Inspection Report

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

Westgate House Care Centre

Tower Road, Ware, SG12 7LP

Tel: 01920426100

Date of Inspection: 23 April 2013

Date of Publication: June 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✔ Met this standard
Meeting nutritional needs	✔ Met this standard
Cleanliness and infection control	✖ Action needed
Management of medicines	✔ Met this standard
Records	✖ Action needed

Details about this location

Registered Provider	Westgate Healthcare Limited
Registered Manager	Mrs. Shiji Mathew
Overview of the service	Westgate Care Centre is a purpose built care home providing nursing care to elderly residents. The home has a purpose built unit for people living with Dementia. The home also provides rehabilitation care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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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 23 April 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

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 found that the home involved people in decisions about their care. However we also found that people's dignity was not always respected.

We found that care records were comprehensive and contained individual goals for people to achieve. One member of staff told us, "If any care worker comes here to work, we make sure the records are clear and up to date. That way anybody can read how to care for that person."

People we spoke with told us that the food they received was good. One relative said, "They do get a good meal here." One person who used the service said that the food was "very nice".

We found that the home had an infection control policy in place and staff had received training in how to manage and reduce the risk of infection. We saw that the home had achieved a five star food agency rating for cleanliness, meaning that people received food that had been stored, prepared and cooked in a very hygienic environment. During our inspection we also found that the home had a bad odour for the majority of our visit. People who used the service told us, "Sometimes the bedroom was cleaned but not the bathroom."

We found that staff had received appropriate training for their role and medicines were only administered by trained nurses. We saw that medicines were given to people appropriately and when they required them.

Records were comprehensive and fit for purpose, however we found that people's care records were not stored securely.

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 02 July 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 Environmental Health. We will check to make sure that action is taken to meet the essential standards.

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 ✖ Action needed

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 privacy, dignity and independence was not always respected.

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

We observed the lunch time meal and saw staff encouraging people to eat their lunch and provided support where required in a sensitive and respectful manner. We noted three people being supported to eat their meal and that the member of staff assisting each person was patient, even though the person was unable to respond.

We spoke with one person who used the service and they told us that, "The staff are very good, they are kind and patient and always seem to know exactly what I need and when." Staff demonstrated through discussion that they had a good understanding of each person's care needs and preferences and had delivered care appropriately taking account of people's choices.

We spoke with the relatives of four people during our inspection and were told that they did not feel involved in their relative's care and treatment. We asked if people felt involved in developing their relative's care plan and whether they had seen the records. One relative told us that, "The only time I have seen any documentation from the home is when I get the invoice." We asked if people felt their views and opinions were listened to. One person whose relative had recently been admitted to the home from hospital told us, "I made a complaint a few weeks ago because my relative had lost some money, but they haven't come back to tell me anything about it yet." We spoke with the manager who confirmed a complaint had been made. This had been investigated fully however the manager confirmed that they had not informed the family or the person about the outcome.

During our inspection we spoke with one person's relative who informed us they were unhappy with the manner in which this person's dignity had been maintained. They told us that this person was living with dementia and would pull at the continence pants and remove them. They told us that staff would place the person on a continence sheet but this did not preserve their dignity. We spoke with staff who confirmed that the person had been placed onto a continence sheet. Staff told us that this was due to difficulty in managing

their challenging behaviour and keeping the continence pants in place. We also confirmed with staff that as the door to the bedroom was always open, this did not protect the person's dignity and privacy. We also discovered this same person had a hearing aid which they were not allowed to wear at certain times. This was due staff fearing they were at risk of swallowing and choking on the hearing aid. Staff we spoke with confirmed that they had not allowed the person to have use of their hearing aid for a period of a few weeks. This demonstrated to us that staff had not upheld and maintained the dignity, independence, and privacy of people using the service.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

During our inspection we saw that people's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Records we looked at showed us that each person had an individual set of care records in place to identify their care needs and choices. Care records that we looked showed that an assessment of people's health and support needs was completed prior to admission to determine the level of care required. We saw care records contained comprehensive and detailed information for staff about people's individual requirements.

We looked at people's risk assessments and saw that where risk had been highlighted the majority of care plans had been developed to manage this area of risk. For example we saw comprehensive records relating to people's mobility, mental capacity, moving and handling, nutrition and personal care requirements. All risk assessments we looked at had identified a person's capability to perform each task unaided, and had clear instructions for staff about the type of support a person would require if needed. We spoke with one person who used the service and they told us, "It's lovely here, I can call on the staff day or night to help me and they do." One person's relative told us, "The staff keep us up to date with [relatives] care, I can see that they are happy here and I've never had the need to complain."

Further care records we looked at included a list of people's individual preferences and also contained a summary of the person's life and social background including friends and relatives. We saw that people were offered a varied range of activities to engage with throughout the day. We observed that people were supported to engage with individual. For example, on one floor we saw people in the lounge playing with a ball. People were celebrating a person's birthday on another floor. Bingo was being played on another and people were supported to sit in the gardens if they wished. We were told by staff that activities were varied and were influenced after resident and family meetings which were held regularly. One person told us, "Everyday there is something to do. My favourite is just listening to the old records in the lounge with my friends." Another person told us, "The staff are really good. They will stop by and ask if you want to join in. There is a good choice of things to do. I can do as much or as little as I like really."

However the provider may find it useful to note that one person's care records had not

been updated to manage areas of risk. We became aware that one risk assessment and care plan had not been developed to manage a person's care needs. Where this person demonstrated challenging behaviour which resulted in them being deprived of their hearing aid we could not find a record of how this would be managed. Staff told us that they were concerned the hearing aid may present a choking hazard, but confirmed that there had been no assessment of this. We also found that due to this behaviour the management of this person's continence needs had left them being cared for in an undignified manner. Staff we spoke with confirmed this, and also confirmed there had been no update to their risk assessment or management plan. Decisions and subsequent care provided to this person was determined by who was on duty on a particular day, and care was not provided in a manner which was planned or consistent with the person's needs.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People we spoke with told us that the food and nutrition they received was good and that they got enough to eat and drink, with snacks offered in between meals and fresh fruit available. One relative said, "They do get a good meal here." One person who used the service said that the food was "very nice".

People we spoke with said that they their food and nutritional needs were assessed when they first arrived at the home and that they spoke with a dietician. One person said that, "Staff know what I like and don't like". People at risk of low weight or poor appetite had access to a dietician and changes to diet were reflected in people's care plans. Staff we spoke with told us that food and fluid charts were completed for people at high risk and for people who had recently come into the home, so that their intake could be monitored closely. Staff said that all people who used the service were weighed each month and more regularly if they were at high risk of malnutrition. This was reflected in the care plans we looked at. This meant that staff identified whether the person who used the service was at risk of poor nutrition and dehydration when they first began to use the service and when their needs changed.

Most people we spoke with said that they had a sufficient choice of food and that they were asked what they would like to eat the day before. One person said that, "I am given sandwiches if I prefer it instead of a meal, without pickle because they know I can't eat that". One person asked for ice-cream instead of a pudding and this was provided.

Menus we looked at showed that meals were nutritionally balanced. The chef told us that where special dietary need had been identified they tried to speak with the person where possible so that they fully understood the person's dietary requirements. This meant that staff involved with food preparation produced food to help facilitate a healthy balanced diet.

We observed a lunch time meal being served for people living with dementia. We saw that people were provided with support to eat if needed. We saw that assistance was provided sensitively by staff, in a way that showed respect for the person and at a pace that was right for them. Staff encouraged people to eat and respected their wishes if they did not want to. We saw staff speaking kindly to people and with genuine warmth and concern for their wellbeing. We saw staff helping some people to eat and explained what was on each forkful of food. People were given sufficient time to finish their meal and were offered

drinks. This meant that people who used the service were supported to have adequate nutrition and hydration.

We did observe however that one member of staff called across the room to each person as their food was being served from the trolley. This meant that the environment was noisy at the start of the meal.

The provider may find it useful to note that where people ate slowly they may benefit from food being reheated. We observed that the length of time between serving the main course and the dessert course was 40 minutes and some people had started to fall asleep as a result. One person was still eating their main course 45 minutes after it was served, which could mean that the food was cold.

We looked at food and nutrition audits which were used to ensure that food that was given to people had been prepared and stored safely. These were completed monthly for each floor by the unit manager and approved by the registered manager. We observed systems in place to ensure that people got the correct food, for example, food charts and labelling and also that temperature's were recorded and that food was stored safely.

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 cared for in a clean, hygienic environment.

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

The home had an infection control policy in place which provided staff with guidance in relation to hand hygiene, blood borne infections, dealing with bodily fluids and the use of personal protective equipment. We checked training records for staff and found that most staff had received infection control training in the last year and that for new staff training had been arranged for May 2013. Three domestic staff worked each day, one on each floor.

Care staff we spoke with had received training in infection control and described the steps they would take to prevent cross infection. Domestic staff we spoke with talked knowledgeably about the way they reduced the risk of infection in their daily practices. Staff were wearing personal protective equipment such as latex gloves and aprons and their arms were bare below the elbows to reduce cross infection. We saw that equipment such as mops, buckets and clothes were colour coded to ensure they were only used to clean designated areas to reduce the risk of cross infection. Liquid soap and paper hand towels were available in bathrooms and toilets to reduce the risk of infection. We saw notices on display above sinks in the staff toilet and in a bathroom which reminded staff to wash their hands thoroughly.

We toured the premises on our arrival at the home and noticed a strong odour in the corridors and around the bathrooms. We checked a bathroom and the sluice room on the second floor and saw that clinical waste bins were almost full and that there was a strong smell coming from them. We spoke with care staff who described the systems in place for handling clinical waste. Staff said that clinical waste was placed in a white bag in the person's room and then put into a yellow bag and placed on a trolley which was taken downstairs at the end of a round. However, we observed that not all clinical waste had been removed from the floor at the end of the round on the second floor. We observed that the clinical waste bins were full when we checked them at various times of the day on all floors. This meant that effective systems were not in place to prevent, control and detect the spread of a health care associated infection.

We checked four bedrooms and their en-suite bathrooms, plus several communal

bathrooms and toilets on each floor, and a hot trolley. The overall level of cleanliness was satisfactory. However, the provider may wish to note that the level of cleanliness required improvement in some areas. In two of the toilets we checked the toilet brushes were dirty. We saw food encrusted on one table in a bedroom. Some bathrooms were used to store equipment and did not appear to be accessible to be cleaned. In the server kitchen on the second floor the surface and handles of a trolley were not clean and the floor covering next to the water drink dispenser was dirty.

We viewed daily cleaning schedules in place which detailed areas of the home that had been cleaned. These showed that all areas had been cleaned that day. However, staff we spoke with raised concerns about the number of domestic staff available on each floor. A member of staff said that it would be better to have two domestic staff per floor at least for part of the week to enable one person to do a deep clean each week. One person who used the service said that, "Sometimes the bedroom was cleaned but not the bathroom." They also told us that as far as they were aware the carpet had not been deep cleaned after a commode had been dropped on the floor.

The home's kitchen had achieved a five star award from the environmental health agency meaning that the food people ate at the home had been stored, prepared and cooked in a clean, hygienic and safe environment.

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

We saw evidence that staff had received training in medication management. We also saw that staff's competency was assessed to ensure safe medication practice. We were told by staff that only nurses administered medicines to people. This was confirmed by speaking with staff and looking at medication administration records. This demonstrated that people were cared for by staff who were supported to administer medications safely and to an appropriate standard.

We observed one member of staff giving medicines to a person who used the service. We observed that the member of staff took their time to ensure the person knew what medicines they were taking. We also saw that they spoke with the person in a caring and respectful manner, and that the medicine was given at a pace that appeared comfortable to the person. The member of staff ensured they asked permission prior to administering medicines, and we saw that they gave the medicine according to the directions in the record.

We looked at records that showed us medicines were provided by a local pharmacist. On the day of our inspection the provider was expecting an order of medicines. We saw from records we looked at that the medicines had been ordered appropriately and any medicines for return had been noted. We saw from these records that the provider had a system in place to ensure that appropriate arrangements were in place in relation for obtaining medicines.

We saw that staff at the home monitored the temperatures of the areas where medicines were stored. This included both the ambient room temperature and the temperature of fridges on each floor. We saw from records that these temperatures were recorded regularly and any issues were rectified and recorded.

Appropriate arrangements were in place in relation to the recording of medicine. Medication administration records contained photographs of the person to support clear identification. We checked the medicines and medication administration records for nine people who used the service. We further looked at the controlled drugs records for five people who used the service. Records showed no staff signature omissions and stocks we audited tallied with the relevant person's record. This showed us that people had received

their medicines as prescribed.

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 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 found that care records we looked at for people living in the home contained information and details care staff needed to be able to ascertain exactly what people's care needs were. This meant that care could be provided so as to recognise and uphold people's individuality, personal preferences and took account of their background and health requirements. Records that we looked at were comprehensive and clearly presented. However, during our inspection we found that when we asked to see a copy of a completed risk assessment for one person who used the service, this had not been completed and therefore it was not clear how staff were managing this risk. We had noted in our inspection that one person had demonstrated challenging behaviour and issues relating to their dignity had not been addressed through a risk assessment or management plan to look for alternative measures. This resulted in the person being left in a vulnerable position and their dignity not maintained.

We looked at documentation used for auditing purposes and saw that the staff carried out regular and thorough audits. For example we saw records that demonstrated frequent checks were carried out in relation to the management of medicines. These records showed that medicines were recorded when coming into the home, accurately recorded on the medicine administration record and also when medicines were returned to the pharmacy. Copies of receipts and orders were maintained and available to us, as were audits that had been conducted in relation to stock control and quality management. We were shown a folder containing the home's policies, including their complaints and infection control policy. These were reviewed regularly and through discussion, staff demonstrated an awareness of each policy and where the records were so they could access them if needed.

During our visit we noted that people's care records were stored in a nurse's station on each of the floors of the home. We observed on three separate occasions that visitors would enter the station to sign themselves in for their visit. On each of the three occasions we observed there were no staff present in the room. This meant that people's records were not stored securely and there was a risk that unauthorised people could access

them. We discussed this with the manager who told us that they had implemented the procedure of people signing in on the units recently. This was due to an incident where the staff were unable to identify a visitor to the home. The manager told us that they were aware of the issue and were looking at ways to manage visitors signing in differently in future.

We saw from records that each file where appropriate contained signed 'do not attempt to resuscitate' (DNAR) request forms. These are used in the event of a person's death, so that the person's wishes could be known and respected by staff. The DNAR form on three records we looked at had not been accurately completed. We saw these had been signed by a relative, rather than the person themselves where the person lacked capacity. We found that these had not been signed by a medical professional such as a general practitioner (GP) which would be required. It was unclear to us that the procedure for recording a DNAR decision had been followed because the authorisation of a GP had not been evidenced. However we were able to speak with a doctor on the day of inspection who confirmed that this was not usual practice and had been an oversight by them in signing the form.

When we spoke with the manager about this, they were unaware that the forms had not been accurately completed and would look to address this.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: People's privacy, dignity and independence was not respected. Regulation 17 (1) a (2) a, c(i) and (h)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not cared for in a clean, hygienic environment. Regulation 12 (2)(a)(C)(i)
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 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained or stored securely. Regulation 20 (2) (a)

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 02 July 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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