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

BMI Mount Alvernia Hospital

Harvey Road, Guildford, GU1 3LX

Tel: 01483570122

Date of Inspection: 11 November 2013

Date of Publication: January 2014

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

<table>
<thead>
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<th>Standard</th>
<th>Met this standard</th>
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</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓ Met this standard</td>
</tr>
<tr>
<td>Notification of other incidents</td>
<td>✓ Met this standard</td>
</tr>
</tbody>
</table>
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>BMI Healthcare Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Manager</td>
<td>Ms. Eileen Scrase</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>BMI Mount Alvernia Hospital is an acute independent hospital in central Guildford. It provides services to adults. A range of paramedical services such as physiotherapy and medical imaging are available on site. The provider is BMI Healthcare Limited.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Acute services with overnight beds</td>
</tr>
</tbody>
</table>
| Regulated activities        | Diagnostic and screening procedures  
Surgical procedures  
Treatment of disease, disorder or injury |
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'.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether BMI Mount Alvernia Hospital had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Assessing and monitoring the quality of service provision
- Notification of other incidents

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 11 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 staff, reviewed information given to us by the provider and were accompanied by a specialist advisor.

What people told us and what we found

All eight people we spoke with informed us that they had been asked to provide full details of their medical history prior to their admission. One person told us "Yes, I am satisfied that staff are aware of my medical history." Another person told us, "I have an issue that the anaesthetist needs to know about. The letter has been put on my file for the surgeon and the anaesthetist." One person told us that they had noticed that staff had checked that their information was in their file.

We found evidence in records and feedback from all grades of staff and senior management which suggested that robust actions had been taken to respond to the concerns about the record-keeping of medical staff. For example, the Quality and Risk month end report for September showed that action had being taken to ensure that people admitted to the hospital had been appropriately assessed based on a full medical history. One member of staff told us, "There is no issue in relation to consultant record keeping in theatre".

We also saw records which showed that the service had forwarded Notifications of incidents to the Care Quality Commission. These records corresponded with our records of notification received.

You can see our judgements on the front page of this report.
More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

| Care and welfare of people who use services | Met this standard |
| People should get safe and appropriate care that meets their needs and supports their rights |

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Our inspection of 21 & 22 May 2013 found the provider had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that is inappropriate or unsafe. Regulation 9 (1) (a) (b) (ii).

Following the inspection the provider wrote to us and told us the actions they would take to ensure all the required records would be maintained appropriately to ensure compliance was achieved.

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

We inspected the service on Monday 11th November 2013 unannounced and found that the provider had reviewed its policies and procedures to ensure each service user was protected against the risk of receiving unsafe or inappropriate care and treatment. We spoke with eight people who used the service and eleven members of staff during our inspection.

This meant we obtained a good cross section of people's opinions on the way the service managed their quality assurance measures.

Six of the people we spoke with had either had surgery or were due to have surgery. They informed us that they had all undergone a pre-admission assessment prior to being admitted into the service. All eight people we spoke with informed us that they had been asked to provide full details of their medical history prior to their admission. One person told us "Yes, I am satisfied that staff are aware of my medical history." Another person told us, "I have an issue that the anaesthetist needs to know about. The letter has been put on my file for the surgeon and the anaesthetist." One person told us that they had noticed that staff had checked that their information was in their file.
This meant the provider had reviewed their policy and guidelines on obtaining People's full medical history prior to admission and that people had observed staff checked to make sure their medical histories had been included in their records.

Four people we spoke with told us that they had been seen by their consultant and the anaesthetist prior to their surgery. People told us that the anaesthetist had reviewed their records and asked questions about their medical history. One person told us "The anaesthetist came and discussed my health prior to my operation." Comments people made about the service and the care they received included, "Very good, I cannot fault it". "Care is good". "Very good and attentive. I have no criticism". "Procedures seem solid." "The service is seven out of seven. I like this place, I have been before and the staff are friendly". "It's clean; staff are friendly on the whole. "Very satisfied." "Excellent, very personal". "Care is excellent".

This meant people had been involved in their care and that they were able to discuss their medical histories with the consultant and anaesthetist.

A senior member of staff told us that risks to patients were identified through the pre-admission process. The medical secretaries provided the hospital with a copy of the GP's or consultant's letter and that this was then reviewed by the pre-admission team. We were told that if risks were identified via this process then they were escalated to the interim director of nursing for review. We were informed of an example where risks to a person had been identified via this process and it had been decided that the risks to the person meant that it was inappropriate for them to perform surgery, so the hospital declined the booking.

This meant the provider ensured where policies and guidelines had not been followed suitable actions had been taken to protect people who used the service.

We were also informed that two weeks ago the hospital had introduced a computer based pre-admission process. We were told that as a result of this new process the medical secretaries were submitting more information about people's medical history.

This meant that the provider had taken steps to ensure people's medical histories were submitted and included in their records.

We were told by a senior member of staff that there had been an issue with surgical lists having been sent from another hospital but the information had not been received by Mount Alernia hospital. The new computer based process ensured that information sent was received in good time.

This meant the provider had made suitable improvements for obtaining surgical lists from other hospitals to ensure the care and welfare of people who used the service was upheld.

We were also told that three monthly meetings had been held to date with the medical secretaries to make it clear to them the hospital's requirements in relation to the submission of people's medical histories. The hospital had been working to engage with the medical secretaries to ensure that they understood the requirements and expectations of them.

This meant the provider had arranged opportunities for staff to learn and understand the requirements needed to obtain people's medical histories to ensure safe care is provided.
for people who used the service.

A senior member of staff told us that the pre-admission team followed up on any missing medical histories and that heads of departments intervened if the consultants were non-compliant. They told us that if the required information was not provided then consultants were advised that the World Health Organisation (WHO) checklist would not go ahead. (The WHO check list is a requirement which has to be completed before surgery can take place.)

This meant the provider had suitable provisions in place to ensure people's health, safety and welfare was protected.

We randomly selected people's care notes from three different parts of the hospital, Oncology, Theatre including recovery suite and one ward providing care to people who were in need of both surgical and medical care. We observed that people's care notes were kept in locked cupboards. We saw that people had a pre-assessment of their health care needs undertaken prior to their admission into the hospital. All three care notes included a pre-admission letter from either the person's GP or the referring consultant as necessary. Booking-in forms were also included.

This meant staff had complied with the requirements to ensure that all the information required to offer people safe and appropriate care had been included in their records.

People who required oncology care had a chemotherapy record book included, an oncology pre-assessment record completed as required. For example, tests and their results required prior to each cycle, An assessment of the person's cognitive and perceptual ability, their activity and exercise, medical history and specifically any history of deep vein thrombosis (DVT) had been recorded. Records of social activities, sleep, rest and sexuality had also been documented. We saw that all the information needed for the person's treatment including cold caps were documented with length of time, before, during and after treatment and guidance to increase timing if necessary. (cold cap is a method of preventing/reducing hair loss to people undergoing chemotherapy treatment)

This meant that people's care was tailored specifically to meet their individual care needs.

We observed that people who were cared for in the operating theatre and in the recovery suite had their care notes completed by the appropriate member of staff. We saw that people had a pre-operation questionnaire completed. There was a history of the person's past operations and current medication documented. The surgical procedure pathway was also documented. Date and time of admission, known allergies, past medical history, physiotherapy pre-operation assessment and staff names and signatures for expected care whilst in the recovery suite were all included. There was nursing assessment carried out on the day of admission and a nursing a pre-operation check list was also completed.

This meant theatre staff made sure that suitable checks had been carried out to ensure the welfare and safety of the person who used the service.

We reviewed records which showed that prior to people receiving care and treatment in theatre an assessment of the person's care needs including a pre operation check list had been undertaken.

This meant that people had their care needs assessed by staff.
We saw in the record we reviewed that before the start of surgical intervention the anaesthetist (this is the doctor who puts people to sleep) and/or the surgeon (the doctor performing the operation) confirmed with the person needing the operation what the operation is about. We saw records which demonstrated that the anaesthetist had completed the ‘anaesthetist episode’ which is compulsory for administering general anaesthetic and sedation. We saw that the operating episode had been completed with the date of the operation, the time the person went into the theatre and the time they left the theatre. We also saw that a record of the surgeon’s and his assistant's names and the name of the anaesthetist were also recorded. We observed that the batch number and expiry date of the anaesthetic used had been recorded.

This meant people's care and treatment was done in a way to ensure their safety and welfare had been protected.

Review of the theatre records showed that swabs and instruments count had been carried out pre surgery, at first peri-operative count and at final count. All three counts had been signed by two members of staff. We saw evidence which demonstrated that the scrub practitioner (the surgeon who will be performing the operation) confirmed the procedure and the registered practitioner confirmed the procedure with the team. The surgeon, anaesthetist and registered practitioner verbally discussed any key concerns and management of the person to be operated on.

This meant the planning and delivery of care and treatment was done in such a way as to meet the person's individual needs.

We observed in the recovery suite that the receiving practitioner and other recovery staff had prepared for the acceptance of the person from the operating theatre. We saw they had suitable airway equipment, Intravenous (IV) therapy, oxygen, T-bag (an appliance used in maintaining a person's airway) and IV fluids ready. We saw the person's observation chart was completed as required and additional clinical notes were in place. We saw the person's booking in form had been completed.

This meant the staff had been able to carry on the assessment of the needs of the person to ensure appropriate care was given.

On St Francis medical ward we saw from the care record we reviewed that the record contained people's medical and nursing histories. We saw that people's medical chart was kept up to date. Where people had been transferred from the local general hospital they had discharge letters within their notes. We saw that people's equality and diversity information had been obtained and documented.

This meant that people received care and support that had been tailored to meet their specific needs.
Assessing and monitoring the quality of service provision

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.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

On our inspection of 21 & 22 May 2013 we found the registered provider failed to protect service users against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered provider to regularly assess and monitor the quality of service provision in the carrying on of the regulated activity.

Regulation 10 (1) (b) (2) (b) (iii) (c) (i)

Following the inspection the provider wrote to us and told us the actions they would take to ensure all the required records would be maintained appropriately to ensure compliance was achieved.

During our inspection on 11 November 2013 we saw that the provider had ensured that appropriate systems for gathering, recording and evaluating accurate information about the quality and safety of the care, treatment and support the service provided and their outcomes had been put in place.

This meant the provider had suitable systems in place to ensure risks to people's health and welfare were managed safely.

Detailed reporting of incidents was evidenced. Reports seen showed that there was a robust system in place for staff to report issues, with actions taken to ensure the safety and well-being of people who used the service. Incident reports reviewed showed that all concerns had been or were currently being reviewed by a senior member of management staff. We were told by a senior member of staff that, "Incidents relating to specific areas of care or practice are sent to the relevant department for investigation and reporting back to senior management". Records we reviewed reflected timely reporting and review by senior management.
This meant the provider ensured incidents had been dealt with appropriately and in a timely fashion by the correct person.

We saw improvements have been made to incident reporting systems. For example the service was in the process of developing systems of governance which had a clear audit trail to support improvements in practice. Currently, actions in progress were recorded in a number of ways; including incident reports, outcome of meetings or within an audit tracker.

This meant the recording of incidents and outcomes would be easier to audit.

We saw that the last monthly audit highlighted that there remained issues in terms of the record keeping of medical staff. We were told that some consultants remained resistant to change. We were given an example of one consultant who had expressed their resistance to change and we were shown written evidence that the consultant had been invited to a meeting with a senior member of the hospital management team to address this issue. We were told that since the consultant had been invited to the meeting their record keeping had improved.

This meant the provider had systems in place to ensure staff complied with the service's policies and guidelines.

Records seen at the time of the inspection showed that the service had taken and continued to take thorough actions to ensure that consultants adhered to standards of record keeping. Actions taken were recorded in e-mails; records of meeting minutes, audits and described in feedback from senior management.

This meant the provider had systems in place to take actions when staff failed to adhere to the service's policies and guidelines.

We saw evidence in other records and feedback from senior management suggested that robust actions had been taken to respond to the concerns about the record-keeping of medical staff. For example, Quality and risk month end report for September showed that action had been taken to ensure that people admitted to the hospital had been appropriately assessed based on a full medical history.

This meant medical staff had improved their record keeping.

We saw evidence that the service had written to consultants and required that either a GP letter or clinic letter was provided. In order to ensure that this was being undertaken staff had been checking information received and appropriate action had been taken. For example an admission was cancelled because sufficient information had not been provided. The pre-assessment carried out by staff verified the person's medical history and the hospital took the decision that based on the information, the service could not carry out the procedure requested due to failure of the consultant to provide full information The incident was reported to a senior member of the management team who took appropriate action. A senior member of management staff said that they had spoken to the Consultant's secretary. However we saw no documented record of this conversation.

This meant that the provider had taken robust actions to ensure consultants provided the required information to ensure the safety and welfare of people who used the service.

We saw that spot check audits had been completed to check that pre-admission
information was being collated. A senior member of the management team told us that they had also met with secretaries who would be responsible for passing on details of clinic notes, or GP letters.

This meant the provider had systems in place to check that policies and guidelines had been followed.

We saw evidence that correspondence had been sent to all consultants in relation to completion of documentation and expectations in terms of record keeping, in particular the updating of patient records and the provision of pre-admission information. Further correspondence had been sent to consultants who had not been completing records to remind them of the good practice guidance and the expectation that this be adhered to.

This meant the provider had systems in place to ensure that accurate records of each person who used the service were maintained.

Their daily medical records audit showed if a GP referral letter or copy of consultation letter/notes was present. We were informed that the night staff had been completing these audits. There were no audits available for October 2013 at the time of the inspection visit. A senior member of staff told us that the night staff would be contacted to provide the details of audits undertaken. The provider might like to note that, it is important that information generated from audits is accessible, in particular to key members of management and staff responsible for the effective monitoring of the service. Audits seen for September e.g. 20/9/13 revealed that 9 out of 10 patient notes had no GP letter or clinic notes. Audit details for October 2013 provided to us following the inspection showed that a GP referral letter or pre-admission information in relation to people’s past history had been consistently provided as part of the pre-admission process.

This meant staff had complied with the service’s guidelines and policies in relation to obtaining a copy of the consultation’s letter or GP’s referral letter.

Staff said that record keeping had improved. Consultants were more aware of their responsibilities and were more amenable to completing records. They told us that previously staff had felt reluctant to challenge a consultant, but that they felt more empowered to do so now, as they had the support from management. They said “We have a voice now.”

This meant staff were empowered to speak out when they observed unsuitable practices.

We saw the hospital’s hand hygiene observational audit tool. The tool had been completed and audits seen showed that hand hygiene practices had improved. They had commenced a detailed yearly audit where 10 staff were audited for good hand hygiene practice. This was in progress at the time of our inspection visit.

This meant the service has acted to address concerns regarding standards of hand hygiene.

At their last medical advisory committee (MAC) meeting held on 25/9/13, the Committee recorded that there was confusion about obtaining emergency blood. A senior member of staff told us that action taken, included the displaying of information about how to obtain emergency blood in all relevant areas of the service. This advice was also sent via email to all relevant heads of department. A senior member of the management team told us they
had changed their supplier and blood was now sourced from the Royal Surrey County Hospital (RSCH).

This meant that blood was sourced locally and any misunderstanding could be immediately rectified.

The blood transfusion committee conducted an audit of chemotherapy patients in terms of discussing with patients the reasons for a transfusion. The audit revealed that none of the patients were given reasons for receiving blood transfusion. A senior member of staff told us that further action would be taken which would involve people being asked to consent to transfusions in the future so that they will be provided with information as part of the consenting process.

This meant that people who received blood transfusion would be given a reason for the transfusion.

We saw a record which demonstrated that detailed environmental audits had been carried out from the quality and risk month end report for September 2013. The record stated that all areas inspected and we saw records of actions taken and completed to address shortfalls identified.

This meant the provider had taken actions to assess and monitor the risks and to assure the health, safety and welfare of people who used the service.
Notification of other incidents  

The service must tell us about important events that affect people’s wellbeing, health and safety

Our judgement

The provider was meeting this standard.

The registered person notifies the Commission without delay of the incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.

Reasons for our judgement

Our inspection of 21 & 22 May 2013 found the provider has failed to notify the commission without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity or as a consequence of the carrying on of a regulated activity. Regulation 18 (1) (2).

The provider wrote to us and told us the actions they would take to ensure compliance. We received an action plan from the service dated 22 August 2013 which informed us they were compliant with this outcome.

Events related to people's care that might affect their health and welfare had been sent to CQC.

During our inspection on 11 November 2013 we saw records which demonstrated the service had supplied heads of departments with clear instructions regarding the circumstances within which a notification to the CQC was necessary. A senior member of staff told us that they were now aware of the incidents that were required to be notified to the CQC.

We also saw records which showed that the service had forwarded Notifications of incidents to the CQC since our last review in May 2013. These records corresponded with our records of notifications received.

This meant that people can be confident that important events that affect their welfare, health and safety had been reported to CQC so that, where needed action could be taken.
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)

<table>
<thead>
<tr>
<th><strong>(Registered) Provider</strong></th>
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<tr>
<td>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'.</td>
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<table>
<thead>
<tr>
<th>** Regulations**</th>
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<tbody>
<tr>
<td>We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.</td>
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</tbody>
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<thead>
<tr>
<th><strong>Responsive inspection</strong></th>
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<tr>
<td>This is carried out at any time in relation to identified concerns.</td>
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<tr>
<th><strong>Routine inspection</strong></th>
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<td>This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.</td>
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<table>
<thead>
<tr>
<th><strong>Themed inspection</strong></th>
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<tbody>
<tr>
<td>This is targeted to look at specific standards, sectors or types of care.</td>
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