Inspection Report

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

Stoddart House

University Hospital Aintree, Lower Lane, Fazakerley, Liverpool, L9 7AL

Tel: 01515293782

Date of Inspection: 18 November 2014

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

Details about this location

Registered Provider	Mersey Care NHS Trust
Overview of the service	Stoddart House is a mental health unit based on the University Hospital Aintree site in North Liverpool.The unit provides 24 hour assessment and/or treatment for people experiencing mental health difficulties, including patients detained under the Mental Health Act 1983. Stoddart House is part of Mersey Care NHS Trust, a specialist provider of mental health, learning disability and substance misuse services.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 18 November 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We spoke with one or more advocates for people who use services, talked with people who use the service, talked with staff and reviewed information given to us by the provider. We were accompanied by a pharmacist, reviewed information sent to us by local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

Due to medical conditions some patients were not able to describe their experiences in detail but two patients said they were appropriately cared for. We spoke with seven ward staff, the pharmacist, four doctors and the Modern Matron. The inspection was carried out by two inspectors, a Mental Health Act reviewer, a pharmacy inspector and a physician. We considered all the evidence we gathered under the outcomes we inspected. We used the information to answer the five questions we always ask:

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

This is a summary of what we found.

Is the service safe?

We saw people were being cared for in an environment which was clean. Risk assessments were in place. For health, safety and security reasons, visitors were asked to sign in and out of the unit. We heard when there were not enough staff to meet patients' needs, regular bank staff who were familiar with the ward were used.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity

Act 2005 (MCA). The MCA is designed to protect people who lack the ability to make decisions for themselves due to mental capacity difficulties. The aim is to make sure people in hospitals and care homes are looked after in a way which does not restrict their freedom inappropriately.

Is the service effective?

People's needs were assessed and their relatives were involved in planning and reviewing their care. Where people were detained under the Mental Health Act 1983 (MHA) their capacity to understand their treatment was assessed.

Is the service caring?

We saw that patients' distress levels were responded to calmly and staff supported people with dignity when they were distressed.

Where patients needed to be closely monitored, staff engaged with them in activities that had been identified as being beneficial within their care plan.

Is the service responsive?

The records we saw confirmed care and support had been provided in accordance with people's preferences and diverse needs.

Is the service well-led?

We saw quality assurance processes were in place to make sure the provider monitored the care provided and made improvements where necessary.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

The staff we spoke with understood capacity fluctuated and how patients may have capacity to consent to some things but not others. They confirmed they had received training on the Mental Capacity Act 2005 (MCA), so they knew the procedure to follow if patients could not make decisions for themselves. The MCA states if a person lacks capacity to make a decision, whoever makes the decision or takes action on their behalf must do so in their best interests. They explained how they supported people to make decisions on a day-to-day basis. We observed staff working with patients and saw they took time to explain processes so people could understand and agree to them. Consent was given verbally and non-verbally.

We observed staff giving medication. Three patients were given medicines covertly. This means giving medicines in a disguised form without the knowledge or consent of patients who actively refuse medication but lack capacity to refuse treatment or understand the consequence of refusing treatment. We were told two patients had DoLS authorisations in place and the third was detained under the Mental Health Act 1983 (MHA).

We saw the Trust had produced guidance for staff on the process to follow when patients refused treatment. This included assessment of capacity to consent to or refuse treatment, review of the need for the treatment and the views of the nearest relative or advocate. The multi-disciplinary team (MDT), including the pharmacist, considered whether covert administration of medicine was in the best interests of the patients.

We looked at seven patients' records. We found evidence of discussion about the patient's care needs. Family members were involved in the discussions. We also saw feedback from patients' relatives which confirmed how they were involved in the care and support of their family member. Care plans recorded how patients were included in decision making and their understanding of their care and treatment.

We saw four people were subject to standard DoLS authorisations and three people were

subject to urgent DoLS authorisations. This meant where restrictions were placed on patients, this was done in their best interests and they were cared for and treated safely within appropriate legal frameworks.

Most of the records we saw belonging to patients detained under the MHA contained evidence of attempts to inform patients of their rights but patient's rights forms were not always completed. We found one patient detained under section 2 MHA was not informed of their rights until 17 days after detention, so the right to appeal was lost.

For some patients, we saw evidence of assessments of mental capacity to see if they understood when they were informed of their rights. Staff recorded whether patients understood and if not, they repeated the process. If patients understood some of the reason for the detention this was recorded. We saw staff had also discussed patients' rights with their relative or carer.

We also saw reviews of mental capacity were completed for some patients and we found evidence staff discussed with patients the reason for their admission so they could assess how their capacity had improved. We saw one patient's detention was not renewed because they had improved. The patient did not appeal against detention because they understood the benefit of their treatment.

Use of patient's rights forms and evidence of capacity assessments was variable. Records should contain all relevant information as required under the MHA.

We saw referrals were made to a doctor for a 'best interests' decision regarding capacity to understand rights and evidence of referrals to the Independent Mental Health Advocate (IMHA). IMHAs provide an additional safeguard for people detained under the MHA. Their role includes helping patients understand and exercise their rights. This meant patients had access to appropriate support.

In some records, evidence of compliance with the MHA Code of Practice (the Code) was poor. The Code states at paragraph 23.37 "The patient's consent or refusal should still be sought wherever practicable and recorded in their notes, as should the treating clinician's assessment of the patient's capacity to consent." One record contained only a one line entry. In another we found covert administration of medication was subject to section 63 but no evidence of compliance with paragraph 23.37.

We found patients had access to an IMHA who visited the ward weekly or when needed. Information about the IMHA service was displayed on the ward. Staff we spoke with told us they made referrals to the advocacy service following discussion with the patient and the MDT. We saw documentary evidence of this.

We contacted the IMHA service who confirmed they received referrals from the MDT and from patients. The service was informed of new admissions by the MHA administrators in relation to patients detained under the MHA. In addition, the IMHA attended the ward without any appointment. This enabled them to engage less formally with patients and staff, to build relationships and engage with patients who may not normally engage with the IMHA.

One patient received support from an Independent Mental Capacity Advocate (IMCA). This was regarding a change of accommodation and because the patient had no friends or family who could help. We saw how discharge was planned with the patient and the MDT. The staff we spoke with explained how having IMCA support was deemed to be in the

patient's best interests. IMCAs represent and support people who lack capacity to make important decisions about serious medical treatment or changes of accommodation. The staff we spoke with knew how to make a referral to the IMCA.

Overall, we found the Trust compliant with this outcome. Systems were in place to gain and act on patients' consent or ensure their best interests were considered where they lacked capacity to consent to or refuse treatment.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Clarence ward accommodated up to 17 patients of both genders. One bedroom was located centrally which gave flexibility as to the gender of patients admitted. All rooms had washing facilities and there were communal bathrooms.

Some patients had personal items such as photographs to make their rooms homely. However, we found in one bedroom the wardrobe had a keypad lock. Staff told us this wardrobe was borrowed from another ward. In another room, the wardrobe was unstable and a drawer was missing. Using pieces of furniture which were unsuitable or in poor repair was not conducive to patients' wellbeing.

We saw anti-ligature fixtures but also some ligature points, such as fixed handrails in the bathrooms. A ligature point assessment had been carried out; however the ward was exempt from completing ligature work. The risk register stated anti-ligature fittings were inappropriate for the ward and the Trust would carry the risk. During feedback we discussed how the mitigation of ligature points was managed as these were identified as hazards in the audits completed for the environment. We asked the Trust to assure us areas with ligature points used by patients would take account of individual risk. We have done this as the service is to move to a new site in early 2015 so we will be confident risks will be managed appropriately.

We saw evidence of assessment of patients' needs in the care records we looked at. The records provided clear directions for staff to follow in order to ensure patients' needs were met and their independence maintained. They were written in a person centred way. Person centred means care is planned in a way which focuses on the individual. Most of the care records we saw were up to date. However, one record did not reflect the new legal status for a patient detained under section 3 MHA following detention under section 2 MHA.

We looked at the findings of an inpatient survey carried out in October 2014 and saw 100% of patients who responded had stated they were involved in developing their care plan.

We saw the support provided included individual risk assessments which described how

risk was managed. Risk assessments were used to identify things which might cause harm to people and the steps which needed to be taken to protect them, for example the risk of falling. This meant foreseeable hazards were identified and managed appropriately.

Staff told us a handover took place at every shift. We saw a handover book was in use which detailed changes in patients' needs. This showed there was a culture of sharing information and ensured staff were up to date so patients received care appropriate to their needs.

The staff we spoke with told us about the needs of the patients they cared for and the support in place for them. It was clear they knew the patients they supported very well. They described how they supported them to remain independent, to make choices which reflected their preferences and how they ensured privacy and dignity was maintained. We saw staff were patient and encouraging when they were supporting people so they could do things at their own pace and were not rushed. We spoke with two patients about the care they received. One said, "I'm unsteady on my feet but the staff keep me safe, I can't remember having any falls". Another told us "Staff are very good, they go out with me, there's plenty to do on the ward".

We saw patients were engaged in activity throughout our visit. We spoke with occupational therapy staff who explained activities were planned for individual patients to support independence and preparation for discharge. Progress was reviewed every week. In the files we looked at, occupational therapy plans sat alongside care plans.

Group activities were planned which took account of patient's interests. A 4D session was in progress during our visit. 4D is an 'immersed space activity' where projected images, music and lights create a sensory experience linked to themes for discussion. We observed this session and saw patients were engaged and appeared to be enjoying themselves. One patient said "I never liked the Beatles but liked John Lennon, but it's great to see the pictures, listen to the music and dance". Later in the day, a therapy pet visited the ward and we saw patients enjoyed stroking and holding it.

For some patients, a cognitive stimulation therapy group was available, in line with National Institute for Health and Care Excellence (NICE) guidance.

We heard medical cover was mostly good. However, at times medical staff were based at other sites and we heard cover could be poor at those times. This meant people may be at risk of not receiving medical care in a timely manner.

We saw documented evidence of physical health checks being carried out for some patients but not all.

Physical health needs were managed by contacting the medical registrar at University Hospital Aintree; however, this was only for advice and patients requiring care for medical problems or emergencies were transferred to the Accident and Emergency service.

For ongoing medical conditions, we heard there were good links with Aintree for services such as neurology, cerebrovascular disease and cardiology. Specialist nurses were available for patients with needs such as diabetes, tissue viability and podiatry. The unit had its own dieticians and a link nurse for diabetes.

However, some staff commented patients needing nursing care for physical conditions had to be transferred to Aintree. They felt this could be resolved by closer links with Aintree,

such as a consultant geriatrician carrying out ward rounds.

All staff said the care from Aintree was good but voiced concerns the future move to the Walton site meant the arrangements may not continue. We heard about plans to contract with Aintree and with community health services, and to appoint a registered general nurse (RGN) to support patients with medical needs.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Medicines were stored securely and kept at the correct temperatures. Medicines for use in an emergency were checked regularly and easily accessible. The Trust's processes for handling controlled drugs were in line with national guidance; we saw on the two wards we visited staff followed these processes. Controlled drugs were subject to extra legislative controls because there was potential for them to be abused, causing possible harm. The temperatures of medicine refrigerators were monitored. This ensured medicines kept in the refrigerator were safe to use. Appropriate arrangements were in place for the disposal of medicines. This reduced the chance of medicines being mishandled or misused.

A pharmacist and pharmacy technician were present on the wards Monday to Friday and they provided good clinical and pharmacy support services. An on-call pharmacist could be contacted outside the normal working day and at weekends. This meant doctors and nurses had access to guidance to help them decide issues around the prescribing and administration of medicines.

The pharmacy team conducted audits to help ensure that medicines were used effectively; for example, one audit looked at the availability of prescribed medicines at the times patients needed them and another at whether appropriate antibiotics were prescribed. This helped ensure people using the service were protected against the risks associated with the unsafe management and use of medicines.

We watched some patients being given their medicines after lunch and saw that nurses were friendly and patient and followed a safe procedure. However, two patients were given a medicine that should have been administered before lunch to be fully effective.

We looked at the prescription charts of ten patients. Each chart contained a photograph of the person named which helped ensure staff could recognise them and ensure medication was administered safely to the right person.

Medicines were correctly prescribed on the ten prescription charts we examined; one dose error for a medicine to relieve pain had been corrected by the consultant. Patients' allergy status was recorded on the front of the charts and the pharmacist checked this information when reconciling patients' medicines upon admission. This helped ensure medicines were

prescribed safely. However, we found eleven 'gaps' in the administration records on ten charts, where nurses had neither signed to show they had administered a dose of medicine nor entered a reason for non-administration. This meant there was an increased risk of a mistake being made. We discussed this with the Trust's management team who explained the process for training staff in the management of medicines. We were told if staff made consistent errors they had to undertake further training and assessment of competency.

We saw examples of how incidents on the wards involving medicines were reported and recorded on the Datix system. The action taken and learning outcomes were documented.

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 receive.
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We found systems in place to monitor the quality and effectiveness of the service provided for patients.

A range of audits were carried out. These included medication prescription, administration and infection control audits. There was evidence care plans were audited by the deputy managers.

A fire safety audit was undertaken in December 2013. This was broadly compliant and we saw an action plan most recently updated in October 2014. Some remedial work had been carried out but only one action point had been completed. We noted this was due to the forthcoming move to new premises and the corporate business team had undertaken to manage the risk.

We saw incidents and accidents were reported on the Trust system. When we spoke with staff they could explain how incidents and accidents were reported. Staff confirmed they felt information and learning from themes and serious incidents was appropriately disseminated across the Trust via a range of methods such as staff meetings, emails, e-bulletins, training sessions and a staff magazine.

We saw copies of the Trust's reporting on delivering same sex accommodation requirements and noted during the last three month period no breaches were reported. This meant people's privacy and dignity was protected.

We also saw a risk register which identified risks, controls and actions was in place. A local inspection of the ward which identified hazards and the immediate and longer term actions to be taken had been carried out in October 2014. This meant foreseeable risks were identified and managed appropriately.

All the staff we spoke with commented positively on the support they received as part of the multi-disciplinary team (MDT) and from management. Staff told us they had regular

supervision and appraisals and from documents we saw, it was clear arrangements for performance management were in place.

Before the inspection we were made aware of a number of incidents which had been brought to out and the Trust' attention, one of which was a serious complaint. We saw the Trust's response to the complaint made about the care of a patient as well as how the Trust had investigated and responded to the incidents. The Trust had produced an action plan to address the outcomes of the complaint investigation and a feedback sheet had been prepared which recognised lessons learned. We spoke with the deputy managers about the action plan. They were aware of the recommendations identified from the outcome of the complaint.

For example, we saw the deputy managers commented they had read recent entries in daily notes and reviews of care plans. Other staff we spoke with confirmed their notes were reviewed by the management team.

Care plans were developed by the MDT and included plans relating to physical care. We saw documentation which outlined the responsibilities of the named nurse, which included ensuring weekly review of the care plans, making appropriate referrals to services and for alerting the MDT when a 30-day inpatient review was due. The staff we spoke with confirmed this when they explained their role. They also described discussion of the named nurse's role and responsibilities which took place in supervision, along with development needs and training. This meant care was reviewed and monitored on a regular basis by staff who were supported and competent to do so.

We noted 'fall safe' information was displayed around the ward. This means slips, trips and falls are being prevented by good housekeeping practices and use of appropriate floorings and footwear. We saw that falls risk assessments were carried out and falls prevention plans were in place. This meant risk was assessed and managed appropriately.

There was evidence the ward sought feedback from patients and relatives about their experience. We were shown the findings of an inpatient survey carried out between August and October 2014. Patients were asked for their views about their care, treatment and experience on the ward and the findings indicated they were generally satisfied.

We also saw comments displayed on the ward which were positive about the service and included "Quality time like they have at home", "I was encouraged to be involved" and "Made me feel part of the team". This demonstrated positive engagement with patients and their families.

The complaints procedure was displayed on the ward. Other than the complaint made in 2013, the service had not received any other complaints. Complaints were recorded and responded to. At local level, staff completed a resolution form. The staff we spoke with confirmed this was sent to the management team for review. This meant complaints information was monitored and patterns or trends could be identified and addressed.

Concerns were also raised through monthly meetings with patients and their families, which were led by a health support worker. We noted comments from relatives had been responded to and the actions taken were displayed for patients and relatives to see. This showed the ward took account of issues people raised and acted on them to make improvements.

We did not see evidence of Patient Advocacy Liaison Service (PALS) presence on the ward but contact information was displayed and there was ample evidence of IMHA presence and involvement. This was in line with the action plan developed following the complaint.

As a result we concluded lessons had been learned and the improvements were embedded in the quality assurance system.

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.

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