Inspection Report

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

Eastfield Farm Residential Home Limited

Eastfield Farm, Southside Road, Halsham Hull, HU12 0BP

Tel: 01964671134

Date of Inspection: 09 July 2013

Date of Publication: August 2013

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

Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Requirements relating to workers	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Eastfield Farm Residential Home Limited
Overview of the service	Eastfield Farm Residential Home is a care home that provides personal care and accommodation for older people, inlcuding those with dementia related conditions. The home is situated in open countryside in the village of Halsham, close to the seaside town of Withernsea in East Yorkshire. There is a new extension that provides access to an enclosed garden. Lounge areas and bedrooms have recently been upgraded; most bedrooms now have en-suite facilities. There is ample car parking space.
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 9 July 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information sent to us by commissioners of services.

What people told us and what we found

We spoke with two people who lived at the home, two members of staff, the manager and one of the providers as part of this inspection.

People told us that they were well cared for by staff. One person said, "Staff are very good – they chat to us and help us when we need it". We saw good interaction between people who lived at the home and staff on the day of the inspection. Care planning documentation included the information needed by staff to provide the care that people needed.

The home was clean on the day of the inspection but we had concerns about the risk of infection posed by the arrangements in place in the laundry room. Other aspects of the infection control guidance policy needed to be implemented.

We saw that staff were recruited safely and that they worked alongside long standing staff to gain experience before they worked unsupervised with people who lived at the home.

There were sufficient numbers of staff on duty, although staff said that they would have liked more time to spend with people who lived at the home, and people who lived at the home said that they would like more outings.

Monitoring systems were being used to measure the quality of the service that was provided at the home and there were numerous ways for people who lived at the home to express their opinions about the service they received. Staff also had regular meetings.

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

What we have told the provider to do

We have asked the provider to send us a report by 16 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

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

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

Our judgement

The provider was meeting this standard.

People experienced care and support that met their needs and protected their rights.

Reasons for our judgement

Peoples' needs were assessed and care was planned and delivered in line with their individual care plan, and in a way that was intended to ensure people's safety and welfare.

We saw good interaction between people who lived at the home and staff. Staff engaged people in conversation and were seen to understand people's individual needs and respond to them appropriately. People who lived at the home told us that staff were attentive and that they received support when they needed it. One person said, "Staff are very good – they chat to us and help us when we need it".

We looked at the care records for two people who lived at the home. We saw that information had been gathered at the time of the person's initial assessment and that this process commenced prior to them being admitted to the home. The assessment included details of their general health, mobility, bathing, dressing/undressing, vision, hearing, medication and continence needs. There was a dependency assessment that measured the level of their need for support, including the mobility equipment the person needed to use and how many staff were needed to support certain activities. Assessment tools had been used as part of this process where appropriate, such as those for nutrition, pressure care and moving and handling.

Where an area of concern had been identified, a risk assessment had been produced. We saw that people had risk assessments in place for the risk of falls, the use of mobility equipment, leaving the premises unaccompanied, scalding and the use of bed rails.

On the day of the inspection we noticed that the carpet fitted on the upstairs corridor was uneven. The manager told us that it was stretched regularly to reduce the risk of trips and falls. The provider may wish to note that this was identified as a trip hazard on the day of the inspection.

Individual plans of care had been developed for people that were based on information gathered at the time of their initial assessment, as well as risk assessment documentation

and 'getting to know you' information. In the care plans we viewed, we noted that people had signed a consent form to record that they had been involved in the care planning process. We saw that care plans included sufficient information to inform staff how the person wished to be assisted or supported, such as, "Be aware that I am not able to lift my right arm higher than 45º from my body, just enough to wash under my arms" and "I am afraid of thunder and lightning".

Monitoring forms were used to record a person's weight and assistance with personal care. Although these were mostly up to date, the provider may wish to note that there were some gaps in recording and this could have led to confusion over whether the activity had actually taken place. We also saw movement monitoring forms; these were used to record when a person had been moved from one position to another to reduce the risk of pressure sores developing. These records were seen to be up to date.

We noted that accidents and incidents had been recorded appropriately, including the use of body maps to record information about any bruises, skin tears or other injuries sustained. However, the provider may wish to note that not all injuries had been recorded on body maps. This could have made it more difficult for any injuries to be monitored by staff and health care professionals. The recording on accident and incident forms indicated that appropriate advice had usually been sought following accidents at the home.

Advice had been sought from health care professionals in respect of a person's on-going care needs. Details of these contacts had been recorded, including the reason for the contact and the outcome. Both of the people whose care plans we checked had been visited by their GP to undertake a medication review. However, we saw that one person had suffered five falls in 2013 and they had not been referred to the falls team. A risk assessment had been developed and a sensor mat had been placed at the side of the person's bed to alert staff to their movements during the night. The manager said that they would contact the falls team for advice as soon as possible.

Care staff told us that it was usual practice at the home not to wake people routinely during the night to assist them to use the toilet, but "To wake them when they were wet". There was no information in care records to indicate that advice had been sought about whether people should be woken during the night to avoid them becoming wet in bed, or that people had been asked about their wishes.

We saw that monthly reviews of care planning documentation had taken place and that these were a detailed account of any changes to a person's care needs. However, some of these reviews had not been carried out since March or April 2013. The provider may wish to note that the reviews had not resulted in care plans being updated so staff had to read the care plan and the reviews to obtain up to date information. This had been recognised by the manager, who had plans in place to ensure that care plans were updated on the database and printed off each month.

A fortnightly movement, music and memory session was held at the home. This provided people who lived at the home with an opportunity to exercise and to socialise. The new extension led to an enclosed garden area where people could take a walk in a safe environment.

Patient passports had been completed for people who were not able to provide information to hospital staff. Patient passports are documents that people can take with them to hospital appointments and admissions to inform hospital staff of their physical and mental health needs.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

Effective systems were not in place to reduce the risk and spread of infection.

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

Reasons for our judgement

People were not protected from the risk of infection because appropriate guidance had not been followed.

The home had numerous copies of the Department of Health guidance, "Code of Practice on the prevention and control of infections and related guidance" and the provider told us that each member of staff had received a copy. This guidance advises that an infection control lead needs to be appointed and manager told us that she would take on that role.

There was an infection control policy and procedure and a hand hygiene policy in place that had been purchased from a company that supplied policies, procedures and advice to care services. This had not been personalised to include specific details for Eastfield Farm Residential Home. No annual statement on infection control and prevention had been produced.

The survey undertaken in the summer of 2012 included a question about the cleanliness of the home. The action recorded, "The home will endeavour to review cleaning schedules within the home to establish any improvements". We saw that there was a list of cleaning duties for domestic assistants but no cleaning schedules or any records of which tasks had been completed each day, week or month, including when a 'deep clean' had been carried out. Domestic staff had different coloured buckets and mops but there was no record of which colour corresponded to which areas of the home.

The people who we spoke with told us that they were happy with the cleanliness of the home. One person said, "Oh yes, my room is always lovely and clean".

We did not see any risk assessments in place in respect of the control and prevention of infection, including information about the management of infections such as Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C.diff). The manager told us that there had been an outbreak of diarrhoea and vomiting at the home. They had contacted the Health Protection Agency but had not submitted a notification to the Care Quality Commission. We advised that a notification should be submitted under Regulation

18 of the Care Quality Commission (Registration) Regulations 2009 2(g) – 'any event which prevents, or appears to the service provider to be likely to threaten to prevent, the service provider's ability to continue to carry on the regulated activity safely, or in accordance with the registration requirements'. There was no record of this outbreak to enable such events to be monitored and no signage ready for use, for example, to request that people did not visit the premises during the outbreak.

We saw that staff wore disposable aprons and gloves when assisting people with personal care. Toilets and bathrooms had been supplied with liquid soap and paper towels in place of soap and towels and there was signage that demonstrated good hand hygiene in the staff toilet.

Domestic assistants were employed at the home apart from on a Sunday. This meant that care staff were responsible for domestic and laundry duties on Sundays; undertaking these tasks in addition to supporting people with personal care could increase the risk of infection.

We saw that the laundry room was small and very cluttered. Soiled linen and clothing was brought to the laundry room in a red bag that dissolved in the washing machine and this provided some protection against cross infection. However, there were no distinct 'dirty' and 'clean' areas in the laundry room and we saw that clean clothing was stored on a rail close to soiled laundry and close to mops and buckets. The storage of clean linen was unsatisfactory; we saw that clean linen was piled up at the end of the upstairs corridor and not stored in a cupboard.

The manager told us that an officer from the Environmental Health Department had visited the previous week and had been satisfied with the standard of hygiene in the kitchen, although the 'due diligence' book could not be found on the day of their visit.

Structural alterations were being carried out at the home and this created a lot of dust outside the premises. We saw that the internal areas of the home had been kept free of dust.

There were appropriate arrangements in place for the storage and collection of clinical waste.

Requirements relating to workers ✓ Met this standard

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

Appropriate checks were undertaken before staff began work.

We checked the recruitment records for two new members of staff. We saw that they had completed an application form and that this was accompanied by a curriculum vitea (CV). We saw that application forms included details of the person's employment history, education and a criminal conviction declaration. We noted that applicants were required to provide information about any breaks in employment. A record of interview questions and responses had been retained.

We saw evidence that confirmed two written references, a Disclosure and Barring Service (DBS) first check and DBS clearance had been received prior to these people commencing work at the home. Both new staff had worked for a week prior to being placed on the staff rota and during this period they had undertaken training on moving and handling theory, infection control and food hygiene as well as shadowing experienced staff.

The manager told us that new staff received an induction pack that they held themselves. We saw that the induction programme met the requirements of Skills for Care and that there was a pack available for staff who would be working at different levels, for example, care worker, senior care worker and domestic assistant. Staff also received a copy of the General Social Care Council code of conduct and a CQC booklet entitled, "Our new rules for checking health and adult social care services".

The manager showed us a form that had been introduced to give to people who lived at the home. This asked for their opinion of the new employee and included questions about dignity and respect. Other questions included, 'Is this person caring?", "Do you like them?" and "Should they become a permanent employee?". This gave people who lived at the home the opportunity to influence which staff were employed to provide them with a service.

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

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

The manager told us that there were currently 23 people living at the home. The standard staffing levels were four care workers throughout the day and two care workers during the night. The manager was on duty in addition to this, Monday to Friday. Ancillary staff were also employed; there was a cook on duty each day and either one or two domestic assistants on duty each day. We examined the staff rotas and saw that these staffing levels had been maintained consistently.

We saw that the staff rotas recorded the new employees in green type and that they were on duty in addition to the usual staffing levels, so that they could shadow an experienced care worker.

People's dependency levels had been assessed and were recorded in care planning documentation. We spoke to two care staff who told us that seven people who lived at the home needed the support of two care workers when they required assistance with personal care or with transferring. Care staff said that one member of the team had to assist in the dining room from 9.00 am and that this took them 'off the floor'; this made it difficult for staff to spend time with those people who chose to get up around this time. The manager told us that task lists had been introduced to ensure that all duties were completed each day and that these were shared equally between the staff on duty. One of the duties on the list was assisting in the dining room.

We asked how frequently people were checked during the night and were told that everyone was checked every two hours. The provider may wish to note that this indicated that people had not been asked how often they would like to be checked during the night, as it would be unlikely that every person would choose two hourly checks. The provider told us that night staff were only expected to undertake light domestic duties during the night so would have time to undertake more regular checks if they were needed.

The manager said that they were working towards having two domestic staff on duty each day. They then hoped to introduce a 'late shift' so that domestic staff could assist with cleaning communal areas of the home.

There was no activities co-ordinator employed at the home. We saw that, at certain times of the day, care staff had time to sit and talk with the people who lived at the home, although staff told us that they would like more time to do this. People who lived at the home told us that they would appreciate more outings. One person said, "It would be lovely to go out somewhere every now and again". The manager said that they were aware of this; they had the use of a company car and intended to take people out into the local community in small groups.

There was a mix of male and female care workers on duty so that if someone who lived at the home had expressed a preference to be assisted by a care worker of a particular gender, this could be accommodated.

There was a handyman employed who worked for six hours per day, Monday to Thursday. This ensured that day to day repairs were completed in a timely fashion.

The provider told us that a new training policy was being developed. This recorded that mandatory training for care staff would consist of moving and handling, health and safety, infection control, safeguarding adults from abuse, fire safety, dementia awareness, first aid, medication, deprivation of liberty safeguarding and the Mental Capacity Act 2005. Although staff had already completed numerous training courses, this policy would ensure that all staff had the skills and knowledge to carry out their roles effectively.

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.

Reasons for our judgement

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

Policies and procedures were in the process of being updated. Those completed included: involving service users in their care, consent to care and treatment, self-care and treatment, medication to be taken 'as required', use of oxygen, Deprivation of Liberty safeguards, advocacy, equality and diversity, and general health and safety.

We saw that audits had been introduced by the manager on medication management; one would be completed by the manager and another would be completed by the heads of care. These had only been introduced during the week of the inspection so there were no records available for checking. However, we did see the templates that were to be used to undertake the audits and noted that they contained suitable information to enable thorough checks of the systems in place to be monitored. We saw that accidents and incidents had been recorded but we did not see any evidence that they had been analysed to identify patterns that had emerged or any improvements that needed to be made. The manager was aware that other quality audits needed to be introduced to provide evidence that policies, procedures and systems were being adhered to by staff.

There was an information and training pack available for staff on 'dealing with service user concerns and complaints'. This defined complaints, learning from complaints and anticipated outcomes. The provider may wish to note that this training had not yet been undertaken by staff. The policy and procedure on complaints had been updated and was waiting to be 'signed off'. The manager told us that no formal complaints had been received by the home since the last inspection by the Commission.

People who lived at the home who we spoke with us told us that they would have no hesitation in talking to staff if they had any worries or concerns. They said, "Staff would definitely help if we had any worries and I'm sure they would put it right if they could".

A suggestion box had been purchased and the manager told us that it would be fixed to the wall in the lounge so that it was easily accessible to people who lived at the home and

visitors. The most recent service user survey had been undertaken in the summer of 2012. This had been analysed and the outcome shared with people who used the service and staff. The analysis recorded that 100% of people said they were happy with the care they received and with the menu choices. Most people felt that they were treated as individuals by staff and had been satisfied with the cleanliness of the premises. There was a record of the action that had been taken to make the necessary improvements.

There were blank surveys for relatives/friends and allied professionals in place ready for use. The manager told us that these and surveys for people who lived at the home would be distributed in July 2013 and we saw this task being carried out on the day of the inspection.

The most recent residents meeting had been held in March 2013. We saw the minutes of the meeting and noted that they recorded areas for action. The action taken following the meeting had been recorded in red type. The manager told us that this had been circulated amongst the people who lived at the home and that, in future, minutes would be displayed on the notice board. One of the issues raised included meal choices and it had been agreed that a hot meal choice would be introduced but that soup and sandwiches would remain as an option. Some people had requested that fresh fruit be provided and the minutes recorded that fresh fruit would be available each meal time and on the tea trolley. One person had requested a larger clock in the new extension and this had been purchased.

Staff meetings had been held approximately every two months. The minutes of the most recent meeting recorded that the topics for discussion had included the 'red bag' laundry system, rotas, activities, training (infection control training was imminent) and the provision of drinks. The identification of 'champions' for the topics of dignity, stroke, diabetes, nutrition, end of life care, pressure care and dementia was also discussed. We saw that staff were given the opportunity to make suggestions and ask questions under 'any other business'. A management meeting had also been held and minutes had been recorded.

We saw evidence that fire safety systems and equipment, the call bell system, mobility hoists and the stair lift had been serviced. We noted that there was no passenger lift installed at the home. One of the people who lived at the home raised this as a concern, as did some of the staff who we spoke with.

We observed that care plans had been reviewed and updated on an on-going basis. Formal reviews of care plans had been undertaken by the local authority, although these were in 2011 for the people whose care records we checked.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: Regulation 12(1) The registered person had not ensured that service users, persons employed for the purpose of the carrying on of the regulated activity and others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity were protected against identifiable risks of acquiring such an infection by the means specified.

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

The provider's report should be sent to us by 16 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

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

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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