Inspection Report

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

The Raphael Medical Centre

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Hildenborough, Tonbridge, TN11 9LE

Tel: 01732833924

Date of Inspections: 20 September 2013
19 September 2013

Date of Publication:
November 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
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	Raphael Medical Centre Limited
Registered Managers	Mr. Tanesh Bhugobaun Dr. Gerhard Florschutz
Overview of the service	The Raphael Medical Centre provides care and treatment for up to 50 people with an acquired brain injury. The service is divided into three areas: the main unit, Tobias House for patients in reduced states of consciousness, and the Special Care Unit for patients with a mental illness in addition to an acquired brain injury.
Type of services	Long term conditions services Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures 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 19 September 2013 and 20 September 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

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

What people told us and what we found

Patients and relatives were pleased with the quality of care. One patient said," they know me well … the physio is good". One relative commented," they give me hope … they simplify things, I am no longer overwhelmed by the complexity of things". We saw that there were thorough assessments of patients' care needs and care was tailored to meet them.

The Raphael Medical Centre(RMC) worked closely with other providers and in particular through its participation in the Kent Acquired Brian Injury Forum (KABIF).

All the patients and relatives that we spoke with felt safe at the RMC. One patient said, when asked about raising safety concerns, "I would be listened to by staff". Another, a relative of a patient who was not able to communicate, said, "I would recognise it (if the person were being abused)".

The RMC was clean and there were procedures in place to protect people from acquiring preventable infections.

There were proper recruitment process in place and staff had been vetted before being employed in order to protect patients who used the service.

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others..

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 30 November 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.

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

Reasons for our judgement

Patients and relatives were pleased with the care delivered. The Raphael medical Centre (RMC) was able to be flexible in its approach to care. We saw one instance where a patient had been admitted to hospital. The nearest relative wanted the patient back at the RMC. When staff looked into the request in detail they found that the concern was that the patient was being looked after by staff who were unknown to him. The RMC was able to send staff to the hospital to care for the patient although only on the night shift.

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We saw that patients' needs were assessed prior to their admission. Staff from the RMC would visit the patient at the place they were being treated. We saw one occasion where the RMC had decided not to admit someone because it did not feel that it had the necessary elements in place to care for them properly. The assessment varied according to the unit to which patients were admitted. Some of the assessments we saw included daily living tasks, mobility, communications and cognitive ability. Others concerned spirituality, psychology and continence. Where appropriate we saw that there had been assessments of suicide and ligature risks.

We looked at tracheostomy (a surgical procedure where the surgeon creates an opening in the neck at the front of the windpipe) care. In patients' rooms we saw that there was the necessary equipment for suction and changing of tubes, including a variety of catheter sizes according to the size of the tracheostomy tube. We spoke to nursing staff who described how they would change the suction catheter after each use. This is in accordance with current good practice, although the provider might like to note that the clinical guidelines to staff were out of date; saying that the suction catheter could be re-used.

When the patient was no longer to have a tracheostomy, the patient was seen by an ear nose and throat (ENT) consultant and plans were made for how they would be weaned from it. The process was regularly monitored by the ENT consultant. Staff said they would

not attempt the process without close instructions from ENT specialists. We spoke with an independent therapist at the RMC who confirmed this.

Treatments were tailored to meet the needs identified. We saw notes on the use of rhythmical massage therapy which indicated the improvements a patient had experienced. We saw where art therapy had been used but when it was found to be ineffective it was stopped. There were speech and language, occupational, music and other therapies also available. Patients had individual therapy plans with goals that the therapists wrote up.

We looked at care plans in the special care unit. The provider might like to note that we saw several instances where staff talked about patients in their presence without acknowledging that they were there. Also most patients, when asked, were not able to tell us about their care plan. However in one case we saw that there was direct evidence of the patient's involvement in his care, in that the plan had direct quotes from the patient. Generally plans did not have evidence of direct patient involvement. We discussed this with staff including the consultant psychiatrist and consultant nuero-psychologist. They said that most of the patients lacked the insight to allow them to contribute directly to care plans or to review meetings of their care. We saw that there was indirect evidence of involvement much of it based on subjective observation. For example we saw that in one case staff felt that an individual was ready to be moved from the special care unit but when they planned for this he experienced increased episodes of incontinence. Staff felt that this was evidence of his unhappiness with the changes and did not carry on with the plan. Others notes showed that some patient had signals, for example thumbs "up" or "down" to various options.

We looked at Multi-disciplinary Team (MDT) meetings. We saw that they were attended by nurses, doctors, therapists, managers, patients and/or relatives. They were well documented with clear outcomes and goals set. In the cases we looked at the MDT meetings happened when scheduled.

We saw that the RMC made use of assessment tools recommended as "good practice" in relation to the care of acquired brain injury. For example the Berg balance scale, a clinical test of a person's static and dynamic balance abilities, and the Addenbrookes cognitive examination, a neuropsychological assessment. Other examples included the Functional Independence Measures and Functional Assessments Measures (FIM/FAM), used by the teams working across disciplines to chart changes in a patient's dependency and the Northwick Park dependency scale to provide information about patient progress.

We saw that staff knew people and their care needs well. They were able to interpret behaviours, for example, one patient would ask to use the telephone when asking to go to the lavatory. We saw many demonstrations of warmth between the patients and staff.

Cooperating with other providers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We talked with patients and relatives about their experiences of co-ordinated care. One patient had been transferred from another hospital. The patient said that there had been a discharge meeting where staff from the hospital and the Raphael Medical Centre (RMC) had been present. The discharge process had been explained to the patient and the relative. The patient said they felt informed and involved, "the cooperation was good … I felt confident because what they said would happen did happen … and it happened when they said it would"

We saw there was close cooperation with the Lane Fox respiratory unit, which is a national referral centre for chronic (long term) respiratory failure. Staff from the unit came to the RMC and helped to settle the patients and set up the equipment, which was required to be tailored to the individual. Once the equipment was set up by staff from the unit it was locked so that it could not accidently be altered. Staff from the Fox Lane unit made random visits to the RMC to ensure that the equipment was working correctly. Staff from the Fox Lane Unit provided training on respiratory issues to staff from the RMC.

The RMC was a founding member of the Kent Acquired Brain Injury Forum (KABIF). This group brought together partners from NHS, the education department, the local authorities and both the private and voluntary sector. The achievements of the group included constructing a county wide strategic plan for commissioning of services for acquired brain injury. Kent was the first county in England to have done so. The RMC was actively involved in the forum. On the day of our visit the nominated individual for mental health services at the RMC was chairing a meeting of the forum.

We saw from patients' records that the RMC cooperated with, and made referrals to, other providers. We looked at a recent referral to an acute hospital for medical reasons, not directly related to the patient's brain injury. This had happened at a weekend. The on call doctor had attended the patient. There were comprehensive notes of the doctor's conversation with the hospital. The hospital had been informed of the care needs of the patient, in respect of the brain injury as well the more immediate problem. When the hospital wished to discharge the patient the RMC had been unwilling to accept the

patient's return until they were satisfied that the patient was medically stable.

The RMC made routine referrals for patients' physical needs. We saw letters of referral for dermatology, surgery and nuero-surgery. We saw that these had been followed up and in one case how the outcome of surgery had impacted positively on a patient's care plan.

There were discharge meetings involving other providers. We looked at a selection of notes of these. There were representatives from other health providers, local social services departments, families and voluntary agencies. We saw that discussions focused on finding the most appropriate placement for the individual and mapping out a care pathway. We also looked at the records of a 'best interest' meeting held prior to a patient's discharge. People present included health professions, social workers and an independent advocate. The patient's nearest relative had been invited but was unable to attend. There was however a letter from the relative which had set out their aspirations for the patient.

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

We looked at training records and saw that staff were up to date with training in safeguarding vulnerable adults. Staff from the local social services safeguarding team had been involved in training staff at the Raphael Medical Centre (RMC). We saw that safeguarding training was part of the induction process for new staff.

Staff we spoke with were able to explain that safeguarding involved maintaining the privacy and dignity of vulnerable adults and identifying and reporting any instances of abuse. They understood abuse could be physical or mental and included neglect. Staff said that they had never seen any type of abuse whilst working at the Raphael Medical Centre (RMC). They told us that they would report any abuse to their line manager. Some staff said that if they were not able raise issues through the proper channels with the RMC they would go to the police.

Staff told us that there was guidance on reporting safeguarding issues in the nurses' stations of the different units within the RMC. We looked at some nursing stations and found that the guidance was available.

We saw an example of where staff had recognised and dealt with a safeguarding situation. This was a case involving the financial affairs of patient about to be discharged. The staff recognised that patient's mental state and capacity to make decisions made them vulnerable. The RMC engaged the services of an independent firm of solicitors who, together with the patient's nearest relative, took steps to ensure the patient's financial position was safeguarded.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

Patients and relatives told us they always found the Raphael Medical Centre (RMC) clean and had no concerns over cleanliness or infection prevention control (IPC). Patients we asked said that staff wore protective clothing such as gloves and washed their hands prior to examinations. We saw that there was information about cleanliness and IPC available to visitors. This included information about hand washing. There were antiseptic gel dispensers at strategic points for maintaining good hand hygiene. We saw staff asking visitors to use the gel. We saw that taps at the hand wash stations were activated by using a "hands free" button. This reduced the risk of contamination arising from manually operated taps.

Records showed the RMC had policies and procedures in place to manage cleanliness and IPC. However, the provider may find it useful to note that these policies and procedures did not contain information of their origin, ratification or clear information on monitoring. There were no references to other policies, procedures or guideline documents covering specific areas of infection control. They did not detail the composition of the IPC team. This meant that the guidance and policies may not contain all the most up to date and relevant information.

An identified lead for IPC had been appointed and when we spoke with them, they understood their responsibilities.

Staff we spoke with told us they had been trained in IPC and the training records confirmed this. The notes from recent staff meetings demonstrated that IPC was a regular agenda item. We were told that audits had been regularly completed to show that good standards of hygiene had been achieved.

We saw that staff followed recognised hygiene practices. These included wearing clean uniforms, washing their hands thoroughly as well as using hand disinfectant such as antiseptic gel and using personal protective equipment, such as disposable gloves, aprons and face masks / visors if necessary.

One member of staff told us "we wear gloves and aprons when feeding patients through

their PEG (this is a feeding tube into the stomach through the patient's abdomen).

We were informed that the RMC was cleaned from 7am to 5pm daily seven days each week by cleaners dedicated to a specific area. We saw cleaners working in the RMC during our inspection and the whole building appeared clean, tidy and free from unpleasant odours. We saw waste bins clearly marked as clinical waste and the RMC had appropriate procedures in place for the removal of waste and 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

We looked at 14 staff files for the purpose of checking compliance on staff recruitment. These showed that there was an effective recruitment and selection process in place to help ensure that staff were safe to work with vulnerable people.

The regulations require that certain information be obtained from people seeking employment at the service. This includes a recent photograph, proof of identity, health information, a Disclosure and Barring Service (DBS) check (formerly Criminal Records Bureau (CRB) check), a full employment history, and references. We found that the files checked contained the required information.

There is a requirement to check a job applicant's reason for leaving their previous employment, where they had been employed working with children or vulnerable adults. We found that, in the majority of cases, this information had been recorded.

All the files contained the notes of the applicants' face to face interview.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Although there were some monitoring processes and guidance in place,

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

A survey of patients and relatives had been carried in June 2011. This showed a high degree of satisfaction with many aspects on the care and treatment. In particular there was high degree of trust and confidence in the staff. However some results highlighted concerns such as patients' lack of knowledge of their care plan.

The Raphael Medical Centre (RMC) was part of the Kent Acquired Brain Injury Forum (KABIF). This linkage enabled health professionals to remain up to date with the latest developments in treatment. We saw that staff regularly attended specialised conferences which again helped to maintain their professional development.

There were some systems in place to protect patients from unsafe or inappropriate care or treatment. However it was apparent that they had not been kept up to date. We looked at the minutes of the clinical governance meetings. The minutes generally comprised single line entries to represent discussion on agenda items. For example the minutes of the meeting of 1 November 2012 state "(name) to be asked to make formal application for craniosacral therapy". The minutes of the meeting of the following March state, "agreed to include craniosacral therapy". There was no evidence of the benefits or risks of the therapy and no evidence of any discussion of the reasons for its adoption. This meant that there was a lack audit or accountability of the decision making process. When we spoke with staff who were at these meetings they told us that the entries did not represent the breadth of discussion that took place.

On other occasions matters were not followed up. For example, in the same two sets of minutes as above, a training issue was raised in the first meeting to be followed up in the second. It was not followed up. Therefore it was not possible to say whether shortcomings, that the governance process had rightly identified, had been resolved.

The frequency of the meetings was not clear. There was a meeting on 17 May 2012 during which an issue was to be followed at "… next meeting on 27 June". However the next

meeting, according to the file we were shown, was on the 1 November 2012.

The medical advisory committee and clinical governance committee met on the same day and had the same membership. It was difficult to understand the relationship between the two. There was no input from the RMC's full time doctor into clinical governance generally.

We were told that a number of medical audits had been carried out. However the results were not available because the lead for this work was on leave. We were told that there were comprehensive health and safety policies in existence, again these were not available because the lead was on leave. In both cases the documents were locked up. This meant that they were not readily available to staff to consult.

Many of the policies and guidelines we looked at were not correctly produced as per national guidance. For example we looked at the Guideline for Procedure for Suctioning. The document was not dated and had no information on its creation, ratification, review or monitoring. There were inconsistencies between this document and both the draft Tracheostomy Guidelines for Adult Patients at Raphael Medical Centre and the Guideline for Removal and Cleaning of Inner Cannula. This guideline document also was not correctly cross referenced to other relevant guidelines such as the Tracheostomy Guidelines for Adult Patients at Raphael Medical Centre or the Guideline for Removal and Cleaning of Inner Cannula. The clinical guidelines were also contrary to the processes actually being used, as described by the nursing staff. This meant that if staff followed the Guideline for Procedure for Suctioning they would be using procedures that were out of date and not in accordance with current best practice.

We looked at the immediate life support policy for the RMC. This policy mentioned that there was a medical emergency response team but failed to indicate how it should be summoned. It was also not clear what procedure staff in different parts of the RMC should follow. For example, it did not indicate that a portable defibrillator needed to be retrieved from the main house in the event of a cardiac arrest in Tobias House, how that should happen and in what time frame. It did not indicate the levels and frequencies of resuscitation training that staff should undergo.

The hydrotherapy pool policy was not readily available and the risk assessment did not include any emergency evacuation procedure training, any audit of staff rescue skills and evacuation procedures. The physiotherapy professional body recommends these procedures are tested every six months. The staff we spoke with were not aware of having to practice pool rescue procedures.

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 activities	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider had some systems in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others, however it was apparent that the systems were not being operated effectively.

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 30 November 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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