Inspection Report

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

RNIB Wavertree House

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Tel: 01273262200

Date of Inspection: 05 November 2013

Date of Publication: December 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✗ Action needed
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Royal National Institute of Blind People
Overview of the service	RNIB Wavertree House provides residential and personal care for up to 44 older people. The home is specifically designed to cater for the needs of people with varying degrees of visual impairment, other disabilities and the associated problems of old age. There are particular adjustments in place in the home to meet the needs of people with a visual impairment.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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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 5 November 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 and talked with staff.

What people told us and what we found

As a Royal National Institute for Blind People (RNIB) home, staff and people who used the service had the support of and access to the skills and expertise of the organisation.There were specially trained staff experienced in supporting people with sight problems and/or hearing loss. The home had been designed to support people who had been blind or partially sighted for many years, or had only begun to experience difficulties with their sight as people had got older. Equipment was available in the home to enable people to reference information in a format to meet their individual care needs.

There were 28 people who used the service at the time of our inspection. We looked at supporting care documentation and staff documentation. There was not a registered manager for the service. We spoke with the manager, the deputy manager, two senior care workers, three care workers, an activities co-ordinator, seven people who used the service and a visiting relative. We observed care workers supporting people in the service.

This told us people's care needs had been assessed and reviewed, and care and treatment had been planned and delivered as detailed in their individual care plan. Comments received from people who used the service included, "You're in a community, I'm very happy here," "It's very good here. What I like is that it's quiet and peaceful," "It's good here. The treatment is co-operative here with the manager and the staff," and "Best care you can find because it's geared towards the blind."

All the people we spoke with told us they thought the service was kept clean. However, there were not effective systems in place to reduce the risk and spread of infection.

Appropriate arrangements were in place in relation to obtaining, storing, administering and recording medication. All the people we spoke with told us where their medication had been administered this had worked well.

Records and processes in place ensured staff who worked in the service had the right skills and qualifications to undertake their job. Staff had training and development

opportunities and told us they were well supported.

Systems were in place to review and monitor the quality of the care provided.

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 25 December 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

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

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

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We were told that people who used the service and their representatives were supported where possible to be involved in creating and reviewing their care and support plans.

The manager told us that care workers had been made aware of their responsibilities in relation to obtaining consent from people regarding their care and treatment. Four care workers we spoke with confirmed this. They told us that they only provided support to people who had given their consent for them to do so. They told us that if a person refused support, then they had respected their wishes, documented this within the person's daily records and referred this back to their manager. All the people who used the service we spoke with told us they had been consulted with about the care to be provided.

The manager told us that they and the deputy manager had completed training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). They told us they were aware who to contact to initiate a best interest assessment should this be required. They were able to describe to us an occasion when a best interest meeting was held to support one person with their finances. They had also identified and sought guidance on a potential DoLS assessment. This demonstrated that where people did not have the capacity to consent, staff knew how to act in accordance with legal requirements.

We looked at a sample of staff training records which detailed where care workers had received training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Four care workers we spoke with confirmed they had received training in these topics and all were able to tell us their responsibilities with regard to this legislation. Where some care workers had not yet received this training, the manager told us that there was a programme in place to ensure all the care workers received this training. Where care

workers had not yet completed this training this had been booked for the care workers to attend.

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

The manager confirmed that there were procedures in place to assess the care and support needs of any potential new people prior to their admission. This was to ensure that people's care needs could be met by the service. We spoke with one new person admitted to the service since our last inspection and their relative. They told us that a pre-admission assessment was completed prior to moving into the service. They commented "The communication was excellent" and "It's a very warm welcome."

We looked at four care and support plans which had been drawn up from the initial assessment or review which had been completed. Interactions with health care professionals had been recorded. Risk assessments completed included, a falls risk assessment, a pressure ulcer risk assessment, and a malnutrition screening assessment. Food and fluid charts were available for use where people had been identified as at risk. We looked at the records for one person who used the service, which had been fully completed. However, the provider may find it useful to note where people had moving and handling identified the risk assessment completed had not been undertaken or reviewed by a person trained to undertake moving and handling risk assessments.

Care workers spoken with told us that staff had been updating the care and support plans and that the system had been working well in the service. There was good communication in the home, with detailed handovers recorded between staff shifts, and monthly staff meetings where people's care needs had been discussed. This had ensured the staff team continued to be updated and aware of people's care needs. They had also read the daily records of care provided which had highlighted when there had been changes to people's care plans. We looked at a sample of the daily records of general care and activities, which was informative. All the care workers spoken with told us they had been given the information they had needed to provide the care required.This meant that were arrangements to ensure staff had current information on people's needs and care.

Four care workers spoken with demonstrated a good level of knowledge of the needs of the people who used the service. They told us they had the time and support they needed

to meet individual people's care needs. They demonstrated an understanding of culture and of respect for privacy, dignity and diversity. People who used the service commented, "They treat me with dignity and privacy, they are very good to people," "I'm involved in my care and I feel that I'm treated with respect," and "They always knock before entering. I feel that my privacy and dignity is respected." We observed that all the staff who worked in the service during our inspection had positive relationships with the people they supported. Care was seen to be provided in a discreet and dignified way that fully respected the needs of the people who used the service. We observed people were offered choices in relation to the care provided.

People who used the service we spoke with spoke well of the care that was provided. Comments received included, "I feel fully involved in my care and I am fully aware of my care plan," "Staff are very polite and helpful," and "I feel listened to and involved in my care." Where people had used the emergency call bell they told us they had had a good response. Comments included," They know if I press my call bell to come quickly," and "They always respond quickly when I press my call bell."

We observed that people were relaxed in the service. Some people had chosen to spend time in their room and others were in the communal areas. We noted people looked content and were engaged in a range of activities such as watching television, reading newspapers and books. There was an activities programme displayed in the service. We spoke with an activities co-ordinator who told us that as well as group activities they also went to see people individually in their rooms where people could not attend the activities. This was to ensure that all the people who used the service had an opportunity to socialise in the service. There was an activities meeting held during the afternoon of our inspection. People also had the opportunity to discuss potential activities in the residents meetings. Comments received included "The minister comes monthly which I enjoy," "A volunteer comes once a week which I thoroughly enjoy," "The activities are very good here, you can always ask for alternative activities as well," "They put on a lot of activities, but people do not always turn up," and "There are lots of activities and I'm involved in the residents meetings and what to do when we are left legacy money." This showed that there were opportunities for meaningful activity and social engagement for people who used the service.

All the care workers we spoke with told us they had received training in first aid and basic life support appropriate to their role. We looked at a sample of training records which supported this. There was an out of hours on call facility within the organisation which the care workers could ring for any support and guidance needed. This demonstrated there were arrangements in place to deal with foreseeable emergencies.

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.

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

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

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

The provider had infection control policies and procedures in place. However, these had not been reviewed to include the requirements of the Health and Social Care Act 2008 and the Department of Health's 'Code of practice on the prevention and control of infections and related guidance.' A copy of this guidance was not available to reference in the service. There was no member of staff allocated and trained to be an infection control lead in the service. An infection control audit for the service to identify any risks had not been completed.

The cleaning of the building was undertaken seven days a week by two domestic assistants employed by the provider. A further vacancy for a domestic assistant was being covered by an agency staff member. A cleaning schedule was in place with records of when areas in the service had been cleaned and by whom. This was to ensure that appropriate standards of cleanliness and hygiene were maintained in relation to the general premises.
However, there was not a formal documented process in place to monitor the standard of cleanliness in the service.

The service had a separate laundry area with a washing machine equipped to wash any dirty laundry that met current requirements. Care workers told us dissolvable bags were available to be used for the safe handling of soiled laundry.

All the care workers we spoke with told us they had received infection control training and hand washing guidance. However, the staff training records we looked at did not record that all the care workers had completed this training or received refresher training. The training records for the two domestic assistants recorded they had both received infection control training and Control of Substances Hazardous to Health (COSHH) training. However, refresher training to ensure they were aware of current requirements and guidance had not been provided.

We saw there were areas identified in the service for the safe storage of cleaning equipment and products. We saw cleaning mops and clothes were colour coded to ensure they were used in the appropriate areas of the building. All the staff told us they had good access to disposable, gloves aprons and when these would be used. People who used the service told us "They always put gloves on when putting my cream on," "They always wear gloves when supporting me to wash," and "Very good at washing their hands."

The manager told us the service had a contract with a local firm for the disposal of waste. We saw documentary evidence of this to view during the inspection. Bins used for discarding sharp instruments, such as needles were available if required. All clinical waste was in a bin in an area at the rear of the building. The bin was not locked to ensure the safe storage of any clinical waste. The manager rectified this during the inspection.

We saw hand sanitisers was located in the reception area and around the service. The care workers told us of procedures were in place where people who used the service had an infection. All the people had a single bedroom for their use. This had helped to reduce the risk of cross-infection with other people who used the service. This meant the provider had made people aware of systems to minimise any spread of infection.

We spoke with seven people who used the service. All feedback confirmed that the service was clean and that staff had washed their hands at regular intervals. Comments received included "I have got a very good cleaner," and " I make my own bed and the cleaner hovers the floor and my daughter dusts."

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Medicines were handled appropriately.

Policies and procedures were in place in relation to obtaining, storing, administering handling and recording medicines. However, the provider may find it useful to note that this detailed the last review of the policies and procedures was in April 2012. One senior care worker had been given the lead for co-ordination of medication administration in the service. The seven people who used the service and relative we spoke with told us that they were satisfied with the way their or their relative's medicines had been handled. They told us that they were administered to them as prescribed. Comments received included, "They come round every morning at 6.00am to give my medication and a cup of tea, when I moved in, they agreed this time with me, I like it as I always have my medication on time," "I get my medication on time. It's spaced out appropriately as the prescription says," and "I always get my medication on time."

The senior care worker told us that the medicines received had been checked against records of medication ordered. Records had been maintained of any medicines that had been disposed of. Body maps were used to identify where any creams should be applied. The provider may find it useful to note that where people had medication administered as and when required (PRN), that there was no guidance in place for staff to reference. This was as to when this medication should be administered and for how long before seeking further guidance from a General Practitioner (GP).

We noted that all medicines were stored securely. Lockable facilities were available in people's rooms for the storage of medication. We looked at a sample of the records of administration of medication, which had been maintained and these were accurate and legible. The senior care worker told us that the medication administration and recording was checked at the end of each shift. We looked at a sample of the recording of these checks which confirmed this. Additionally a monthly audit of the medication had been completed as part of the monthly ordering of new medication. Medications and creams were checked to ensure these remained in date and could still be applied.

The care workers spoken with told us that only care workers who had received medication training administered medication in the home. The four care workers we spoke with told

us they administered medication in the service and had completed medication training. We looked a sample of the staff training records which confirmed this.

We looked at four care plans which had been drawn up from an initial assessment or review which had been completed. These detailed where people had been supported with their medication. Where people were self-administering their medication, procedures were demonstrated to be in place to support people to manage their own medication through a risk management process.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate professional development.

We spoke with one new care worker who had commenced working in the service since our last inspection. They told us that they had completed an induction and had undertaken mandatory training. They had started to work in the service after a period of shadowing an experienced member of staff in the service first.

The manager had undertaken the Registered Managers Award and a National Vocational Qualification (NVQ) Level 4 in Health and Social Care. The deputy manager had completed an NVQ Level 4 in Health and Social Care. Of the 11 care workers who worked in the service 94% had undertaken NVQ Level 2 or 3 in Care.

Four care staff spoken with told us that they had undertaken or were due to complete the organisation's mandatory training, which included, moving and handling, medication administration, health and safety/first aid awareness, safeguarding vulnerable adults, infection control /basic food hygiene, Mental capacity Act 2005, Deprivation of Liberty (DoLS),equality and diversity and fire training. They told us that there was good access to mandatory training and they would be alerted to when they needed to update any of their training. This demonstrated a formalised and individual approach to staff development. However the provider may find it useful to note that not all the care workers had received refresher training.

The manager told us staff annual appraisals were late in being completed. They were due to complete further training in the completion of annual appraisals. The organisation had made changes to the process to be followed and after the training all of the staff's annual appraisals had to be completed by the end of March 2014. Three care staff spoken with told us they had received supervision which was recorded and had an appraisal completed. Four care workers had been able to attend regular staff meetings. We looked at the minutes of the last team meeting, which detailed care workers had been able to discuss people's care needs and been updated on the services policies and procedures. Care workers told us that they had felt well supported. One commented, "The training is very good here."

We spoke with seven people who used the service. They told us that they believed that all staff understood their care needs the in roles that they undertook, had been pleasant and acted professionally.

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

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

People had care and support documentation in place which identified their care needs and which included their or their representative's involvement where ever possible. All the care workers we spoke with told us this information was regularly updated and reviewed.

Recording systems were in place to detail any incidents and accidents which had occurred. We viewed a sample of these records. Incidents and accidents were reported to the provider's quality assurance team who monitored these and provided support and guidance to the manager of the service.

We looked at the complaints log, which had a record of one concern which had been raised since the last inspection. The manager told us any complaints received had been used to inform the service of the care provided and any adjustments required. For example concerns raised about the food provided had led to changes in the menu provided. One of the people who used the service we spoke with had raised a concern. They told us they had been happy with how their concerns had been dealt with. All the people we spoke with told us they felt they could raise any concerns and they would be listened to. One person commented, "If I had any concerns or complaints I would go to the manager."

Regular residents meetings had been held. We looked at a sample of the minutes which recorded people had been able to influence the care provided. For example there had been regular discussions about potential activities and outings for people to attend. The last quality assurance surveys had been sent out in 2011. The manager told us that a new survey had just been sent out to ensure that further feedback was gathered from people who used the service.

Care workers had received supervision and had an annual appraisal of their work which had been used to identify any training needs that they had. There were regular team meetings where the care provided, practice issues and incidents accidents or complaints received had been discussed. For those who had not been able to attend the meeting

there were minutes for them to read. This demonstrated the provider had ensured that there were regular opportunities for feedback on the quality of the care provided.

The service had received regular monthly quality assurance visits from a representative of the provider. They had looked at how the service had met the essential standards of quality and safety. This detailed what providers should do to comply with the Health and Social Care Act 2008. Where any issues had been identified the manager had an action plan to follow to address these. An internal financial audit had also been completed in 2013.

The manager had received regular supervision with their manager. They had completed a monthly quality assurance review which was sent to the provider to inform them of the service's activities. The information provided related to the care provided, trips/slips and falls, staffing levels, medication, incident and accidents, and complaints. We looked at a copy of the last review completed. This demonstrated that the provider was regularly made aware of the issues which had affected the running of 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 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) (a) (b) (c) Paragraph (2) (a) (c). The registered person had not ensured effective systems were in place to assess the risk of and to prevent, detect and control the spread of a health care associated infection. Or the maintenance of appropriate standards of cleanliness and hygiene.

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 25 December 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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