Inspection Report

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

Queen Elizabeth Medical Centre

Edgbaston, Birmingham, B15 2TH

Tel: 01216271627

Date of Inspections: 26 July 2013
24 July 2013
23 July 2013
22 July 2013

Date of Publication:
September 2013

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

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✗ Action needed

Details about this location

Registered Provider	University Hospitals Birmingham NHS Foundation Trust
Overview of the service	The Queen Elizabeth Hospital is part of the University Hospitals Foundation Trust. The hospital provides acute services to over 640,000 patients every year. The trust is a regional centre for cancer, trauma, burns and plastics, and has the largest solid organ transplantation programme in Europe.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Management of supply of blood and blood derived products Services in slimming clinics Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

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 22 July 2013, 23 July 2013, 24 July 2013 and 26 July 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 sent to us by commissioners of services. We talked with commissioners of services, talked with other authorities, talked with local groups of people in the community or voluntary sector 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.

We were also supported by an analyst to look at information held about staff training.

What people told us and what we found

During our inspection we looked at how people were cared for at every stage of emergency treatment. We spent time in the emergency department and in the clinical decisions unit where people were often transferred to from the emergency department. We visited the planned treatment / day surgery unit. We also visited three wards for a short time (513, 514 and 516) to follow up on the care of people who had been admitted via the urgent care route. We spoke with 56 people who used the service and 48 staff.

People made positive comments about the care and treatment, one person commented that: "Staff are very informative." "I was in a lot of pain when admitted but the staff sorted that out." People spoke about staff being attentive and responsive but we did receive comments about delays experienced: "We were let down by the delay because the scan took so long [to be carried out]." We received many positive comments from people attending for day surgery: "It has been excellent." "They treat you as a person and take into account your feelings."

We followed up on concerns we raised last year in respect of surgical theatres and had evidence that action had been taken to address concerns.

We have identified some concerns about how the care provided to people is checked and monitored by senior staff on wards and units. Whilst the hospital does look into all serious issues, some routine checking to ensure people received planned care and treatment was

not evident.

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 29 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

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

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

Our judgements for each standard inspected

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.

Arrangements in place to deal with foreseeable emergencies were clear and known to senior staff and ensured that people received treatment that met their needs. The departments inspected responded to urgent admissions and emergencies.

Reasons for our judgement

During our inspection we spoke with 56 people in the departments we visited. We also spoke with relatives and carers of some of the people using the hospital services and spoke with doctors and nurses. The majority of comments we received were positive about the care and treatment people had received; comments we received included: "I was in a lot of pain when admitted but the staff has sorted that out now."

We arrived in the main emergency department at 7.30am on the first day of the inspection and spent 12 hours looking at the treatment and care people received. The department was very busy on the first day of the inspection and we were later advised that it had been the second busiest day ever in the department. We were supported on the inspection of this department by a special advisor in critical care. The advisor assisted us as we followed the care of people from the time of their admission through to receipt of urgent care. A number of people also needed to have tests and diagnostic procedures including x-rays, scans and ultrasound. People's needs were assessed and care and treatment was planned and delivered in line with their individual urgent care needs. One person commented: "Care has been really fast here, I had only been here about four or five minutes before a doctor came to see me." In respect of being informed about treatment to be provided, most people commented that they were given clear information. One person commented: "Staff have explained to me why you cannot drink fluids. They are going to see if I can swallow tomorrow and will give me a drip until then." This means that people are informed about the outcome of initial assessments or diagnoses and know of the next steps to be expected.

We visited the critical decisions unit (CDU) which is also part of the emergency unit where people are frequently admitted to from the emergency department. We followed the care of five people in detail and this involved us talking to the person, observing the way they were

cared for, reading records that had been written about their treatment and care and talking to staff about each person. We were supported on this part of the inspection by an expert by experience. This person, who has had personal experience of caring for someone who has used this type of service, assisted us by talking with other people in the unit and observing how care and treatment was provided by staff. They focussed on the experience of the people in receipt of the service. We received a number of comments from people who were in CDU and most people made positive comments about the staff and how they were treated, although some people commented on experiencing a delay waiting for diagnostic tests to be carried out. We were told that call bells were answered promptly and that nurses were usually visible and within calling distance. People made positive comments about how quickly they were monitored: "Nurses came and chatted with me as I was under constant observations, I was treated very well and I felt listened to."

We also spent some time in the department where people were admitted to receive day surgery care or treatment. In this department we were able to follow people on their pathway from the time of their early morning admission through to discharge later in the day. Some people spoke to us about their experience of having planned treatment and shared with us their views and feedback on their experience. All of the people we spoke with said that staff had explained the treatment and procedures to them and people said that they felt supported to raise questions and express concerns with staff which were answered and responded to.

We also went to three medical admission wards where some of the people had been admitted to after arrival to hospital via the emergency department. On the three wards we used general observation to inform us about how people were being cared for and we spoke with some people who were willing to share with us their views of their care. We also spoke with staff. We looked at records for some of the people and checked the care and treatment that was planned against the records of care they had received. We were on two of the wards at mealtimes and were able to see how people were supported when they needed assistance to eat their meals.

We saw that some staff on the wards who were supporting people to have their meals were skilled and encouraged people to people to eat well at a pace that suited them. However we did notice on one ward that two different people were not being appropriately supported to have their meal. When we brought this to the attention of senior staff on the ward the support provided to the two people immediately improved, as did the interactions between each member of staff and the person they were supporting. The observations indicated that some people were not always receiving the support they needed to consume adequate amounts of food and this had not been noted by senior staff.

People who needed soft or pureed food were catered for and the food was presented to be as appetising as possible to encourage people with a poor appetite. There were specific paper records available for staff to complete to indicate how much people had eaten at each meal so that they could monitor nutritional intake. We found that records were made after mealtimes by staff to record how much people had eaten. However, we did raise concerns about the accuracy of some records in respect of the amount that people had eaten. On another ward we noted that whilst people were being well supported by some staff at mealtimes with encouragement provided, the records of food consumed were not completed. This had not been noted by senior staff.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who used the service were protected from the risk of abuse because the trust had taken reasonable steps to identify abuse and prevent abuse from happening.

Reasons for our judgement

During our inspection we spoke with a number of staff in the wards and departments we visited about their role in protecting people from abuse.

All staff within the hospital have received basic training in respect of safeguarding. This level of training ensured that staff knew how to identify possible safeguarding issues and were aware of their own responsibilities in respect of protecting people and raising an alert if necessary to ensure that vulnerable people were protected. This meant that people who use the service could be confident that the staff would take action to help identify the possibility of abuse and prevent it from happening.

In addition to the basic training provided the trust had ensured that a high proportion of managers had completed a higher level of training and we were informed that this training was to be provided to the higher band nurses in the departments we inspected. We were told that training in respect of the Mental Capacity Act and Deprivation of Liberty and how the impact of the legislation needed to be considered was covered in training that was specifically related to dignity and mental health. In discussion with staff we were assured that they knew about people's right to be protected from abuse and understood their own role in respecting human rights.

We saw examples of where staff had supported people who were unsure about receiving treatment and noted that staff were very clear about people's right to decline treatment or change their mind when they had already given consent to treatment. Where staff were concerned about a person's ability to decline treatment they had access to support from mental health professionals on site to ensure people had specialist support. On occasions the support that had been provided to help people had included giving a patient advance opportunity to become familiar with medical equipment and the clinical environment prior to planned admission to alleviate their anxiety. A specific familiarisation project had been led by a member of the emergency department to support people with loss of sight and hearing who might need hospital treatment. The project had included providing opportunities for people with sensory loss to have access to some basic medical equipment that they might encounter if they were admitted to hospital. Another popular method of supporting people was used by the hospital, known as hospital passport documents. These documents assisted people who had complex communication needs

and contained information about the person's method of communication, health concerns and prescribed medications. Staff we spoke with were very clear about how they had used such information when they were treating and caring for people so that their rights were not breached and they were safeguarded.

A flow chart was available to all staff about the process to follow in respect of any safeguarding concerns that arose outside office hours and at weekends. The chart had contact numbers for social work staff and out of hours departments. We noted however that on one occasion staff did not appear to have consulted the chart as there was some confusion about fax numbers that delayed the safeguarding referral. The person responsible for taking a lead role on safeguarding within the hospital was aware of the multi-agency safeguarding procedures and staff had access to this safeguarding lead for advice and guidance.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people needs.

Appropriately skilled and specialist staff were available to meet the medical needs of people who were admitted to the emergency department.

Reasons for our judgement

We looked at the number of staff on duty in the departments and on the wards that we visited and noted that there were enough staff on duty. Staffing had been provided in line with the ratios that the trust had determined were necessary to meet the needs of people using the services

In the emergency department we noted that a consistent number of staff across all grades was available at all times including evenings, nights and weekends. The emergency department had experienced an increase in numbers of people attending for treatment and had maintained staffing levels. The numbers of staff on duty had been mainatined at a level to ensure that people did not experience overly long waiting times for medical assessment and treatment.

We saw that the staff in the emergency department were able to seek and receive support from specialists within the hospital who were needed at times to treat people with trauma who had arrived at the department. We saw that when telephone notice had been received informing the hospital that people were on their way to hospital with critical health conditions, arrangements were made very quickly for specialist support to be provided in a timely manner when people arrived. This meant that people using the services were assessed promptly to enable treatment to commence.

We observed the staff working well together to respond to medical emergencies when people arrived with critical health issues. Leadership amongst the team of doctors and nurses was apparent and every person knew what their role was and worked well together. We noted that clinical decisions made within the emergency resuscitation part of the emergency department were reviewed by a senior consultant and on two days in the emergency department we saw that this review was conducted by the Deputy Medical Director of the hospital (which we were advised was the doctor's specialism). The response of staff and availability of specialists ensured that people were treated and supported by staff with suitable qualifications, skills and experience.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for and treated by staff in the departments and wards visited who were supported to deliver care and treatment safely to an appropriate standard.

Reasons for our judgement

During the inspection we met with a number of staff who were responsible for or involved in ensuring that the training needs of staff were addressed.

We received evidence that indicated induction training for medical staff at all levels who were new to the trust was well organised and classified as mandatory. In addition to corporate induction training, specific role related induction training was provided and was tracked on a database with prompts forwarded to managers if new staff had missed any training sessions. This meant that staff new to the trust received essential training to help keep people who used the hospital services safe.

On-going and mandatory training procedures had been reviewed annually by the trust. The trust advised that they had planned to conduct a review of who needed what training, and how often, in line with the range of job roles and responsibilities to inform future training programmes. An annual training needs assessment formed part of the staff appraisal scheme and the topics and areas of practice that needed to be covered were collated for notification to the training department. Each staff member had an individual computer held record that they could access and check up on when mandatory training needed to be repeated as well as specific training needs. Each staff member's individual electronic record also provided them with access to information about their pay, appraisal dates and annual leave. In respect of support needs, the trust had identified concerns with numeracy skills of some newly qualified nurses. In addition to raising this with the local universities where they had studied, the trust had set up support for the individual staff members and issues such as this were noted on their electronic record. Staff received professional support in respect of their on-going development and staff were supported to keep up to date with their training needs profile.

Newly qualified nurses completed mandatory preceptorship training which provided them with a period of time where guidance was provided to support them to make the transition from student to nurse and to develop their practice. The trust had monitored progress through the preceptorship course and advised that at all times they could check how staff were progressing. Clinical training needs were identified by staff themselves or by their managers and arrangements had been made to ensure that the needs were addressed. This meant that people who received treatment and services could be sure that staff

training was up to date, was monitored and was appropriate for the staff member's role and responsibilities.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider had a system in place to assess and monitor the quality of service that people receive. However the system was not effective in identifying risks to the health and welfare of people who used the service when they had not led to serious incidents.

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

During our inspection we spent a great deal of time looking at the governance in the hospital and spoke with trust staff who had specific roles relating to continuous monitoring and improvement. We were supported on this part of the inspection by a specialist advisor in governance.

We followed up on an issue of concern raised last year when we inspected the surgical theatres and noted that surgical safety checklists were not being used consistently as intended. We also found in one of the theatres that there were three different operating lists in place for the same day and staff could not confirm at the time which list would be used. Since then significant improvements have been made by the trust in respect of use of the checklist. We saw evidence of how the trust had ensured that compliance with the surgical safety checklist across all theatres had been maintained and we were advised of further improvements that were being introduced to increase safety. The issue with theatre lists had been addressed and training was being rolled out to all senior members of theatre teams to make use greater use of an electronic system and remove any risk from multiple lists.

The trust operated a system of electronically monitoring aspects of care and treatment which ensured that people received comprehensive treatment in a timely manner. The system ensured that if people did not receive treatment as prescribed there was a system generated alert which prompted staff to respond quickly. An example of this was measures that were in place to prevent oversight of administration of antibiotics. If a person who had been prescribed antibiotics had not been administered them at the planned time, staff would be alerted and the alert would escalate to more senior staff if it was not responded to. This meant that the trust had identified an effective way to manage some aspects of treatment and provide a service that met people's needs and reduced risks.

In one of the units we visited we noted from records that two people were not repositioned

as often as they should have been in line with their plan to prevent pressure area sores. We were provided with an explanation of a disruptive event that had taken place on a day when the two people had not been attended to for a period of time. The lack of leadership to ensure that essential care tasks were not missed due to the impact of a disruptive event indicated that opportunities to take action to avoid deterioration in people's health were at times missed. This meant that people could not be sure that checking mechanisms had been used to identify gaps in their care or treatment needs. We also noted concerns on a ward where gaps in records indicated that people had not been supported in line with their pressure care plans. The trust may wish to note that the lack of thorough routine checking did not provide assurance that any early signs of a person's deteriorating health, if it occurred, would be noticed. We raised this issue with senior trust members at feedback and were advised of steps that would be explored to ensure that in the future better checking mechanisms of care, particularly in respect of pressure area care, would be introduced.

Whilst visiting a ward we noted that on some of the food intake records there was no evidence that poor dietary intake over consecutive days had been monitored or responded to. In addition some of the records made about how much a person had consumed were poor and would misinform any assessment of the person's appetite. This lack of reviewing of records and recording practice meant that people who had not eaten very much were at risk of health issues related to on-going poor nutritional intake. We raised this lack of checking and monitoring with senior staff on the ward at the time and they agreed that there was no evidence of checking and responding to poor dietary intake. Senior trust members at the feedback meeting advised that action had already been initiated to ensure that localised checking on wards by senior staff would improve and be addressed to ensure that people's care and treatment was comprehensive.

Staff were supported to become involved in suggesting changes and improvements and an example of this involvement was in use in the emergency department. Staff, in consultation with colleagues at an improvement group, had identified what would be useful to support them in treating people quicker and reduce treatment delays. This meant that staff had the opportunity to propose changes to benefit people's care and were responded to appropriately.

We spoke with the lead person for the management of complaints and they advised how they undertook analysis of complaints received to inform any identifiable training needs. The reflective learning from complaints was delivered via courses and seminars. This meant that where necessary changes were made on the basis of analysis of past incidents. An example of the changes made as a result of concerns was illustrated in how the trust has improved in respect of falls. There had been a number of falls sustained by vulnerable people in the hospital and, as a result of analysis of contributory factors, services provided had improved on this aspect of support and greatly reduced the number of falls, which meant that people were safer.

We noted that the system used by the trust to review serious incidents was robust. In addition to full documented investigations and action plans, the reviews of serious incidents were reported to an advisory group of the chief executive who agreed the action plan and recommendations as appropriate. Monitoring of such action plans were allocated to clinical quality groups for different divisions. This meant that people could be assured that the trust had an effective system in place to review and learn from serious indents, if a failing was identified, to prevent them from occurring again.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: Monitoring and assessing of records relating to care and treatment, which would indicate a lack of care delivery in line with plans, had not been consistently provided.

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 29 October 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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk