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 Inspections: 09 October 2013
07 October 2013

Date of Publication: November 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✓ Met this standard
Safety, availability and suitability of equipment	✓ Met this standard
Supporting workers	✗ 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

We carried out this inspection to check whether North Court Care Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Management of medicines
- Safety, availability and suitability of equipment
- Supporting workers
- Records

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 7 October 2013 and 9 October 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other authorities. We talked with other authorities and 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

People told us that they had a good experience of care which was delivered with compassion. One person told us, "The food is spot on. I like their shepherd's pie. All the carers are lovely". We observed care and support given to people and found it respected their dignity and human rights.

The service had a temporary manager in place that was working to ensure systems in place were safe and effective. However, we found that improvements were needed in the management of diabetes and wound care. We found that trained nurses needed to be more aware of current practices.

Records in place did not support the service effectively. We found records cumbersome, repetitive and key issues such as diagnosis and reason for using the service hidden in the mass of recording.

We found that the service had appropriate arrangements in place for obtaining consent to care. We saw that people had been consulted in the consent to their care. Where appropriate the service had assessments in place for people in accordance with the

Mental Capacity Act 2005.

There was enough equipment to promote the independence and comfort of people who use the service. We found that medication was generally well managed and people received medicine that was prescribed for them. There had been improvements in the provision of equipment, especially relating to pressure relieving equipment.

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

What we have told the provider to do

We have asked the provider to send us a report by 16 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

Respecting and involving people who use services ✓ Met this standard

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 meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

We spoke with seven people who used this service. One person said, "I have a bath every Thursday. Every other morning the staff pop me on the commode and give me a good wash. I prefer the older carers they seem to know what they are doing more. I had a man help me and I did not like that. I spoke with them and they have changed that – so now I always have women help me. They are all quite nice to me". Another person told us, "I have always liked it here. The staff treat me very well". This meant that people expressed their views and were involved in making decisions about their care and treatment.

We observed the lunchtime meal support in different parts of the service on three occasions during this visit. We observed good interactions between staff and people who needed support to eat their meal. Staff talked directly to people and maintained eye contact. They used people's names and encouraged people to eat by describing what the meal was. Staff offered choices of drinks and offered second helpings when people had completed what they had on their plates. Staff stayed with people until they finished their meal even though distractions were around them. During the mealtime we observed staff chatting about life in a local village and followed the lead of one person who was singing a well-known song. This meant that staff treated people with respect when supporting them with food and hydration.

We observed one person being supported to walk around the service. They were led to a chair and asked if they wanted to be seated to have their lunch. Staff used a lap belt to keep this person safe and explained that they could have another walk after their meal. We observed another person whilst they had their blood sugar levels tested. The nurse clearly explained to them what was happening, and obtained a blood sample without causing distress to the person. This meant that staff promoted people's autonomy and dignity.

We observed several visitors over the two days we were inspecting. The activities person

also took two people out to Abbey Gardens on the second day of our visit. We saw two people access the community independently. We saw several people join in bingo on the first afternoon and decorate cup-cakes on the second afternoon. One person was not well enough to join the group in the lounge and therefore the activity was taken to them in their room. This meant that people were supported in promoting their independence and community involvement.

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

We examined eight care plans for people who used the service. We saw that care plans required the consent of people in a variety of ways. This included the use of photographs, bed rails, agreeing to flu vaccinations and agreements on advanced care plans. This demonstrated that people expressed their views and were involved in making decisions about their care and treatment.

Care plans had various examples of matters relating to consent. For example one care plan contained information about consent to hoisting and another contained consent to support with personal care. We also saw care plans in place for advanced decision making about end of life care, which involved people and their families. We examined the consent policy which covered matters of consent to various situations and how consent was obtained. The policy provided a guide to staff on talking with people about their expressed wishes. The policy also referred to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards as well as advanced decision making.

We were able to see evidence in care plans that people had been identified as either having capacity or not having capacity. Where a person does not have capacity it was identified what additional support would be needed to make decisions regarding the provision of care. This demonstrated that the service was aware of legal duties and had addressed matters relating to consent and mental capacity. The provider may find it useful to note that mental capacity assessments were not stored in the person's records and could not be located. This is referred to in the, 'records' section of this report.

We viewed the do not attempt resuscitation (DNAR) forms for two people who used the service. We saw that in both cases the decision not to resuscitate had been discussed with the person receiving care, their family, the care staff and the GP. In both cases the form detailed the discussions and decisions made in the best interest of the person. The form was signed by the GP authorising the decision. . This meant that before people received any resuscitation care or treatment they, and their families, were asked for their consent and the provider acted in accordance with their wishes.

During the inspection we saw that some people had gates across their bedroom doors. These were of similar style to child gates. We also saw that people had lap belts in situ whilst sat in armchairs. We found on review of these people's care plans that paperwork was in place to support and authorise their use in accordance with the Mental Capacity Act 2005. The provider may find it useful to note that alternative types of support to people for security reasons and for those at risk of falls could be considered. This could enable their wellbeing.

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.

Care and treatment was planned but not always delivered in a way that ensured people's safety and welfare.

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

This inspection was to follow up on the minor compliance action we set at our inspection of 23 April 2013. At that time we reported concerns around the management of diabetes care and the management and prevention of pressure sores. We received an action plan from the provider that stated that the service was complaint and meeting this outcome. In addition we were notified of a safeguarding concern that related to a person being admitted to hospital who had diabetes and a pressure ulcer. Therefore this follow up inspection focussed on these matters. We looked at the care and welfare of all people currently using the service who had similar care and welfare needs relating to diabetes and wound care. Generally we found that both diabetes care and wound management was acceptable, but that matters could be improved to ensure people received appropriate care and treatment.

We examined eight care plans. We found that people with diabetes had care plans in place. These were individualised and set out the range that was acceptable for people's blood sugar levels. Plans also set out the signs and symptoms of high and low blood sugar levels. What was not always clear was what action to take in relation to seeking other medical advice or what to administer to bring blood sugar levels back into normal range for that individual. One care plan was quite confusing as it spoke about several matters at once and would have been better communicated in concise points. This plan also said that the nurse administered insulin by injection, but the nurse on duty said that the nurse obtained the insulin from the fridge and the person injected themselves and liked to be independent.

Care plans for diabetes also spoke of the need to have other regular health checks such as chiropody and eye screening. However, plans were so large in paper volume we were unable to track easily if appointments had been obtained, attended and, if so, what the outcomes for individuals were. Having read these plans for some hours we believe that three people were getting chiropody treatment on a regular basis. Two people were seeing a chiropodist from time to time and one person had not seen a chiropodist. In relation to people attending eye screening appointments we could not be assured that people were

attending appointments. These health appointments were needed to ensure the health and wellbeing for people with diabetes, failure to have regular checks placed people at potential risk. This meant that people's needs were assessed but that care and treatment was not planned and delivered in line with their individual care plan.

We examined the care plans of two people that had pressure ulcers. In both cases we saw that the wound was healing. However, the documentation in place to support this was not comprehensive. In both cases the quality of the photographs was poor. These were not dated nor had a disposable measure been placed by the wound to correctly measure and note progress in successive photographs. In one care plan we saw duplicate documentation recording entries twice. However what we did not see was evidence that the wound was dressed twice a week as indicated in the care plan. This meant that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We wanted to ensure that people were supported by nurses who were trained and aware of the latest guidance and research. We saw that in care plans there was information on diabetes in the form of a company policy. We were informed that three qualified nurses had attended up to date training in diabetes and two had attended training in tissue viability. At the time of our inspection none of these nurses were on duty. Therefore we could not be assured that people's care and treatment reflected relevant training and research.

When we were looking around the premises we saw that windows on the first floor were not adequately restricted to prevent people falling out. We found one window unrestricted and windows that were the older metal frame design were held by a chain that was not adequate and in some cases could be removed. We brought this to the attention of The Health and Safety Executive and managers within the organisation. On the second day of our visit the managers had placed an order for window restrictors. Even though managers took immediate action to address issues when we raised them, they had failed to identify these issues and ensure the safety of people using the service.

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

Suitable arrangements were in place in relation to obtaining and disposing of medicine. The provider may like to note that there were eight sharps boxes awaiting collection and disposal.

Two qualified nurses on duty said that they had received training in medication and that they had had their practice observed. There was a medication policy in place issued in May 2013. We examined the medication administration records and found that these were appropriately completed. There was a second recording in place for boxed medication. This was explained as a quality control check, but this was not part of the service's policy and procedures currently in place. However we found appropriate arrangements were in place in relation to the recording of medicine.

We observed a qualified nurse monitor a person blood sugar level and administer the afternoon drug round. The approach of the nurse was kind but efficient. They ensured that people's privacy and dignity was persevered when administering medication. They always sought consent from individuals and explained what they were doing. We observed that the nurse washed their hands and used protective gloves and suitable equipment when needed. This meant that prescribed medicines were given to people appropriately.

Medication was securely kept in a locked metal facility and the nurse in charge held the key. Medication that needed to be refrigerated was kept secure in a locked medical fridge and the temperature was regularly monitored. This demonstrated that medicines were kept safely.

We found that there were individual guidelines in place for as and when medication and medication that may change such as Warfarin and pain killers. This showed that medicines were safely administered. However, the provider may wish to note that in two cases we were told by a nurse that they anticipated a person's need in respect of needing pain relief when they may have lacked capacity. The nurse explained that as well as asking the person, they observed the person, taking account of their facial expression, verbal expression and how 'fidgety' they appeared. What we did not see in place was a pain score assessment for people who lacked capacity to enable staff to assess more formally.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

At our inspection on 23 April 2013 we found that people were not always protected from unsafe or unsuitable equipment. We found that suitable pressure relieving equipment was not available. Weighing scales and moving and handling equipment had not been appropriately maintained.

During this inspection we found that the provider had purchased new equipment to support people identified as at risk of pressure ulcer development. We saw that chairs, mattresses, air boots and cushions had all been replenished and were readily available and maintained appropriately. This meant that there was enough equipment to promote the independence and comfort of people who use the service.

We viewed the moving and handling equipment available for use. We found that the hoist and slings had been serviced since our last inspection and were assessed as safe to use. We saw that slings had been replaced and were in good working condition. We spoke with a staff member who told us that they check the slings for damage each day and report any concerns to the manager. This meant that people were supported by equipment that was safe to use.

During our inspection in April the radiators were on during a warm day, and the exposed metal on the radiator pipework presented a risk of burns to the people using the service. During this inspection we found that the service had continued with the extensive refurbishment plan which included upgrading the heating system. We found the temperature in the home to be of a suitable level. We saw that exposed metal on the radiators had been covered and meant that people were protected from the risk of ham from burns.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not consistently cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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

We spoke with three qualified nurses during our inspection. The three nurses felt that the nursing team had support from each other and worked well as a team. They spoke of the regular meeting each morning between the two nurses on duty and that from time to time all nurses met and discussed their role and clinical matters within the service. We asked for the minutes of the last meeting, but these could not be located. One nurse said that she had never been asked to do anything outside of her nursing knowledge and competence. She felt that there were good nursing outcomes for people using this service in respect of pressure sores. One nurse showed us the 'staff daily update reminder'. This was a recent introduction of a mini profile of each person using the service. It stated brief key elements about people such as risk of choking, non-weight bearing, diabetic or the type of diet a person had. The nurse found this useful especially when they had not been on shift and people's needs had changed or new people had been admitted. We asked to see evidence of formal and clinical supervision of the nursing staff in the previous three months. There was evidence of one occasion when this occurred. On 15 May 2013 group supervision took place and matters such as care plans, nutrition, mental capacity and bedrail safety was discussed with nurses. This did not demonstrate that nursing staff received appropriate supervision.

We wanted to know that people were supported by nurses that had up to date clinical skills in tissue viability and diabetes care. We had been informed by the provider that staff had received training. We asked for verification about how many staff currently employed at the service had received this training. On the day of our inspection three nursing staff had attended diabetes training on 29 May 2013 and two nursing staff had attended training on tissue viability on 24 May 2013. None of these staff were on duty on the two days we inspected. Additional training dates had been set for October for nurses to attend. Therefore at this present time we cannot say that nurses had been appropriately trained with updated professional development in diabetes and tissue viability. The provider had not worked continuously to maintain and improve high standards of care by creating an environment where clinical excellence could do well.

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.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not 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

At our inspection in April 2013 we found that the records did not support the care that people required. We found that the quality of records meant that people were placed at risk of harm because the records did not accurately reflect the care people had received.

We examined eight care records within the service including care plans, risk assessments and the daily records completed by care staff. The care plans and risk assessments maintained by the service were lengthy and time consuming to complete by staff. At the end of each shift a staff member would have to document care provided under each section of care given. For example if a person had been bathed, moved, dressed, supported with eating then staff would have update each section individually. This was further evidenced by the length of time we observed staff writing in the records during our inspection. Overall we saw that the requirement of the service to complete the lengthy documents took the care staff away from their provision of care responsibility.

We found that the care plans were incredibly complex to read and had vast amounts of information in various sections. However we found that it was difficult to track people's medical conditions clearly through their records. For example in one case we were only able to establish what a person's medical history was through reading their do not attempt resuscitation (DNAR) form. This meant that the current care planning system placed people at risk because the records were not fit for purpose.

We found a lack of clinical evidence from the nurses recorded in the care plans. A majority of a person's care was recorded by care staff and much of the records did not reflect the nursing clinical needs and support provided by trained staff during the days care. This meant that we were not assured that the records clinically supported people's care provided by nursing staff.

During this inspection we found that the overall quality of records had improved in some areas but we also found a decline in other areas of the records management within the service. We were not assured that the records of care currently used by the service

accurately detailed, evidenced or supported people's care needs.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The delivery of care and treatment did not always meet peoples assessed needs or ensure their welfare and safety in respect of diabetes and pressure sores/wounds. Regulation 9 (1) (b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Nursing staff were not appropriately supported in relation to their responsibilities because they had not received appropriate training, professional development, supervision and appraisal. Regulation 23 (1) (a)

This section is primarily information for the provider

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:** Regulation 20 (1)(a) records in respect of service users were not always fit for purpose.

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

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

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