two people's relatives and eight staff. We also spent time observing how staff interacted with people and supported them and we looked at four people's care records. This helped us to understand people's care and daily living experiences.

Two people's relatives told us they were happy with the care provided at Fisher Close, which they both described as "excellent." They also said that staff were "brilliant" and "caring." One person said, 'He's been in a few homes and has been much better here; they keep me informed and I have Sunday lunch there with him."

We saw that staff supported people safely and in a way that met with their needs and known preferences. This included support with their medicines, mobility, meals and drinks. We found that staff understood people's individual needs and any known risks to their safety and welfare. We saw that staff communicated well with people, in a caring manner. They supported them at their own pace and in a way that recognised their individuality. This included promoting people's privacy and dignity and helping them to make simple daily living choices. For example choice of meals and drinks. We saw that a toolkit of picture cards was being developed to further help people to choose their meals.

We found people's care and treatment was mostly planned and delivered in a way that was intended to ensure their safety and welfare.

We looked at four people's care records and saw they had a range of health conditions and disabilities, which could present risks to their welfare and safety. We saw that people's needs were assessed in a way that met with recognised guidance and that work

had commenced to develop people's care plans so that they were more person-centred. Key concepts of person centred care include, respect and holism; power and empowerment' choice and autonomy and empathy and compassion.

Two people's health care needs were mostly accounted for in their written care plans and their care and treatment was planned and delivered in a way that was intended to ensure their safety and welfare. Their care plans were regularly reviewed and revised where required, to meet with any changes to their risk assessed needs. We also saw that contacts and interventions from outside health care professionals concerned with people's care were detailed. This included routine health screening and the reason and outcome of these.

We saw for one person that a detailed behavioural assessment screening tool and care plan was introduced for staff to follow, which reflected recognised guidance. Discussions with staff told us this helped them to understand, prevent and manage aspects of the person's behaviour that sometimes challenged people. There was a specific monitoring tool for staff to record episodes of this type of behaviour, where required and to help them to review the effectiveness care provided in this event.

The provider should note that one person's care records did not fully account for their safety and welfare needs. This was because some of their personal care needs relating to risks from their medical condition were not being regularly reviewed. However, records showed that the manager had identified this in some of their recent checks of people's care plan records. They had also given written instructions to staff about the action to be taken to address matters. Our discussions with staff about the person's care told us that they received safe and appropriate care.

Arrangements were in place for dealing with foreseeable emergencies. This included procedures for the reporting, recording and action to be taken in the event of accidents or incidents causing harm or abuse.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who used the service were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

One person said they liked their own room and we saw that people's room were well personalised.

We found that the provider had taken steps to provide care in an environment that was adequately maintained and equipped and mostly suitably designed.

There are three five bedroom bungalows on the site at Fisher Close. All provide a communal lounge/dining room, bathroom and toilet facilities and sensory room and well-kept gardens. Most people were not able to tell us about their experiences of living at Fisher Close due to their medical conditions. We saw that the home was comfortable, clean, fresh and well decorated, furnished and equipped. It provided safe access for people with mobility problems to most of their communal and personal living accommodation.

We saw there were adequate arrangements for the security of the premises and to maintain the gardens and grounds. However, the provider should note that the garden to Bungalow number 1 provided a large lawn and a small patio area. This meant that the people living there were not able to make full use of the garden, because of their mobility problems. This was because the patio area was limited in size and it was too difficult for staff to move people in their adapted wheelchairs on the soft grass area. There was also no separate quiet room for people to receive their visitors in private, other than in their own bedrooms.

Arrangements were in place for dealing with foreseeable emergencies and for the regular servicing and maintenance of equipment, which were up to date. Revised business contingency plan packs, for staff to follow in the event of an emergency, were being introduced into each bungalow.

Derbyshire Fire and Rescue Service have provided us with a copy of their report following their inspection at Fisher Close on 27/03/2014. This tells us they found the provider was broadly compliant with fire safety requirements.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were usually enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

At our last inspection we found the provider had not taken appropriate steps to ensure there were sufficient numbers of suitably qualified, skilled and experienced staff, to safeguard people's health, safety and welfare. Following our visit the provider told us what action they were taking to make improvements.

On 14 April 2014 we received a copy of a complaint made to the provider alleging insufficient staffing levels in one of the bungalows on 30 March 2014. We asked the provider to tell us about their complaint investigation findings and any action they may take as a result. The information they provided, told us that the staffing levels were compromised that day due to a staff member's absence and procedural failures in securing additional staff cover. At this inspection we found the provider had taken the action they told us about. This included instructing staff about the procedures they need to follow in the event of any staff absence.

At this visit we found that there was usually enough qualified, skilled and experienced staff to meet people's needs.

We spoke with two people's relatives who felt people received the care and support they needed, which included support to attend health and medical appointments and to engage in activities in and outside the home. One person said that staff sometimes appeared stretched but did not feel that people's care was compromised because of this. Another relative told us that occasionally there were changes to the type of transport arrangements for the person's regular social visits home. However, they also said that the person's visits home were never compromised.

Staff said they mostly received the training they needed and told us about improvements in the provider's arrangements, to ensure they received regular or periodic updates and refresher training where required. A summary record of staff training was provided, which reflected this and included training planned.

Duty rotas we looked at and discussions that we held with staff showed that staff rotas were usually planned to meet people's needs. Minutes of staff meetings and update letters to staff, told us that staff were consulted about staff deployment arrangements.

This included procedures to be followed in the event of staff sickness and absence. We found that staff deployment arrangements were subject to review by the manager to promote and secure more flexible working across the three bungalows for the benefit of people living there.

We found that staff supported people to engage in planned activities and attend health care appointments in the local community. Staff said that planned staffing levels and skill mix were usually sufficient to provide people with the care they needed. This included planned social and recreational activities for people outside the home. The provider should note that staff in one bungalow felt that the behavioural needs of one person sometimes prevented spontaneous trips out for other people at weekends. However, we found there was work in progress to review staff skills and to develop more proactive approaches to people's care. This included assessing and responding to people's behavioural needs and developing a more person centred approach to meet people's complex care needs.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider's systems were not wholly effective to assess and manage risks to people's health, safety and welfare and to monitor the quality of services provided.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with the manager about the provider's arrangements to check the quality and safety of care people received at Fisher Close, including the environment and equipment there. We also looked at some of the provider's records of this. We saw that a range of checks were in place. These included care plans, medicines, staff training and staff recruitment records, environmental health and safety and maintenance and equipment checks. The manager showed us the documentation for a new checking system for infection prevention control had been developed, which they were about to implement.

Records showed that complaints, accidents and incidents and errors and near misses were also monitored to check whether changes or improvements were needed to people's care. Recent improvements from these included medicines systems and the development of person centred care planning and approaches, which was work in progress. This also included the development of care approaches for managing behaviours that challenge others and the commencement of a programme of related accredited staff training.

We saw that provider had external management monitoring arrangements, which included a recorded annual audit. This audit was used to check the quality and safety of people's care against the Care Quality Commission's essential standards of quality and safety guidance about compliance. However, although it was completed to show the provider's systems that should be operating; it did not record whether they were. This meant it was not wholly effective in assuring the quality and safety of people's care.

We found that staff, were asked for their views about people's care and treatment and consulted about any changes. Records we looked at reflected this, which included staff meeting minutes and staff advisory updates. One person, who also advocated for others in the home, had regular one to one meetings with their named nurse regarding the general care, staffing and daily living arrangements.

The provider sent us the results of their most recent satisfaction survey, which they had

formally conducted with people across all of their registered homes during May and June 2013. The survey was conducted with people by the staff caring for them, who asked people to rate aspects of their care and services provided. The results showed that people were mostly satisfied and showed a few areas where improvements could be made. For example, informing and involving people in their care plans. Where the survey identified improvements that could be made, there was no action plan for these; no information about the relevance of the survey and its findings to Fisher Close and no involvement of advocates or people's representatives. This meant that people's views about their care and treatment were not always obtained or accounted for.

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 activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The registered provider's arrangements were did not always meet with legal requirements, where people did not have the capacity to consent.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have wholly effective systems to regularly assess and monitor the quality of services provided. This was because they did not regularly obtain or act on the views of people receiving care at Fisher Close or, where appropriate, person's acting on their behalf.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

The provider's report should be sent to us by 09 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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