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

Queen Alexandra Hospital

Queen Alexandra Hospital, Southwick Hill Road, Cosham, Portsmouth, PO6 3LY
Tel: 02392286000
Date of Inspection: 16 May 2013
Date of Publication: July 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

- Respecting and involving people who use services: Met this standard
- Care and welfare of people who use services: Met this standard
- Cooperating with other providers: Met this standard
- Management of medicines: Met this standard
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Maternity and midwifery services  
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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 16 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We were accompanied by a pharmacist and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

This inspection focused on the discharge process because the public had raised concerns to us. In order to assess the discharge process we spent time in the discharge lounge, on ward F4, the pharmacy and the various wards within the Medical Assessment Unit (MAU). One member of the inspection team spent the day with the hospital's lead in Discharge Liaison. This included spending time with other professional's from external organisations and attending a multidisciplinary meeting where discharges were discussed and arranged. Over the course of the day we spoke to 33 patients, five relatives/friends of patients, three doctors, twenty two nurses, eleven support workers, three pharmacists, a pharmacy technician, a ward clerk and at least nine professionals from other organisations.

We met and observed a variety of other staff such as porters and physiotherapists. On the wards and units we observed that people were spoken to in a friendly manner and their wishes were respected. The majority of people we spoke to were happy with their treatment and their plans for discharge. Records showed they were consulted on the decision making and their relatives and other professionals were also consulted if necessary. We found that the provider had robust systems for discharge and worked well with other providers to ensure safe and successful discharges took place. Sometimes those systems fell short of ensuring this for every patient in particular those admitted for short periods.

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

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 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

People expressed their views and were involved in making decisions about their discharge arrangements. The hospital had a large discharge lounge on the ground floor for patients waiting to be discharged that day. We saw that patients were brought from their ward and were looked after by a dedicated team. We looked at 28 sets of patient records during our inspection, seven of which were in the discharge lounge with the patients ready to leave. We saw that their records showed evidence of them being consulted on their treatment and their arrangements for discharge. Where necessary "Family meetings" were held and these were recorded on the patient’s file.

People’s dignity, privacy and independence were considered and respected. We saw that people were 'welcomed' into the discharge lounge, made comfortable, given a call bell and offered refreshments. Staff were polite and respectful and involved patients in discussions about their discharge.

The discharge lounge had a policy that people should be dressed when waiting there. On the day of our inspection we saw that a patient was brought from their ward in their night clothes. The staff in the discharge lounge established that this was their choice so they were supported to wait in a side room. We noted that drinks and their lunch were served to them and their records showed they were being transferred to another hospital by ambulance.

We met a patient that was due at another hospital for renal dialysis, this was unconnected to their admission. Staff in the discharge lounge were concerned that there was no support for them once they got home and the patient told our expert by experience they were concerned about cooking and shopping. Their records showed they had refused any help when it had been offered to them in the emergency department. Within half an hour a physiotherapist assessed the person and a social worker was also called.

The majority of patients were pleased with the treatment they had received and felt they had been treated with respect, empathy and dignity. The one criticism that occurred with
three of the interviewees concerned treatment in the emergency department with comments like "Staff had not been helpful on admission" and "Poor attitude of A and E staff on admission".

We met a patient on one of the wards who was being discharged that day. They were refusing to leave the ward because they wanted to go home to their own flat. The person lacked capacity to make decisions about their care and was told they needed to go to a nursing home. They were very distressed and we saw that staff handled the situation in a calm and dignified manner. The patient was being accompanied to the care home by one of the mental health team. We saw that their care plan had recorded their mental health needs and referred to a mental capacity assessment which had been carried out by a member of the older person's mental health team. There was a best interests meeting noted on their file where the decision for them to be discharged to a nursing home was recorded.

We saw signs and displays around the hospital promoting the privacy and dignity of patients to staff, patients and the public.

We heard doctors handing over information to ward staff. We noted they spoke quietly and were considerate of people's situations, for example we heard a doctor informing staff that a patient's daughter had recently died. We also heard doctors relaying information to patients' relatives in a sensitive and respectful manner. One doctor was heard telling a relative that a mental capacity assessment had been carried out on their relative and it was deemed they did not have the capacity to make a decision about where they should be discharged to. The doctor felt a care home was needed. The relative was asked for their views and feelings about this.

We observed a range of staff supporting people and with the exception of one minor incident we found that staff were kind, patient, respectful and promoted people's independence. We saw staff encouraging people to do some tasks for themselves and records showed that patients who needed certain skills to return home were supported to meet their goals. The one exception was a member of staff who was heard speaking about a patient in a way that could have been overheard by other patients.
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.

The majority of people experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. However, the provider may find it useful to note that the systems in place did not ensure that every patient had a positive experience and smooth discharge. The majority of patients were satisfied with the treatment they had received and felt their care and treatment met their identified needs. A patient who was being discharged said "I have been well looked after and I'm being discharged to a care home as there was nobody at home to look after me". It was noted that when patients felt unsure of going home alone, arrangements were made for a member of the hospital staff to accompany them.

One patient had been assessed by the community matron and deemed unsafe to go home. They had an existing package of care in place which no longer met their needs. The community matron was able to source a rehabilitation bed for the person at Petersfield Hospital.

One patient who was not satisfied had been deemed medically fit for discharge on the morning of our inspection but the discharge was delayed because the patient's wife stated she would need additional support at home. The nursing staff we spoke to were not aware of this problem. The patient was then referred to Social Services and the Community Matron who was able to put the support in place and the patient was able to be discharged later that afternoon.

We looked at 28 sets of patients' notes. The majority of these demonstrated an initial assessment and were detailed and showed evidence of patient involvement. On one ward we noted that nine out of 18 sets of notes for people who had been admitted overnight were not fully completed. We saw they were brief and the section on the front page of the document was not completed. This section included next of kin details, allergies, emergency contact details and their preferred name. The registered nurse on duty in that area informed us that on the previous evening there was only one registered nurse instead of two, due to sickness. We discussed the issue of recording important information with the Head of Emergency Nursing who confirmed that despite the ward being short staffed they would have expected the next of kin details and emergency contact details to have been documented in all of the care plans. They said they would bring this issue to the matron's
attention for urgent action.

We were told by staff that discharge planning started shortly after admission to hospital. We saw evidence of this in records we reviewed. However, in some cases for short stay patients, the plan for people's discharge was missing from the "5-day nursing plan". For example, one person's records detailed information in the medical notes section about the challenges to the person's discharge. However, there was no record of this in the "5-day nursing plan" and no clear plan in place. The person had been deemed medically fit for discharge on the day prior to their discharge, but, still had to wait for their medication to be dispensed on the day of their discharge. We spoke with the patient and a relative, who said that although the care in the hospital had been "terrific" the planning regarding discharge from the hospital had been traumatic for the relative.

Other records we looked at clearly detailed patients' journey through the hospital from admission to discharge. Their diagnosis, treatment plan, rehabilitation needs and plans discharge were recorded. We saw that patients and/or their relatives were consulted and their views recorded in the care plans.

The discharge planning process on ward F4 showed there were clear plans in place for each patient on the ward. There was a patient journey planning board with symbols that identified each stage a patient was at during their stay. Each had an estimated discharge date, which we saw was monitored daily by the trust. A specialist registrar told us they started planning discharge fairly early on in the person's stay and "flagged up" the need for social services support. They also said that communication was essential with patients and their families to ensure that they understood that although a person may be medically fit for discharge they may require packages of care to be put in place to support them prior to going home.

Our observations of care were positive and we saw some good examples of people receiving care and treatment that met their needs and enabled them to be safely discharged. For example, we observed a consultant encouraging a patient to take some responsibility for their own care and encouraging them to pay more attention to their own nutritional needs. This patient was suffering from the effects of alcoholism. The consultant informed us that that the patient would be discharged from hospital when deemed medically fit and would be followed up by the Mental Health Team, based at the hospital. The patient would also be automatically referred to the Alcohol Support team, alerted via the Alcohol screening tool. We observed other staff supporting people for example, a clinical support worker supporting a patient whilst walking from the bathroom to his bed. The support worker displayed a good rapport with this patient and spoke to him in a pleasant manner, encouraging him by informing him that "He was doing very well". We also observed a physiotherapist advising someone using a walking frame and making the necessary adjustments to suit that individual.

We felt the provider was meeting this standard because we saw information to suggest good discharge processes were in place for most people. We saw from 142,386 discharges in 2012/13 there were 62 complaints. This equates to 0.04% of total discharges.
Cooperating with other providers

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked well with other organisations and providers to plan discharge effectively.

During our visit we saw evidence of a multidisciplinary team approach to discharge planning through the provider based Integrated Discharge Bureau (IDB). This unit was managed by a senior nurse, with responsibility for the Discharge Lounge and the IDB. The Discharge Planning Team were based within the IDB and provided additional resources for ward staff to support complex discharges. This team was highly respected within the ward environment and ward staff told us they valued their expertise. The disciplines of staff involved with this team were varied including nursing, social work and therapy staff.

The ward staff told us, "Some of the discharge team come from other organisations and this helps us to understand what services are available for people outside of our hospital." We saw staff from other organisations engaging with staff on wards to facilitate discharge.

We saw that the provider worked directly with more than four other health and social care organisations, including Hampshire Social Services, Portsmouth Social Services, Southern Health NHS Foundation Trust and Solent NHS Trust. The provider also worked with voluntary organisations on site such as the Red Cross. This organisation supported people with domestic arrangements. For example, if a patient lived alone someone from the Red Cross would put on their heating and do some shopping for them prior to their discharge. Multi-agency working such as this ensured that people received efficient, safe and well coordinated care planning for complex discharges from the hospital.

We saw that people who were in receipt of community health services prior to their admission were highlighted to the discharge team early in their admission. The use of electronic records enabled staff to access information to support people with their consent. The Community services gave comprehensive information for staff on people's support needs in the community.
A lead coordinator from one of the involved organisations was identified for each patient. We were told that the patient would know who the identified lead for them would be and those patients and their families were actively involved in all planning of care. We saw that multidisciplinary meetings were held to include patients, family members, and carers. The identified lead person was responsible for coordinating care, treatment and support for the person to ensure a safe discharge from the hospital. Patients’ records that we looked at in the discharge lounge showed evidence of “Family meetings” where relatives and professionals had met to discuss the person’s plans for discharge.

A multi-agency meeting was held twice weekly to focus on a team approach to discharges. On the day of our visit we sat in on a meeting. It was attended by 14 people of different disciplines who reviewed 56 cases and 12 complex discharges were confirmed as completed on the day of our inspection. Several discharges were delayed due to the medical deterioration of the patient and they were being reassessed by clinicians. These plans would be updated at the next meeting. All patients on this list had an estimated planned date of discharge with a clear plan in place to ensure timely, well supported discharge. A multi-agency approach was clearly identified as a contributing factor to supported discharge. Several people needed access to residential care and the social care staff had arranged meetings with patients and their families, therapy staff and ward staff.

We spoke with staff from the other organisations who worked within the hospital. The staff told us that the smooth transition of care for people was greatly supported by good multi-agency working and that communications were very good.

Staff from a social care service told us, "We know that an efficient system is in place to coordinate care needs of people." Another told us, "The twice weekly meetings to coordinate complex discharges are really focused and get results."

Four different information systems supported the discharge processes. They all assured consent to share people’s information with other organisations using permission to share documentation. We saw that if people did not agree to information sharing then this was respected. For example one staff member told us that should a person not wish their organisation's information to be shared with the hospital then they would discuss this with the person. An informed decision to withhold information from other providers would be respected whilst ensuring the safety and welfare of the person.

We were told by staff that should a person need an urgent assessment or response to discharge problems then the multidisciplinary team would endeavour to work with ward teams to support the person’s safe discharge. We saw that nursing staff alerted staff within the IDB to the need for equipment to expedite a patient’s discharge and that they were able to work with the ward and Occupational Therapist to ensure this issue was resolved quickly and aid discharge. One staff member told us of their work with supporting the discharge of a very ill patient from the intensive care unit and their involvement to ensure all equipment and services were put in place to ensure that this patient received the correct care. The staff member described this work as immensely satisfying.

We saw that complex discharges were supported well and staff told us, "There is work to be done on identifying people with complex discharge needs earlier in their journey and we are working towards this."
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

Appropriate arrangements were in place in relation to obtaining medicine. The pharmacy department had a good system in place to get supplies to the various areas within the hospital that it served. There were seven satellite units which they referred to as 'pharmacy near discharge'. Pharmacy staff prepared discharge medicines from these units. We looked at an audit of this system and saw evidence that it had cut patient waiting times. Nursing staff we spoke to told us that there was good support from the pharmacy staff. Ward pharmacists spent all of their time on the wards working directly with medical and nursing staff. On the day of our visit we saw pharmacy staff on the wards undertaking a variety of activities.

Appropriate arrangements were in place in relation to the recording of medicine. We looked at treatment charts on the ward and saw that nursing staff had signed for medicines given. Doctors had written out the prescription clearly and further information was added to treatment charts by pharmacy staff to further clarify the prescription. Medicines were handled appropriately. We saw that controlled drugs were stored and managed according to the requirements of the Misuse of Drugs regulations 1973. However, the provider might find it useful to note that we saw a large bag of patient's own medicine, brought in from home, in the corner of their single side room. The bag, which had the name of a high street pharmacy on it, was in view from the corridor. The patient told us that this had been there for two days, however, nursing staff said it had been brought in the previous evening. It had not been safely stored according to the hospital's own policy. We asked for medicine error reports to be sent to us following our visit relating to the week of the visit and noted that this bag of medicines was not reported as an error. We also saw medicine for another person in an unlocked medicine cupboard by their bedside.

We saw one example of a patient's prescribed course of medicine not continued whilst in hospital. The patient and their relative were concerned and the patient's relative told us they had asked if she should bring the medicine in from home and staff had replied "No". We asked staff to explain why this had happened. There were no records of why this had happened. We later received information to indicate the medicine was discontinued by the clinician but not recorded in the notes. The patient had not been informed. The provider might find it useful to note that from the time that this patient had been told that they were
being discharged they had waited five hours for their medicines to take home. However, the medicine required was already available in their bedside medicine drawer, correctly labelled to take home.

We saw minutes of meetings that senior pharmacy staff attended which included: Patient safety working group and medication safety committee. All these evidenced the action plan for any concerns or improvements identified. We saw that pharmacy staff attended various training sessions to keep up their learning.
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.
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:

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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)

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<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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