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

**Autumn Vale Care Centre**

Danesbury Park Road, Welwyn Garden City, AL6 9SN

Date of Inspection: 27 January 2014

Tel: 01438714491

Date of Publication: May 2014

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

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<tr>
<td>Care and welfare of people who use services</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Cooperating with other providers</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✗ Action needed</td>
</tr>
<tr>
<td>Registered Provider</td>
<td>GCH (Heath Lodge) Limited</td>
</tr>
<tr>
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<tr>
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<td>Autumn Vale Care Centre is a purpose built 69 bed care home, providing care and accommodation for predominantly older people, including those who require nursing care and/or live with dementia.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Care home service with nursing</td>
</tr>
</tbody>
</table>
| Regulated activities  | Accommodation for persons who require nursing or personal care  
                          Diagnostic and screening procedures  
                          Treatment of disease, disorder or injury |
When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people’s experiences of moving between care homes and hospital.

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 27 January 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 carers and / or family members and talked with staff.

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

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We saw that people in the home who were living with dementia did not always have their needs recognised and met. We saw that staff treated them with respect and kindness and tried their best to care for and offer comfort to the people. However the staff were not trained effectively to ensure the people had optimum choice and independence. Care plans were not written in a manner that assisted staff to deliver good care.

We were given mixed responses on care delivery by the people and their relatives, some thought it was good, however most of the people we spoke with had some concerns. Generally people told us that they were not involved in the planning of their own care and where appropriate their relative’s care.

Among the comments told to us by the people living there and their relatives were: "I like it [at the home], I like the staff, they look after me." Another person said that "They don’t come when I need help. They don’t listen to me" “They don’t spend time with me they do what they have to do and they’re gone”.

Discussions with relatives told us that “We’ve had limited involvement in [their relatives] care. We haven't been involved in many decisions about care planning.” Another said that “The staff always close the doors at times of personal care”. We were told that the staff were “Really lovely with the residents. They treat them respectfully”. "The staff are
compassionate but there's not enough of them to provide anything but the basic needs.”

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 16 May 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

**Care and welfare of people who use services**  
**People should get safe and appropriate care that meets their needs and supports their rights**

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**Our judgement**

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

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.

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**Reasons for our judgement**

How are the needs of people with dementia assessed?

The care plans we looked at had comprehensive assessments that had been completed by social workers. These assessments contained useful information on the person's physical and mental health, their likes, dislikes and had a social history on the person. However, ongoing assessments did not include the person or their relatives to determine what care was best suited to them. We were told by relatives that they were not consulted on the food and drinks the person liked. Other relatives told us that they were not consulted on male carers caring for their female relative. A review of care plans showed that people had not been consulted on how they wanted their care delivered. We saw that risk had been identified for example one person had been identified as being at risk of developing a pressure area and had been provided with a pressure relieving cushion. The directions to staff were not clear that the person needed pressure relief at all times and we saw that during the course of the inspection the equipment wasn't used. This left the person at risk of developing a pressure area. The staff were not able to identify to us the people who had a pressure area.

How is the care of people planned?

We looked at the care plans for five people who had been diagnosed as living with dementia. We compared what was recorded in the care plan with the care we observed and where possible what the person using the service told us. We used this information to help us make a judgement about whether the service was meeting people's needs.

The care plans we looked at provided some personalised information about the person. However, there was no detail on how the person's dementia affected them in their daily
lives, or how staff should care for them to ensure that they had optimum health and welfare. We did find that staff delivered basic personal care in a dignified manner. An audit conducted by a senior manager in December 2013 highlighted that the care plans had not been reviewed. The manager told us that their priority had been to appoint suitable staff. We were told that this had now been completed and that there was a plan in place to train staff to care for people living with dementia and also to ensure all the care plans were reviewed on a regular basis. Discussions with the manager showed that they had an understanding of the care needs of people who were living with dementia but at the time of the inspection this was not evident throughout the home.

During the day we saw that staff were not proactive in providing care, for example one person was walking around pacing and appeared to be looking for something and was visibly distressed. They were not offered comfort by the staff. We alerted staff to the person's distress and we saw that staff responded to our immediate concern but saw that the person was not offered further comfort as the day progressed and was left to walk and pace as before.

Are people able to make choice about their care?

We were told that every effort was made to ensure the people had choice, however we did not witness this in the interaction between staff and the people. Care plans did not contain enough information on the person's needs, likes, dislikes and wishes, for staff to be able to offer choice. For example during lunch, we observed one person who was waiting for their lunch reach to another's plate and eat their food, the person was angry and hit the first person on the hand. This went unobserved by the staff on duty. When the person waiting then got served their food it had pureed. Initially the person used their cutlery to eat their food and then we saw that they dropped their cutlery staff did not see this. The person then resumed eating using their hands. This detracted from the person's dignity and made lunch a difficult experience for them, as eating pureed food with fingers was difficult and they were clearly hungry. We checked their care plan to see why they needed pureed food. We were unable to find any information relating to this in the care plan. The lack of information could have presented a risk to the person as if they needed pureed food they could have been at risk when eating solid food unsupervised and from another person's plate.

Are people with dementia provided with information about their care?

We saw that staff were not trained to care for people who were living with dementia and were unable to offer information to the people on the choices available to them in a manner the person could understand. For example one person continually showed their distress by saying said that they wanted to go home. Staff were not skilled and trained to offer distraction and comfort them. The staff did try and resorted to singing to the person, however the choice of song further distressed the person. The staff we spoke with were aware they needed training to care for people who were living with dementia and told us that the training was being arranged by the manager. Discussions with the manager confirmed this.

One of the units we spent time on did not have any objects of stimulation or comfort for the people. This included items such as books, newspapers and magazines. These objects could have assisted the staff to communicate and to offer choices and information to the people.
How is care delivered to people with dementia?

We saw evidence that care was delivered in a task orientated manner. The staff focused on the task to be done rather than focusing on the person and what their emotional needs were. Staff were working with care plans that were not well written and did not explore how the person's dementia effected their emotions and behaviour. None of the care plans gave directions to staff on how to ensure personalised care was delivered.

We saw staff try to offer comfort to distressed people but some staff did not have the skills to distract them or to respond to them in an effective manner. For example one person who cried out most of the time we were there. Staff were unable to communicate effectively with them in a manner that offered them comfort and reassurance. We heard the person ask to go home and the staff member asked where they lived. This was not a suitable response as it could cause further confusion and distress to the person. Later in the day we spoke to the person we were able to communicate with them. They appeared distressed and told us that they did not want to live in the home and asked if could we take them away.

However, there were areas of good practice we saw that most staff members were kind and caring, but lacked direction on how to care for distressed people. We were told by the manager that daily information was collected on the people with regard to their health and welfare. This record was to include their how their behaviour effected them and their food and fluid intake. We looked at these records and saw that the recording was haphazard, not all the days we looked at had notes relating to the person. An example of this was one person’s chart said 'less shouting', very noisy, shouting, they were scratched on their face by XX. Good intake of food and fluids’. Staff were unable to tell us what was done with the information. There were no notes of what was done to assist the person. The manager was unaware of the poor recording in the notes.

Risk assessments had been carried out but were patchy in their effectiveness. For example two people who were identified as been at risk of developing pressure areas and in need of pressure relieving equipment had been left without pressure relieving equipment during the day. We were told that there were cushions for the people to use during the day. They were not used during our visit. The manager told us that they should have been used and would investigate why they were not in use.

We observed people had little interaction with staff during our time on the unit. People concentrated on activities of their own making. For example some people rearranged their clothing, but did so in a manner that compromised their dignity. Staff were unaware of this and did not assist the person to be stimulated in a manner that promoted their dignity.

Is the privacy and dignity of people with dementia respected?

Care plans were not personalised therefore staff were not directed on how to care for the person in a manner that promoted their dignity as a unique person living with dementia. We saw that there were variations in how staff assisted people to retain their privacy and dignity. Some staff were kind caring and very supportive and tried to recognise and meet the person's needs in a dignified manner. An example of this was staying with the person when they were distressed and been soothing and comforting. Other staff members were task focused and did not show recognition or respect for the dignity of the person they were caring for. We saw one person walking around in wet track suit bottoms for 20 minutes before staff noticed them and took them to their room to change their clothes.
We saw that at all times people had their personal care delivered to them in their own rooms. Visiting health care professionals saw people in the privacy of their own rooms.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was not meeting this standard.

People's health, safety and welfare was not always protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider could not always be sure they were working in the person's best interests.

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

At the time of the inspection no one from the home was currently in hospital so we were unable to access the admission process. We were told that a summary of the person's health was completed on the day of their admission to hospital and was sent to the hospital with them. We saw a hospital discharge summary for a person who had recently spent time in hospital, this gave useful information on the person's medical condition and their proposed course of treatment. We were told by relatives that the home had not followed the hospital's directions when caring for their relative and that because of this their relative lost weight.

Are people with dementia able to obtain appropriate health and social care support?

We saw that the home had a good relationship with the GP practice and worked with them to try and avoid inappropriate hospital admissions. When people first came into the home they were asked if they would prefer to stay in the home or go into hospital for their end of life care. The home used the appropriate end of life documentation that had been completed with their GP and where possible themselves or their families.

There were some people who would have benefited from an assessment of their mental and physical health by appropriate professionals. We did not see any evidence that this had been carried out. For example we were told that people who have a pressure were referred to a tissue viability nurse for treatment and advice. We did not find any evidence of this. This delay in contacting the tissue viability nurse could cause unnecessary delay and distress.
Assessing and monitoring the quality of service provision

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess, monitor and improve the quality of service that people receive.

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

How is the quality of dementia care monitored?

Both the home manager and the regional manager were new to their posts. Both of them had identified areas in the home that needed to be improved.

We were told that staffing levels and the quality of the staffing had improved since they had taken up their posts. Both were aware of how the needs of people who were living with dementia should be met however this was not translated into the care of people who lived in the home. Training needs had been identified, however no effective training had yet been carried out. The needs for stimulation was recognised and understood, however we found no evidence of this. The manager was aware of this and told us that the decoration in the unit had not been completed and they undertook to furnish objects of stimulation and comfort the next day.

Discussions with the deputy manager indicated that they were happy with the care of people in the home and told us that people living in the home had a good quality of life but were unable to give us examples of how people with dementia were living well.

Staff we spoke with were unaware of how to care for people living with dementia, the risks to them had not been assessed appropriately therefore staff were unaware of the risks the people and how to reduce or prevent risks.

There were some systems in place for recording the daily lives of the people, we found no process in place to extract this information from the daily records and for it to be used to improve the quality of people's lives. This meant that people did not have optimum care.

We were told annual satisfaction surveys had not been completed in the past year. We saw that there were regular checks on the environment, fire procedures and the number of times people fell was recorded, but not addressed in a manner that would reduce their falls.
We did not see any regular monitoring of the services people received, for example the quality of the care plans or the administration of medication despite these been raised as non complaint by the Provider’s own quality checks.

How are the risks and benefits to people with dementia receiving care managed?

The care plans contained basic risk assessments which were not always specific to the person. There was no evidence that actions that could be of benefit to people had been identified and incorporated in the person’s care plan. This included stimulation and actions that could offer comfort. We saw when a risk had been identified; action had not always been taken to keep the person safe.

Are the views of people with dementia taken into account?

We did not see evidence that the provider took the views of the people who use the service into account. Relatives told us that care planning and changes were not discussed with them. The home had a high turnover of staff and had not had stable management over the past year, therefore the staff did not know if the care they delivered was what people wanted or needed to promote their health, welfare and independence. This meant that the people could not be sure they were had the best care. An audit by the Provider identified the need to have meetings with the people and their relatives. At the time of our inspection the meeting had not taken place.

We saw evidence of other individuals making major decisions for the person without consulting them and without a mental capacity assessment having been made to ascertain if the person could make decisions in their own best interests.

None of the people had information on how to access an advocacy service. At the time of the inspection no one in the home was using an advocacy service to assist them to make independent decisions. This could mean that issues that were important to the person went unrecognised.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Care and welfare of people who use services</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider has failed to take proper steps to ensure that the planning and delivery of care, and where appropriate treatment meets the individual needs and ensure their welfare and safety.</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Regulation</td>
</tr>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 24 HSCA 2008 (Regulated Activities) Regulations 2010</td>
</tr>
<tr>
<td>Diagnostic and screening procedures</td>
<td>Cooperating with other providers</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>The provider did not always ensure that the people living at Autumn Vale had access to independent advice when making decisions regarding their health and welfare.</td>
</tr>
</tbody>
</table>
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 16 May 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.
## 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:

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

## 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.