Inspection Report

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

The Old Hall

Send Marsh Road, Send, Woking, GU23 7DJ

Tel: 01483211674

Date of Inspection: 06 January 2014

Date of Publication: February 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	The Old Hall (Send) Co Limited
Registered Manager	Mrs. Heidi Elizabeth Cox
Overview of the service	The Old Hall is a privately owned care home providing accommodation and personal care for up to 39 elderly people who are not suffering from dementia or other serious health conditions.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 6 January 2014, observed how people were being cared for and sent a questionnaire to people who use the service. We talked with people who use the service, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

On the day of our visit there were 38 people residing in the home. We were met by the registered manager and briefly met the owner of the service.

We found that people who used the service were always being asked by staff if they consented to their care, and their right to refuse care was being respected. The people we spoke with said that care was never forced upon them.. We also found the provider had a process in place to deal with situations where decisions had to be taken in a person's best interest.

We found that people were happy with their care and that staff engaged with people in an appropriate and sensitive manner. People said things like: "It couldn't be better"; "The staff are very thoughtful, kind and generous"; We also found that people's needs were being properly assessed, managed and reviewed.

We found that people were being properly protected against abuse and staff were able to identify, respond to, and report abuse. All the people we spoke with said they felt safe from harm in the home.

We found that there were enough staff to provide proper staffing cover at all times. However, some people and staff we spoke with said they thought staffing was an issue on occasions.

We found that the provider was regularly obtaining feedback from people and staff. We also found that the provider monitored and assessed the whole service on a regular basis, although most of this was not being recorded.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We looked at how staff ensured that people who use the service were giving consent to their care. The five people we spoke with said that staff members would always ask their permission before offering them any form of care, which mainly consisted of making sure they could manage to care for themselves. They said staff never forced anything onto them, including medicines.

All the staff members we spoke with said that they would always ask people's permission before offering any form of care to them, and would always explain to them what they were doing and why. One staff member said that many of the people who used the service simply needed encouragement, for example to take a bath, to eat breakfast and to take their medicine. They said that they would say things such as: "It's your bath day today – would you like to take a bath?"

All the staff members we spoke with said that if a person refused care they would never force it upon them. Instead they would offer them more encouragement and explanation about why the care was important. If the person continued to refuse they would refer this to the manager. They said that if a person refused to take their medicine they would respect this choice but if it continued they would liaise with the person's GP and relatives as well as the manager. One staff member said: "It's their choice if they refuse to take their medicine." Another said: "It's their choice at the end of the day."

From our conversations with people who use the service and with staff we were satisfied that people were being asked for their consent before any care or treatment was offered to them, and their right to refuse care and treatment was being respected. This meant that people's dignity, freedom of choice and human rights were being respected.

We looked at what would happen if an important decision had to be made regarding a person's care and wellbeing but where might be some doubt as to whether they could give their consent.

The people we spoke with said they had made a conscious decision to come into the home and were able to make informed decisions about their day to day care. One of the staff members we spoke with said that 95% of the people who use the service were able to make informed decisions about all aspects of their every day living. They said that if a serious decision had to be regarding the person's care, for example to move them to another care home because their condition had deteriorated, then the manager would take over and liaise with the person's GP and relatives.

The manager said that if a serious decision had to be made regarding a person who uses the service, for example if they had to be moved to another establishment, then a best interest meeting would be called involving the person's GP, their relatives, the person themselves and the manager. We asked if there were any notes to these meetings and the manager said these were not easily accessible because they had been archived after the person had left the home.

From our conversations with people who used the service, staff and the manager we were satisfied that the provider had processes in place to deal with situations where decisions had to be made about a person's care and wellbeing but where there was doubt about their capacity to give consent to such decisions. This meant that the provider could ensure that they were acting in the best interest of the person.

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

We spoke with five people who used the service. Overall they seemed very happy with the quality of service and the way they were treated by staff. They made comments such as: "It couldn't be better"; "The staff are very thoughtful, kind and generous"; "I haven't heard a cross word since I've been here." All the people we spoke with said they particularly liked the friendly attitude of the staff. They also commented on the range of activities on offer, which included regular outings to places like local garden centres, the seaside and local towns. One person said: "We are not allowed to stagnate in our rooms."

None of the people we spoke with said they could think of anything that could be improved apart from the fact that at weekends the reception desk was unmanned. They said this worried them because it meant anyone could walk into the building and there was no-one to greet visitors. We asked the manager to comment on these concerns and they said that the problem was compounded by there being two entrances to the home, and that some visitors would use a different entrance to the main one. They said that because people were free to come and go as they pleased they could not lock the main doors, which would solve the problem of anyone being able to walk into the home.

Throughout the day we were able to observe how staff engaged with people who use the service. At lunch time we watched as staff assisted some people to the two dining rooms and noticed that they were respectful towards them and did not try and rush them. We noticed that whilst most of the people in the dining rooms were able to feed themselves, five people, who were sat apart from the others, needed more assistance. We watched as one staff member helped to gently spoon feed one person, and cut up the food for another person so they could eat it more easily. As we walked around the building during the day we noticed several people being attended to in their rooms and we saw that on all occasions staff were polite and respectful towards them.

From our conversations with people who use the service and our observations we were satisfied that people were generally happy with their level of care and that staff were engaging in an appropriate and sensitive manner with people. This meant that people and their relatives could be reassured that they were receiving care that was both safe and of a sufficient quality to promote their health and wellbeing.

We looked at how people's needs were assessed, managed and reviewed. The people we spoke with said that when they had been admitted to the home staff had sat down with them to discuss their particular needs. Two of the staff members we spoke with said they were actively involved in the initial assessment of new people and would go through the whole admission process with the person and their relatives. They said the whole assessment process revolved around the person's individual choices.

We looked at the initial assessment forms for four people who used the service, which were contained within their main care plan folders. We noted that the assessments covered a number of key areas including breathing, cardio-vascular function, communication, and eating and drinking.

We looked at four people's care plan folders and noted that each one contained an admission and assessment form; a set of individualised care plans, called Activities of Living (AOLs), tailored to needs of each person; daily notes specific to each AOL; and a separate clinical notes section. Some of the individual care plans also had risk assessments attached to them.

The manager explained that the main part of the care plan was built up from the information provided in the initial assessment document and from working with the person after they had arrived in the home. They said that the individual care plans were based on the activities of living philosophy, which looked at how well a person could function in relation to a specific area of need, and any issues that related to that need. We noted that the AOLs covered areas such as personal cleansing and dressing, eating and drinking, mobilising, wounds and skin, sleeping and pain.

We noted that some AOLs had risk assessments attached to them, for example the ones for mobilising, and for wounds and skin. There was no standard format for the risk assessments but typically they identified the particular area of risk, the level of risk, and actions to reduce the risk. The clinical notes included records of key measures such as the person's blood pressure, weight, and blood sugar level. These measures were only recorded when there had been any change.

We noted that all the care plans were reviewed on a monthly basis and that there were forms at the back of each care plan folder to audit this. All the care plans we looked at had been updated. We also noted that there was space for people who use the service to sign to say they agreed with the outcome of the monthly review but that none of the care plans we looked at had been signed by people. The manager said that a large proportion of the people who used the service did not sign their care plan reviews and had expressed no interest in doing so.

We looked at the daily notes for each AOL and noted that these recorded any changes or issues relating to the specific activity of living. We noted that these were all up to date.

From our conversations with people who use the service, staff and our review of care planning documentation we were satisfied that people's needs were being assessed, managed and reviewed in an effective manner. This meant that people used who used the service could be confident that their care plans were being tailored to their individual needs and preferences, and being kept under continual review.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

All the people we spoke with said they felt perfectly safe in the home and that if they had any worries they would report them to the management. All the staff members we spoke with said they had done safeguarding training and were able to identify different types of abuse, for example physical, emotional, financial, neglect and institutional. They were also able to identify the signs of potential abuse, for example unexplained bruising, changes in behaviour, avoidance of certain people. They all said they had read the provider's safeguarding policy and found it a useful document. Two of the staff said that the policy would be particularly helpful for new staff members who were unfamiliar with safeguarding issues.

We noted from the provider's training records that all the staff had done safeguarding training. We were given a copy of one of the safeguarding training lessons and noted that it covered definitions of abuse, different types of abuse, signs of abuse, scenarios regarding abusive behaviour, responding to abuse, and awareness of the local authority's safeguarding procedures.

We were given a copy of the provider's safeguarding policy and noted that this covered definitions of abuse, possible abusers, the signs of potential abuse, the role of staff and managers in dealing with abuse and suspected abuse, and the procedure for reporting abuse. The manager said that the service made reference to the local authority's multi-agency safeguarding guidance which was on the local authority's website.

All the staff members we spoke with said that if they witnessed another staff member acting inappropriately towards a person who uses the service they would ask the staff member to leave the vicinity and reassure the person. They would then report the incident to the manager. They said that if a person told them they had been abused by another person who uses the service they would report this to the manager who would then liaise with the person and their family. One staff member said that if the manager did not take the incident seriously they would report it to the local safeguarding team or to the CQC.

From our conversations with staff and our review of safeguarding documentation we were

satisfied that the staff would be able to recognise abuse or potential abuse and be able to address and report such incidents in an appropriate manner. This meant that people who use the service could be confident that the provider was taking steps to ensure that they were protected from harm, and had proper mechanisms in place to deal with any incidents of abuse or suspected abuse.

All the staff members we spoke with said they would have no hesitation in reporting any incidents of abuse or suspected abuse to the provider and would feel confident that they would be taken seriously and that there would be no recriminations against them. Two of the staff members said they had read the provider's whistleblowing policy but the third one said they did not know there was such a policy and appeared to have no understanding of the concept of whistleblowing, which is to ensure that employees who report incidents of wrongdoing are not discriminated against or victimised by their employer.

We were given a copy of the provider's whistleblowing policy and procedures and noted that this defined who a whistleblower was and made reference to the Public Interest Disclosure Act 1998, which is the legislation that underpins whistleblowing. It then outlined the procedure for staff members reporting issues of concern, which in the first instance involved the staff member meeting with the home manager. The manager would arrange for the issue to be investigated and if unresolved would be passed onto the director (the owner of the service). The procedure also stated that the employee had the right to report the issue to an external agency such as the CQC. However, the policy and procedures made no reference to the employee's right to be protected from victimisation or other reprisals if they were to report an issue of concern.

From our conversations with staff and our review of the whistleblowing policy and procedures we were satisfied that staff would feel confident in reporting any instances of abuse without fear of being victimised. However, the provider might find it useful to note that at least one staff member did not seem to understand the concept of whistleblowing and this might result in them not being sure how to raise concerns in an appropriate manner. Furthermore, the provider might find it useful to note that the whistleblowing policy and procedures did not emphasis the right of employees to be protected from victimisation or reprisals if they were to report issues of concern.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

One of the staff members we spoke with said they had been employed by the provider for 21 years and had NVQ qualifications at levels 2, 3 and 4. Another staff member we spoke with said they had no NVQ qualifications but had a total of nine and a half years care experience, and a third staff member said they had NVQ levels 2, 3 and 5, and a total of nine years care experience. We were given a list of staff who had completed NVQ level 2 or above and noted that thirteen out of thirty care staff had these qualifications.

The people we spoke with said they thought that generally speaking there were enough staff in the home to cater for their needs, but on occasions there had been staff shortages. They said that at night staff would check on them in their rooms every few hours. One person said that if they pressed the buzzer in their room staff would normally respond quickly.

Two of the staff members we spoke with said they thought there were enough staff to cover the service at all times. However, the third staff member said that they thought that there was a problem with staffing because the needs of the people who use the service had increased, even during the short time they had been in the home. They said that this meant staff were having to spend longer with some people and therefore this would put pressure on staff to complete their other tasks. They said they thought it would be helpful if there was an extra 'floating' staff member on duty. They also said they did not think the provider was quick to replace staff. All the staff we spoke with said that the provider had a policy of not employing agency staff and that if a staff member went off sick they would ask existing staff to cover. If this was not possible then the service would run short staffed. One of the staff members said that, "very rarely do we run short."

From our observations during the day we saw no visible evidence of staff shortages. For example, at lunch time there appeared to be enough staff to assist people who needed support to get to the dining rooms and to help those who needed assistance with eating. Whilst we were sitting in one of the main lounge areas talking with people we noticed that there were always several members of staff walking around.

The manager explained the service's shift system to us. They said that there were three shifts: a morning shift from 8am to 2pm, a late shift from 12.30pm to 8pm, and a night shift

from 8pm to 8am. They said there were always at least eight staff on duty in the morning, which included one head of care staff or a senior, five staff in the afternoon, and five in the evening. At night there were three waking staff, including one senior. The manager showed us a copy of the provider's current staff rota and we noted that all the shifts were covered in accordance with what the manager had told us regarding staffing numbers.

From our conversations with staff, our observations and our review of staffing information we were satisfied that there were adequate staffing numbers at all times. This meant that people who use the service could be confident they would always receive proper care and attention in a timely manner. However, the provider might find it useful to note that at least one staff member and some people who use the service felt that the home was short staffed on occasions.

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.

Reasons for our judgement

We looked at how the provider obtained feedback from people, staff and other key stakeholders regarding the quality of the service. The people we spoke with said they did not attend residents' meetings and that there was no organised feedback. They said that if they had any problems they would tell a member of staff and "they would usually fix it." One person said that although the manager would always listen to their complaints and concerns nothing ever got done about them. However, another person said that when they had had a complaint it was sorted out quickly.

We asked the manger to comment on the claim by one of the people who use the service that they failed to respond to complaints. The manager said that she thought this was in connection with an issue regarding the telephones at weekends. They said that during the week calls to people who use the service would be taken at reception and then transferred to the person's room. At weekends an automated system was used which meant the caller would be asked to key in the person's room extension. One of the people had requested that this system be used all the time. The manager said that this was not necessary as there were at least three people in the reception area who could answer the phone.

We were given a copy of the provider's most recent residents' questionnaire and noted that this focused on activities. The questionnaire listed a range of activities and asked people if these had improved, stayed the same or had got worse. The manager said they had not analysed the results yet. They also explained that each year the questionnaire would focus on a different aspect of the service.

The staff members we spoke with said there were daily staff meetings at midday , and that the manager met with senior staff once or twice a month. They said the manager had an open door policy which meant that staff could talk to them at any time.

The manager said the home did not have regular residents' meetings because they were getting feedback from people all the time. They said that with regards staff meetings, up until the previous September they had chaired weekly meetings, which were minuted.

They had then decided to meet everyday at midday and that at present these meetings were not being minuted. They said that staff found the daily meetings very useful. They said there were also weekly meetings with the heads of care where the needs of individual people were discussed, and that these were recorded. They said they might consider minuting the daily staff meetings from now on.

We were given a copy of the minutes of the latest head of care meeting and noted that these consisted of short statements regarding the health and welfare of a number of the people who use the service. We were also given the minutes of one of the last weekly staff meetings that had been taking place up until September 2013. We noted that issues discussed included a new member of staff starting, training, feedback from residents, the role of senior staff, and changes in the kitchen.

From our conversations with staff and people who used the service, and from our review of feedback information we were satisfied that the provider was taking steps to ensure it obtained regular feedback from key stakeholders, much of it in an informal way. This meant that any concerns raised could be acted upon in a timely manner. However, the provider might find it useful to note that the daily staff meetings were not currently being minuted, which meant there was no record of any agreed action points or areas of concern.

We asked the manager how they regularly monitored and assessed the quality of the whole service. They said they did not have any recorded quality assurance material such as audit reports or records of regular management inspections. However, they said that they were in direct contact with the owner of the service every day and attended management meetings with the owner every month. They said at these meetings they would review the service. They also said that the owner had their own office in the building and was in almost every day which meant they would be aware of what was happening in the home.

We were given copies of the minutes of two management meetings and noted that issues discussed included reception cover, activities, furnishing and decorations, training and policies. However, we noted that only some of the agenda items had any notes attached to them and even these notes were very brief. There were no action points to be taken forward or a review of action points agreed at the previous meeting. The minutes gave very little indication of how the manager and the owner were monitoring and assessing the quality of the service.

Following our visit the manager sent us a summary of how quality assurance was carried out in the home, and this reiterated what the manager had told us during the visit, which was that both the owner and the manager were very 'hands on' and were constantly receiving feedback from people who use the service, relatives and staff. It also emphasised that both the owner and the manager were fully aware of any issues arising in the service because they were present in the home at most times.

We were satisfied from the information we looked at that the provider was regularly monitoring and assessing the quality of the whole service. This meant that any problems identified could be acted upon quickly and thus ensure that a safe and high quality service was maintained at all times. However, the provider might find it useful to note that there was very little in the way of recorded documentation of such monitoring and assessment.

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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