Inspection Report

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

Uxbridge Road

623 Uxbridge Road, Hayes, UB4 8HR

Date of Inspection: 19 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**: Met this standard
- **Care and welfare of people who use services**: Met this standard
- **Management of medicines**: Met this standard
- **Requirements relating to workers**: Met this standard
- **Assessing and monitoring the quality of service provision**: Met this standard
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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 19 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

We considered all the evidence we had gathered under the outcomes we inspected. We used the information to answer the five questions we always ask; Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well led?

The detailed evidence supporting our summary can be read in our full report.

Is the service safe?
People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines. When the service had identified that someone was at risk, for example of misusing their medications, then they had put strategies in place to minimise those risks.

People were cared for, or supported by, suitably qualified, skilled and experienced staff. The service asked their staff members to complete mandatory training courses which covered the skills needed to carry out the job. New members of staff were carefully checked in terms of their suitability for the role. For example, the service followed-up on references, required photographic identification, and carried out Disclosure and Barring Service (DBS) checks.

Is the service effective?
We found that the service involved people in decisions about their care through the use of key worker meetings. Members of staff could describe strategies for obtaining verbal consent prior to providing personal care. They respected people’s wishes if they refused the offer of care.

People's needs had been assessed and suitable support plans were in place. These had not always been regularly reviewed. The manager was aware of this issue and showed us the plans already put in place to promote more accurate record keeping.
Is the service caring?
Care staff knew what was required and were following each person's support plan. People told us that they were happy living at the service. One person said "I like living here. I am independent. I am staying here for good." Another person told us "I am still enjoying it here." Someone else said "It's all right here."

We also spoke with relatives of people who were using the service. They told us the new manager had had a positive impact on the type of care being provided. One relative told us "There is a new manager in charge and she has put some good things in place. Staff morale is much better. My [relative] seems to be happier and I have noticed a change in him."

Is the service responsive?
We examined how the service responded to complaints and concerns as well as what actions they took. We looked at responses to any adverse incidents involving people who used the service. We saw that the service responded to these issues by carrying out investigations and then took actions to resolve any problems.

Is the service well led?
The provider had effective systems to regularly assess and monitor the quality of service that people received. The service had carried out a survey with the people using the service, their relatives and relevant health care professionals about the quality of the care they had received. The manager had worked on a development plan and was taking action when they identified any areas of poor performance. Members of staff were invited to attend meetings where they could raise concerns and the quality of care being provided was discussed.

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

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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. The provider acted in accordance with legal requirements where people did not have the capacity to consent.

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. We spoke with six members of staff, including the manager. They were aware of the need to communicate well with people before providing care. They told us that they sought verbal permission from people before they provided care.

Members of staff were clear that they respected someone's decision if they refused an offer of care. We saw evidence in people's medicines administration charts that if people refused their medicine for any reason, then that decision was respected. Staff also described strategies, such as gentle prompting, or offering care at a later time in the day, if the initial offer of care had been refused.

The service sometimes asked people to provide written consent. For example, each person had regular meetings with their key worker where they reviewed the support plans and identified any new personal goals or activities that the person wanted to get involved with. The key worker kept written notes of the meeting and asked the person using the service to sign the notes when they had read and understood its contents.

The provider acted in accordance with legal requirements where people did not have the capacity to consent. There were some people using this service who did not have the capacity to make decisions about all aspects of their care and activities. For example, we noted that some people had advocates in place to assist with managing their financial affairs.

We asked members of staff how they knew about each person's level of decision-making ability. They told us that they worked with each person's care manager at the local authority to understand that person's abilities. Members of staff also demonstrated a good working knowledge of each person's abilities. We reviewed the support plans of three
people using the service and saw that these contained detailed information about people's abilities in different areas.

The manager knew what types of actions could be taken if they identified any concerns about people's capacity to make decisions in any area. For example, the manager was aware of how to request and convene a meeting to discuss someone's decision-making abilities. We observed that a multi-disciplinary meeting took place to discuss one person's abilities on the day of the inspection.
People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at the care records for three of the nine people using the service. Each person had a support plan which described their abilities and need for support in different areas. For example, the support plans identified each person's daily living skills, such as shopping, preparing food, booking healthcare appointments and travelling in and around the community. The plans also described each person's likes and dislikes, as well as their personal and cultural history, and any implications these had in terms of the care provided.

The service supported people to develop their independence as much as possible. For example, the provider employed a member of staff who was a specialist in assessing and providing positive behaviour support. This member of staff was working at the service on the day of the inspection. We saw that some people had positive behaviour support plans in place with the aim of helping people to engage successfully and calmly with other people using the service, members of staff, and their local community.

We also saw that people using the service were encouraged to engage in a range of social activities as a way of promoting their independence or to help maintain their physical or mental health. One person using the service told us that they were going on a day trip to the zoo. Another person was going on a bike ride. Someone else told us that they went to college twice a week. We saw evidence in the support plans that the type of activity that each person liked to engage in was noted and that plans had been put in place to encourage people to engage in a range of activities.

We observed people were generally relaxed in their interactions with each other and the members of staff on duty. The support plans described what strategies might be effective at helping people if they became upset or distressed for any reason. During the inspection, one person became anxious and we saw that the members of staff used the strategies described in that person's support plan to help them manage their feelings.

We spoke with four of the nine people using the service. They all told us that they were happy living there. One person said "I like living here. I am independent. I am staying here..."
for good." Another person told us "I am still enjoying it here." Someone else said "It's all right here."

We also spoke with two relatives of people who were using the service. They told us that the new manager had had a positive impact on the type of care being provided. One relative told us "There is a new manager in charge and she has put some good things in place. Staff morale is much better. My [relative] seems to be happier and I have noticed a change in him." Another relative told us that "Things have improved recently. They have put in place more indoor activities."

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. In the care plans that we reviewed, we saw that risks had been identified for each person. Risk assessments were carried out for each person according to their needs. These assessments identified what the risk was and what could be done to reduce that risk.

The support plans and the risk assessments had a 'signing' sheet for each member of staff to indicate that they had read and understood the content of these. However, the provider may find it useful to note that, following the recent period of new staff recruitment, not all of these forms were up to date. The members of staff that we spoke with were knowledgeable about people's abilities and personal care needs. This indicated that members of staff were familiar with the support plans and were providing care in line with the plans.

Each person using the service had been assigned a key worker so that they could discuss the type of support that they were receiving. The people that we spoke with knew who their key workers were and told us that they had regular meetings with them. There was some evidence in the support plans showing that these meetings had taken place. However, the provider might find it useful to note that not all of the files had notes from recent meetings, suggesting either that these had not taken place or that the notes had not yet been written up. This could mean that the support plans that were being followed did not provide the most accurate or up-to-date reflection of each person's needs.

There were arrangements in place to deal with foreseeable emergencies. Staff told us that they had all received first aid training and we saw a training records which showed that this was the case. Staff were able to describe relevant emergency plans, including what to do in the event of a fire or in a medical emergency. We saw that a fire alarm was in operation and fire extinguishers were available throughout the service. There were two fire evacuation points and all but one member of staff was aware of both of these. One member of staff was aware of only one of the evacuation points.
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

Appropriate arrangements were in place in relation to obtaining medicine. Medicines were prescribed by each person's GP or hospital consultant. The details of each person's prescriptions were recorded in a medicines administration file. These files also held information about people's allergies, including allergies to different medicines.

The deputy manager told us that they were careful to observe whether medicines were being taken appropriately and that they could organise a review if necessary. We saw one, documented example where the service had noted that one person did not like to take their medicine at the time prescribed. A review had been carried out with that person's GP and a change in timing had been agreed.

Appropriate arrangements were in place in relation to the recording of medicine. At the time of the inspection, all but one of the nine people using the service required support with taking their medicines. We saw that the service kept a medicines administration file for each person using the service. We reviewed three of these files. The details of the amount and type of each medicine that had been taken were recorded in an administration chart. The chart showed the time and date medicines were administered and any incidents when they had not been administered and why.

The files also contained a 'counting' sheet which monitored the number of remaining tablets. This was updated every day. We noted that one person's file had a gap in this counting sheet on one day. However, we checked the administration chart and saw that the medicine had been correctly administered and recorded on that day.

Each person also had a record for any medicines, such as paracetamol for pain relief, which could be requested on an ad hoc basis. We saw that a record was kept of how much, and at what time of day, these types of medicines were being given. The service had put in place a system whereby the senior care worker completed a form for each person at the end of their shift to confirm that they had checked that the medicines had been given and recorded in the charts correctly.

Medicines were safely administered. Members of staff had been trained in medicines...
administration. Only those members of staff who had received this training were allowed to administer medicines. We asked one member of staff about how their competency in medicines administration was checked. They told us that they had attended a medicines administration course and that senior members of staff had observed their performance in administering medication.

There was one person using the service who had a medication that could be used in relation to an emergency event. Four members of staff had been specifically trained in administering this medication. The provider might find it useful to note that this may mean that there are not sufficient numbers of trained staff to ensure that each shift includes someone who is trained in the use of this medication. We raised this issue with the manager who showed us evidence in an email trail that training in relation to this medicine was being arranged for more members of staff.

Medicines were kept safely. Medicines were stored in locked cabinets. These were located in each person's flat. There were three people using the service who had been identified as being at risk of misusing their medications. These people had their medicines stored in a locked cabinet inside an office. We saw that each person had a labelled shelf inside the cabinet where their personal medicines were stored. The medicines being used were oral tablets taken at regular intervals. There were no medicines being used which required refrigeration.

We observed that a new delivery of medicines had arrived from the pharmacist and was being stored in a bag in the office. The office was lockable and only members of staff held keys to the office. However, the provider might find it useful to note that the office was sometimes left unlocked and unattended on the day of the inspection. This meant that these medicines could potentially be accessed and used inappropriately.

Medicines were disposed of appropriately. The deputy manager told us that the service returned any unused medicines to the pharmacist for safe disposal. We saw that there was a record kept of which medicines were returned to the pharmacist that included the type and amount of medicine that was being returned. Returns were made on a regular, approximately monthly, basis. We saw that the most recent return had been made in May 2014.
Requirements relating to workers

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

There were effective recruitment and selection processes in place. At the time of the inspection, the service had recently recruited some new members of staff and was actively recruiting additional staff. We spoke with six members of staff and asked some of them about their recruitment experiences. They told us that there had been a thorough recruitment procedure which included the filling in of an application form, an interview and a literacy and numeracy test. We examined three staff files and saw documents which confirmed that this was the case. The staff files also showed that people’s physical and mental health were assessed via a self-completed disclosure form.

Copies of any training course certificates were held in staff files. The service also had a mandatory training programme for all members of staff which covered key topics including first aid, infection control, safe moving and handling, mental capacity, and safeguarding. This training was periodically renewed to ensure that people were cared for by staff who were suitably skilled. However, the provider may find it useful to note that the training records indicated that some training was overdue. We discussed this with the manager who said that some training had already been booked in, and that in other cases they were waiting for the next suitable training course to run before renewing the training.

Appropriate checks were undertaken before staff began work. In the staff files that we reviewed, we saw that new members of staff were required to complete a Disclosure and Barring Service (DBS) check before they began work. They also supplied photographic identification documents including copies of their passports or driving licenses, as well as some proof of current address. Members of staff who were not UK nationals were asked to supply proof of their visa status or work permit.

We saw that the application forms listed the names of two referees who could be contacted to give evidence of people’s conduct in previous employment. The outcome of these references was not held at the service location, but with the main human resources department for the provider. We contacted this department to show us evidence that references had been followed up. We saw evidence via an email that references had been obtained for new members of staff before they started work. Therefore we found that people were cared for, or supported by, suitably qualified, skilled and experienced staff.
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. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

Reasons for our judgement

This service had experienced a number of management changes recently. At the time of the inspection, there was a new manager working at the location. They were in the process of applying to the Care Quality Commission (CQC) to become the registered manager for the service.

The provider had systems in place to assess and monitor the quality of service that people received. The manager showed us a copy of the service development plan. The service's performance against a number of quality indicators had been reviewed. The plan was still being developed, but the manager had already put in place some action plans with timelines for when these would be completed. For example, renewal of safeguarding training for all members of staff was due for completion in August 2014.

The service carried out audits to monitor the quality of the care. Weekly health and safety room checks were carried out by one member of staff. We spoke to the member of staff responsible for this activity. They showed us the forms that they filled in to support this process. We saw that the forms covered checks of electrical appliances, furnishings and water temperature. Any maintenance actions that were identified remained on the checklist week by week until they were completed.

Medicines audits were also completed on a monthly basis. We saw the two most recent audits from June and May 2014. These covered key issues such as security, storage, administration and record-keeping. The need for additional staff training in medicines administration had been identified by this audit. We saw evidence that additional members of staff had received, or were about to receive, this type of training.

Support plans and risk assessments had dates set for their next review. However, the provider may find it useful to note that not all of these reviews had been carried out. This may mean that the plans and risk assessments did not accurately reflect the needs of the people using the service as they were no longer current. The manager was aware of this issue. It had also been raised by a representative of the local authority who had visited the
service in May 2014. We saw that an action plan was in place with dates set for when these reviews would be completed.

The provider took account of complaints and comments to improve the service. We saw that no formal complaints had been recorded since the last inspection. The manager told us that more general concerns were pro-actively obtained using different methods. We found that people who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. For example, a survey of relevant health care professionals, people using the service and relative's views had been carried out in May 2014. The data from the survey were being analysed in order to identify any action points.

We saw evidence in the development plan that the manager had sought information about the quality of the care by consulting people who used the service, their care managers at the local authority, and their relatives. The manager had identified some action points and was implementing these. For example, the need for a review meeting had been identified by someone's relatives. We saw evidence that this had now taken place and that this had led to some changes in that person's support plan.

The people using the service were invited to attend monthly resident's meetings to discuss any concerns. These meetings occurred every month. We reviewed the minutes from the two most recent meetings. The resident's had raised some issues relating to the quality of the premises. We saw that these had been responded to. For example, a new floor covering had been ordered for the communal lounge.

Staff meetings also occurred approximately every three months. We reviewed the minutes from the last two meetings which had taken place in February and May 2014. A wide range of topics were discussed at these meetings which helped to review standards of care. For example, safeguarding and whistleblowing policies had been discussed at a recent meeting.

There was evidence that learning from incidents took place and appropriate changes were implemented. Incident reports were held in each person's support plan files. The manager told us that a separate incidents file was not kept as this reflects best practice in terms of protecting people's confidentiality. However, the manager told us that the provider required an online report to be completed for each incident so that they could feedback the service's overall performance in relation to the number and type of incidents that had occurred.

We reviewed three of the files kept for people using the service and saw some incident reports. We saw that the reporting form allowed for a record to be kept of what had happened, who had been involved and what actions had been put in place to prevent the incident from recurring. For example, one person had an on-going physical health problem which had resulted in an ambulance being called. The service had identified that a review of this problem was needed with that person's GP.

There had also been an incident in relation to administering medicines in November 2013. Someone using the service had not been supported to take their medication in the right amount and at the right time. CQC had been appropriately notified. We saw evidence that the provider had carried out an investigation of this event. The service had followed their procedures in relation to managing any staff misconduct that they identified. The service had also put in place a number of new protocols to prevent the incident recurring. For
example, we saw that senior care staff were now required to check that each person's medicines had been given appropriately at the end of each shift.
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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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.