Inspection Report

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

North Court Care Home

108 Northgate Street, Bury St Edmunds, IP33 1HS

Tel: 01284763621

Date of Inspection: 23 April 2013

Date of Publication: May 2013

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

Respecting and involving people who use services	✖	Enforcement action taken
Consent to care and treatment	✖	Action needed
Care and welfare of people who use services	✖	Action needed
Safety, availability and suitability of equipment	✖	Action needed
Records	✖	Action needed

Details about this location

Registered Provider	Four Seasons Homes No 4 Limited
Registered Manager	Mrs. Elspeth Anne Nicol
Overview of the service	The service provides residential and nursing care to a maximum of 65 people. Some people using the service have specific care needs as they have dementia.
Type of services	Care home service with nursing Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care 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 23 April 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 reviewed information given to us by the provider. We were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We spoke with nine relatives of people using the service. One relative told us, "Nursing staff are gentle with my relative and they understand their needs. Sometimes there is a language barrier as many staff do not speak English as a first language." Another relative told us, "Some carers are better than others. They seem to be in a constant state of hurry." A third relative said, "Staff do not really have time to interact with my relative on a one to one basis. [My relative] cannot understand what some of the staff say. Some of the staff are abrupt with my relative."

We observed that staff did not interact positively with some people using the service and that staff talked about people in front of them and shouted over their heads. Some staff demonstrated a lack of understanding around ensuring the dignity of people with dementia. We saw that procedures to ensure that people were restrained appropriately had not been followed and we have reported this to the local authority safeguard team.

We saw that some people with diabetes did not always have their care needs assessed or appropriately treated. People's skin integrity had been risk assessed but preventative equipment was not always in place to mitigate the identified risks. Nursing staff had not received up to date training around tissue viability and diabetes.

Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete.

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 28 May 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against North Court Care Home to protect the health, safety and welfare of people using this service.

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

Respecting and involving people who use services ✖ Enforcement action taken

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

People's dignity and independence were not respected.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Evidence gathered on the day of the inspection showed that people's values and human rights were often not respected in the two areas downstairs. During our visit on 23 April 2013, we used the Short Observational Framework for this inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who may not have been able to talk with us. We completed the SOFI in both of the lounge areas downstairs. We observed the way that staff interacted with individuals over a five and a half hour period and noted how people seemed to be feeling. We found that five staff demonstrated little understanding of how to communicate positively with people who have dementia. Staff spoke over people's heads. They spoke loudly to other staff about people using the service, whilst they were present in the room. This showed a lack of respect for people's dignity and objectified people inappropriately. Staff demonstrated a serious lack of concern for people's dignity and used negative language to chide the behaviour of some residents. Overall during our observations we noted that there was very little positive interaction between staff and residents. We saw that four people received basic communication during the five and a half hour period. These four people were given a drink and some food, but this was not accompanied by any social interaction or eye contact. Staff did not ensure that they were at the same physical level as people receiving support. They stood over them which was disrespectful. This meant that the service was failing to treat people with consideration and dignity.

People were often not supported in promoting their independence. We observed that four people using the service had lap belts in place whilst they were sitting in chairs. We reviewed the care plans for two of these people and saw that there was a lack of risk assessment and informed consent in place to implicate the need for lap belt constraint at all times. The use of the lap belts had not been reviewed to ensure that their use continued to be necessary. We asked two staff members about one person's mobility and they told

us that the person was able to stand and walk short distances if assisted by two staff members. They told us that staff were not able to assist this person to walk due to time constraints. The service was therefore failing to promote this person's independence and autonomy.

People were often not supported to express their views and were often not involved in making decisions about their daily activities and care. Staff offered people using the service little and, in most cases, no choice around food and daily activities. People with dementia were not shown the meal options available so that they could choose the one they preferred. People were not asked whether they would like to listen to the radio which was switched on and off by staff without consultation. We observed as staff moved people between rooms, staff did not request permission to move people in their chairs to different locations. The staff offered the people they moved no explanation or reassurance about what was happening. On four occasions we saw staff approach someone sitting in a chair and push them to a different location without any communication or eye contact. This meant that the service was failing to ensure that people were enabled to make decisions relating to their care. Staff failed to promote people's autonomy and dignity.

Over lunchtime we observed as staff assisted people with their nutritional needs. Whilst care was taken to ensure that people ate as large a portion as they could manage, we observed that three staff members were supporting people in a hurried and impersonal way. Two staff members referred to people who required more assistance during lunch as "Feeds." The staff were observed shouting this information over people's heads as they asked other staff members how many, "Feeds" they had to complete. This meant that people were not treated respectfully as individuals. We saw that staff members supported people by placing the food on their cutlery and holding it up to their mouths. However, the mouthfuls were offered at a pace too fast for the person. We saw that assistance for people who needed support whilst drinking was also very hurried and we noted that two people choked momentarily as a result of hasty mouthfuls of juice. This meant that the service was failing to treat people with dignity, consideration and respect when supporting them with food and hydration.

Consent to care and treatment ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements.

We have judged that this has a moderate 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

Where people did not have the capacity to consent, the provider had not always acted in accordance with legal requirements. We observed that lap belts were in use for four service users and that these prevented people from leaving their chairs when they wished to. We examined the care plans for two people to see why this form of restraint had been adopted. We noted that mental capacity assessments were in place for both people which recorded the need for advocates to give consent for certain decisions. One person's care plan stated that the lap belt had been in use for over eight months. There was no comprehensive and explicit lap belt risk assessment in place to justify why the use of a lap belt was unavoidable. The falls risk assessment for this person was based on inaccurate information. There had been no review of the use of the lap belt since its introduction. Verbal consent had been recorded as given by the next of kin by telephone. Staff confirmed that the relative frequently visited the service, but that they had not sought the written consent of this advocate. There was therefore a risk that a deprivation of liberty had been put into place without the required underpinning risk assessments, approval from the Local Authority and without the formal consent of an advocate and without the prospect of future review. This meant that the provider had not acted in accordance with legal requirements.

A second person's care plan contained a form of consent (with a note recording verbal consent by telephone from the person's next of kin) for the use of the lap belt, but failed to provide a risk assessment as to why this was necessary. There had been no review of the ongoing need for this form of restraint. Two staff members told us that this person was able to stand and walk short distances, but that care staff did not have time to assist the person to maintain their mobility in this way. By failing to properly justify the need for lap belt restraint, by failing to review the ongoing need for this restraint and by failing to provide people with the opportunity to mobilise with assistance, the provider is failing to act in accordance with the person's best interests. The provider had not acted in accordance with legal requirements.

Covert medication was in place for some people using the service. This meant that people

were given medication that was prescribed but it was hidden in food or drink to encourage the person to take the required medication. We looked at the consent process for two people whose care plans stated that medication was given covertly. Consent forms had not been signed by either an advocate or a GP. The covert administration is a form of liberty derivation and should be undertake in accordance with legal requirements. This meant that where people did not have the capacity to consent, the provider had not always acted in accordance with legal requirements.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There was a risk that people did not always experience care, treatment and support that met their needs and protected their rights.

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

Care and treatment was mostly planned and delivered in a way that was intended to ensure people's safety and welfare. However we found concerns about the way in which care was managed for some people with diabetes. We noted that, for two people, care plans contained little information around their diabetes management. We discussed the management of one person's diabetes with the nurse on duty as we had seen that their blood sugar levels were unstable which could have affected their health or wellbeing. The nurse told us that the person was under the care of the community diabetic nurse and that they had instructed staff that action was only necessary if the person's blood sugar reading exceeded 20 mmols. However there was no evidence of this on the person's care plan. We noted that this person's blood sugar reading had recently reached 21 mmols and that no action had been taken. We found that another person with diabetes had been admitted to hospital following collapse. We examined the blood sugar readings for this person in the 12 days previous to their collapse. We found that their reading had steadily risen from 4.4 to 13.5 mmols. There was a risk that this person's diabetes had been poorly managed. We spoke to the nurse caring for these two people and they told us that they had not received any training around diabetes since they qualified as a nurse. There was therefore a risk that people with diabetes who had a dangerous episode of high blood sugar may not be treated appropriately. This also meant that diabetic people's specific care needs were not being met appropriately.

We found that care and treatment was not always planned and delivered in line with people's individual care plan. We looked at eight people's care plans and saw that assessments had been undertaken for risks commonly associated with people residing in a nursing home. We noted that four people had been assessed as being at very high risk of developing a pressure sore. However we checked and saw that none of these four people were seated on a pressure relieving cushion. We noted that all four people were immobile and sat for long periods of time in the same chair without being assisted to reposition. This demonstrated that even though people's skin integrity had been identified as 'high risk', staff were failing to provide the care or equipment to minimize the risk. This meant that people were at risk of harm to their health, safety and welfare due to poor care

planning and implementation.

We examined the care records for a person who staff had indicated had a wound. Their wound had been recorded as 'a wound of undetermined cause.' The practising professional (nurse) who accompanied us on this inspection sought permission from this person who allowed them to look at their wound. Our practising professional noted that the wound was a healing grade three pressure ulcer and that the likely cause was the uncushioned arms on the chair they sat in for extended periods. The service had not ascertained the cause of the wound or taken appropriate action to reduce the risk of further damage. This person's pressure ulcer had therefore been incorrectly recorded. This meant that the person's safety and welfare had not been ensured in relation to their skin integrity.
We spoke to the nurse caring for this person about their training in tissue viability and they told us that they had not received training on this subject for 11 years. They told us that, due to time restraint, they relied heavily on health care assistants to report any issues around skin integrity. However we found that healthcare assistants had also not received training around tissue viability and were therefore unable to report first signs of skin damage until the problem developed into a gradable wound. This meant that people were at risk of harm to their health, safety and welfare due to lack of awareness of staff about some aspects of care.

During our observations throughout the day we noted that some people were exhibiting signs of distress. Where people exhibited these signs, staff did very little, in most cases that we observed, to reassure people. One person cried for two minutes and asked, "Please can someone help me?" No staff responded to this person, even though their care plan stated that the person, 'has emotional and psychological needs, and can be anxious resulting from disorientation and needs frequent reassurance from staff to feel settled.' This meant that the service was not ensuring the wellbeing of this person.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were not always protected from unsafe or unsuitable equipment.

We have judged that this has a moderate 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 always protected from unsafe or unsuitable equipment. We noted that two people using the service required seating assessments as their feet were unsupported whilst sitting. We also observed that there were two broken tables in use in the downstairs dining room which posed a skin tear risk, particularly where people were living with dementia. During the five and half hours that we spent with people, we observed that five people fell asleep and that the service did not provide cushions to support people to achieve a comfortable position during their nap. This meant that people were at risk to their health, safety and welfare because equipment was not used or was unsafe.

We saw that some equipment had not been maintained appropriately. We noted that there were nine hoist slings available downstairs and we saw that four of these did not bear the date of the next safety review on them. There was no evidence to show that the scales used to weigh people had been calibrated since 2003. Furthermore the service possessed one set of scales to be used for up to a maximum of 65 people. There was therefore a risk that people's weights might not be recorded accurately or promptly. This meant that people were at risk to their health, safety and welfare as some equipment had not been approved as safe to use.

It was a warm day on 23 April 2013 and we noted that radiators were on, such that it became uncomfortably warm within the building. The manager explained there were issues with the heating system which required an engineer to reflush the system before it could be switched off. However this did not enable the service to maintain a comfortable temperature for people living there. We also noted that radiator tops were not covered and so posed a risk of burns as people could easily sit on them.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

There was a risk that people were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

We have judged that this has a moderate 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's personal records including medical records were not always accurate and fit for purpose. We found some instances where the service had failed to record details in people's care plans in a complete and accurate way. For example the outcome of a swab test had not been recorded in one person's care plan. The nurse on duty confirmed that a telephone result had been obtained and that no further action had been necessary. However, there was a risk that other staff would not have known this and would not have known whether further treatment was required.

We found that some information contained within care plans was inconsistent. For example one person's mental capacity assessment stated that food and fluid charts should be in place, but staff told us that only food charts were required. This meant that there was a risk that either both charts should have been in place or that the mental capacity assessment was incorrect. We also noted that the one person's care plan noted the requirements for PRN medication (to be taken if and when necessary). However this did not tally with the information on that person's MAR (medication administration record) chart. We also found that someone's wound treatment chart was out of date and reflected an old wound dressing regime which was no longer in place. The falls risk assessment for one person was based on incorrect information as it stated that they had fallen within the last three months. Falls records and staff confirmed that this was not the case. This had serious implications in terms of this person's liberty. Their advocate had consented to the use of a lap belt for their relative which was linked to an incorrect falls risk assessment. There was a risk that inconsistencies in documentation could lead to inappropriate care from unfamiliar staff.

We asked kitchen staff about the dietary requirements of people using the service. They did not know who was diabetic or vegetarian and they told us that there was no list in the kitchen. This lack of recorded information meant that there was a risk that people could be given foods that did not meet their dietary requirements or preferences.

We noted that, for two people, care plans contained sparse information around diabetes management. For one person who had diabetes, there was no specific dietary information or food preferences beyond 'tea and juice' on their care plan. This incomplete recording meant that we could not be assured that people with diabetes were provided with a diet appropriate to their needs.

Staff records were not always complete and fit for purpose. We requested that the training records be provided to us as part of the evidence required for inspection. The provider was only able to provide part of the information required and this did not constitute a complete and accurate record of the training undertaken by all staff employed by the service. There was therefore a risk that staff had not been provided with comprehensive and relevant training to meet the needs of people living in the service.

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
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements. Regulation 18.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: There was a risk that people did not always experience care, treatment and support that met their needs and protected their rights. Regulation 9 (b) (i) (ii) and (iii).
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: People were not always protected from unsafe or unsuitable equipment. Regulation 16 (1) (a) (3)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: There was a risk that people were not always protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. Regulation 20 (1) (a) (b).

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 28 May 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 10 May 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services** **How the regulation was not being met:** Regulation 17 (1) (a), (b), (2) (a) (g)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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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