# Charing Cross Hospital

Fulham Palace Road, Hammersmith, London, W6 8RF

Tel: 02033113311

Date of Inspection: 22 January 2014
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We inspected the following standards as part of this inspection. This is what we found:

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<tr>
<td>Cooperating with other providers</td>
<td>✓ Met this standard</td>
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<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>✓ Met this standard</td>
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*We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.*
## Details about this location

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Summary of this inspection

Why we carried out this inspection

This inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people’s experiences of moving between care homes and hospital.

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 January 2014, 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 received feedback from people using comment cards. We reviewed information given to us by the provider and were accompanied by a specialist advisor.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

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

We visited Charing Cross Hospital on 22nd January and went to the Accident and Emergency Department (A&E), the Clinical Decision Unit (CDU) and two general medical wards, one of which was specifically for care of older people and one which had beds where the majority were designated for care of older people. We also spoke with staff on the wards and departments we visited, observed care being delivered and spoke with patients and family members. We also spoke with members of the Dementia Care Team in the Trust including the medical lead and a dementia specialist nurse. We received further information from the Trust during the inspection. We looked at treatment records for patients of which we checked six records for people who had dementia and spoke with staff who worked in discharge planning and the hospital social work team.

We looked specifically at people the care and treatment of people who were admitted to hospital and had either diagnosed dementias or identified cognitive impairments who may have been admitted to the hospital for a number of reasons. Most people we spoke with told us that they were happy with the service they received in the hospital. One person told us “they [the nursing staff] are always there for me” and another person told us “I'm looked after absolutely perfectly”. Most care we observed was delivered by nursing staff in a kind and responsive manner. We saw that family members were involved in discussions about their relatives by looking in the notes and by speaking...
with family members.

We saw that the hospital had a process to ensure that people with dementia who had different support needs were identified on admission and provided with care and treatment which met their individual needs. We tracked people’s paths through the hospital and found that this was effective. People’s assessments of needs included their medical history and social needs however there was some variation in the quality and detail of information about people’s social histories and preferences.

Most of the staff we spoke with had received a minimum of one day training specifically related to dementia care and they all spoke positively about this.

There were systems put in place by the provider on a ward and Trust-wide level to monitor the quality of dementia care provided.

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

How are the needs of patients with dementia assessed?

Staff told us that patients who are admitted to hospital in an emergency and are over 75 have a screening assessment of their cognitive state on admission. We looked at the records of patients in the areas of the hospital which we visited and saw that cognitive testing and screening using the Trust's dementia care mandatory assessment had been completed and remained accessible through the patient's stay in the hospital. This tool determined a risk of delirium or dementia which ensured that patients received care which was appropriate.

We saw on the wards, that when necessary, cognitive testing had been repeated to ensure that the patient received the care which met their needs through their stay.

The hospital had a team called the Older People's Assessment and Liaison Team (OPAL) which was a consultant-led team available 24 hours which ensured that older people's needs were specifically identified on admission. We were told that this team saw all patients who were admitted from nursing care in the community or those older people where dementia or delirium had been identified.

We saw that there was a pain measurement tool used in the hospital which formed a part of the assessment process for patients with dementia when they were admitted and as a part of their hourly checks. Staff explained to us how they identified pain in people with dementia who might not be able to verbalise their needs by measuring changes in behaviours and levels of distress or agitation. This was captured by the pain measurement tool.

We looked at nursing notes on the wards and spoke with nurses who told us that they reassessed patients regularly according to their needs. We saw that the records had been updated to include relevant additional information about people's medical and social history which meant that care was provided in a way that was specific to patient's needs.
How is the care of people with dementia planned?

The hospital used a pathway known as FAIR (Find, Assess, Investigate and Refer) which was one of their identified targets by commissioners, to ensure that patients who might have been at risk of displaying cognitive impairments on admission were provided with care, treatment and onward referral through their stay in hospital. We were told that information about a patient's previous admission is held at A&E electronically which goes back to 2005 so details about admissions would be able to inform the care and treatment planning process.

We saw that care and treatment for patients with dementia was based on the assessments which took place and included the input of a multidisciplinary team, for example, there were records of nursing and medical input as well as, when necessary, physiotherapy, social work and speech and language therapists. We saw that this was evidenced on the records that we looked at and by talking to staff who explained to us how they involved different disciplines in the care planning process for patients with dementia.

We saw that the hospital provided information leaflets about different kinds of dementia and we saw the leaflets available relating to Alzheimer's and vascular dementia which helped staff, family members and patients with dementia understand their conditions.

The Trust had a Dementia Care Team (DCT) which had dementia specialist nurses who worked across the hospital sites and provided information and consultation to staff members who needed additional support relating to dementia care and this was a way that staff identified they kept up to date with latest guidance relating to dementia, including NICE guidance. The team had developed an information portal 'microsite' where staff could access information via the intranet if they needed it.

Staff we spoke with on the wards told us that they found this team helpful and responsive. Two members of staff told us about a mobile phone application which the Trust had developed for clinical staff were able to use to understand the basic context of the application of the Mental Health Act and the Mental Capacity Act in the acute hospital setting. We checked this application and the information which it had and found that it was useful to signpost clinicians to additional support.

Are patients with dementia involved in making decisions about their care?

We asked patients if they were given information about their care and offered choices. Most people we spoke with told us that they were. We checked records to look the paths of patients with dementia through different departments or wards in the hospital. We saw through this that patients were encouraged to be involved in their care as their consent was indicated in the records and we saw some evidence in case records that where patient lacked capacity to consent to care or treatment, that best interests decisions had been made and documented on decision specific issues with the involvement of their families and healthcare professionals. However we also saw an example, in one set of case notes, that decision specific capacity assessments were not undertaken which meant that there could be a risk that decisions may have been taken without the involvement of the patient with dementia, however, we saw that family had been involved in discussions around care and treatment.

We were told by staff in the A&E department that information is held on the computer system which is used, about previous advanced decisions and directives which the hospital was aware of. This means that consideration could be given of prior wishes when
they were recorded.

We saw that the Trust had introduced the "This is me" tool which is a document filled out by a patient or someone who knows them, to share information about their likes and dislikes and their social history and background. We did not see these on the wards we visited but we were told that some people may choose not to use it, may not have completed it at the time of our visit or may not have had it with them as it is held by the patient or their family.

Staff we spoke with told us how they involved and listened to patients and their family members when they gave feedback about their care and treatment. Most patients we spoke with told us that they were able to give feedback to staff. We looked at patients' records and saw that it was indicated that patients had been consulted about their care or treatment and family members had been involved in these discussions.

Are patients with dementia provided with information about their care?

Staff told us that they provided patients with dementia with information by explaining the care which they were giving directly to patients. We observed staff caring for patients and explaining what they were doing which showed that nursing staff we saw had an understanding of the need to involve patients in their own care, even if they were not able to respond verbally to prompts. For example, we saw one member of staff explaining to a patient why they needed to use an oxygen mask. One person left a comment about their hospital stay which said "The staff were very kind and explained what they were going to do and what would happen next".

One member of staff told us that the lack of detailed information on the patient headboards in the wards had been a concern as they would like to know about patients' preferred names however on the day of our inspection, we saw that new headboards were being put up on the ward which specified each patient's preferred name, consultant and special instructions. For example, we saw one patient had information on their headboard about their preferred food and drink options.

How is care delivered to patients with dementia?

Staff in all the departments we visited told us that they had access to specific dementia training. The members of staff we spoke with who had completed this training spoke very positively about it and told us that it helped them to carry out their roles.

Most patients we spoke with were positive about the care which they received. One patient told us "they [the nursing staff] are always there for me". Another patient told us "they [the nursing staff] make me a cup of tea when I need it". One family member told us "they [the nursing staff] do their best, they are all nice to [patient]". One comment which was left for us by a family member said "All the staff and nurses and doctors have been fantastic". We observed that most of the care that was given which was delivered with kindness and patience by nursing staff. We saw that nursing staff spent time to explain and talk with patients who were more confused and they did not appear to be rushed. However we saw, at lunchtime that one member of staff was not giving their full attention to the patient who being assisted and did not explain what the food was as they were assisting.

We were told by the Dementia Care Team that some wards had activity boxes which had been produced by occupational therapists for patients with dementia. We did not see these on the specific ward that we visited. We saw there were activities rooms but these rooms
were used mainly for meetings. We saw there was an exercise group taking place during the inspection which was organised by physiotherapists.

From the care records, we saw that the wards used a checking tool called iCare which ensured that a number of checks relating to physical health needs were completed on an hourly basis. This included an assessment of pain levels.

Is the privacy and dignity of patients with dementia respected?

We saw that in A&E patients received care behind curtains which ensured that their privacy was maintained. On the wards we visited, we saw that there was a mix of side rooms and bays which were single sex. Patients who received care in the bays had curtains which could be pulled around their beds to ensure their privacy and dignity were maintained.

We saw nursing staff speaking with patients at a level which would ensure that they were not overheard by other patients in the same bay. This meant that privacy and dignity was maintained. However we also heard one doctor discuss a patient’s medical needs at a level which allowed other people to overhear.

We saw that patients appeared to be appropriately dressed and seemed to be comfortable in their environment. We asked staff how they ensured that patients were treated with dignity. They told us that they would ensure that the curtains around the bed were used when delivering personal care and that they would be aware where possible, of conversations that they had which would be at a level which could not be heard by others.
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

How does the provider work with others when providing care to patients with dementia?

On the wards, we were told that the staff have a good working relationship with the psychiatric liaison service which provides support in the hospital during the working day. This means that patients with dementia who have specific needs relating to their mental health had access to additional professional support when necessary. We were told that the liaison service at Charing Cross is 'age blind' which means that there is not a specific service for older people however we were told that there was an intention to recruit staff into this team who had specific experience of working with older people.

In A&E we saw that there was an 'ambulatory care department' where GPs could refer older people where they had concerns. Patients referred through this route were given an appointment and seen by a geriatrician, occupational therapist and/or a physiotherapist as required and if necessary they were referred on to mental health services or a memory service.

We saw that the hospital had a "Dementia Care Mandatory Assessment" tool which was used to screen patients who were in particular risk groups such as those people who were over 75 who are admitted in an emergency. These assessments were sent back to patient's GPs when they were discharged. This was a part of a target which had been set by commissioners which are called Commissioning for Quality and Innovation (CQUIN) targets which the Trust monitored.

We looked at the records of three patients in the hospital to look at referrals which had been made to other professionals and how services worked together. We saw that one patient who had had a history of involvement from a local community mental health team had had information which had been shared with the Trust and staff from the team had been involved in planning their discharge.

We asked staff about information that they received when patients were admitted from care homes. Staff told us that there they had mixed experiences. One nurse told us, for example, that one care home was very good and kept in regular contact with the hospital,
coming to visit patients who had been admitted and bringing cake in for them but they told us that there were other care homes where they received little information and sometimes found it hard to get in contact with them.

**Are patients with dementia able to obtain appropriate health and social care support?**

We spoke with a nurse in the discharge liaison team who explained that when patients need help at home or residential care when leave the hospital, they work with local authorities. They told us that all the boroughs linked with the hospital have "rapid response" teams that worked to prevent admissions and facilitated hospital discharges.

We also spoke with a member of staff who worked in the hospital social work department for Hammersmith and Fulham to ask how they work with the hospital to ensure that patients' needs are met on discharge. They told us that they had established good relations with nursing staff on the wards on the eighth floor of the hospital, where they receive most of the referrals and feel that this works well to facilitate discharges. They told us that they have access to "good step down facilities". This meant that the provider worked well with local social care providers to meet the needs of patients with dementia on their discharge.

We looked at care and treatment records and saw that patients who had dementia had received appropriate referrals in the planning of their discharge, for example, we saw that one person had a completed assessment for continuing care on their discharge which included full detailed information about their physical and mental health needs as well as their social care needs which had been completed by different professionals to ensure that it gave a holistic picture. This showed that multidisciplinary teams worked together to ensure that patients obtained appropriate health and social care support.
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.

Reasons for our judgement

How is the quality of dementia care monitored?

A dementia care team was set up in December 2012 by the Trust which has a lead executive team member. We saw that a report that had been compiled regarding the work that this team has undertaken and a review of its effectiveness. We saw that there were specific targets which are set by the Trust’s commissioners called Commissioning for Quality and Innovation (CQUIN) which related to dementia and the Trust audited its compliance with these targets regularly.

We saw that there is a specific target, for example, related to screening at least 90% of patients who are aged 75 or over and admitted as an emergency for 72 hours or more for cognitive impairment. We saw that the Trust had achieved this target in the early part of 2013 and was monitoring it monthly.

We saw that there is a dementia board which meets monthly to monitor targets and that patient stories go to the Trust board to demonstrate what the team have been doing. We saw examples of the patient stories which were produced and they provided a reflective analysis of work undertaken by the team with particular patients with dementia. This allowed clinicians to promote good practice in dementia care across the hospital.

Most of the staff we spoke with had attended training related specifically to dementia. We saw a report produced by the Trust which evidenced the roll out of this training across different professional groups for example, HCAs, junior doctors and non-clinical workers and saw that they had compiled a plan to monitor those who had received training and those who were still to receive training related to dementia. This included dementia awareness training which had been built in to the corporation induction programme.

The Trust was signed up to the National Dementia Declaration and was a member of the Dementia Action Alliance. This meant that it had published a publicly accessible action plan relating specifically to dementia care delivered and had set time frames for these action plans to be achieved. This added transparency to the monitoring of its dementia care and identification of where there may be deficits.
We spoke with another ward manager who explained to us that they had developed specific checklists and audit tools related to issues of patient care such as skin integrity which ensured that patients received safe care as this could be better monitored.

The Trust was rolling out "dementia champions" across all staff grades. These are staff members who will be able to provide additional advice and support and who met regularly to disseminate good practice and up to date information to their teams. On the ward, we were told that one of the HCAs was their dementia champion and had attended additional training.

How are the risks and benefits to patients with dementia receiving care managed?

We looked at patient's records and saw that appropriate and up to date risk assessments which related to relevant issues such as falls, nutrition and pressure care were completed and up to date.

We spoke with a matron on A&E who told us that accidents and incidents are recorded on the Trust's 'Datix' system and the information from this reporting tool was used to ensure that lessons were learnt from incidents which occurred. They gave us an example of a situation where there had been an incident related to care and this had been discussed at a team meeting to ensure that there was resulting learning which meant that systems had been changed as a result.

The ward environments were not specifically designed for patients with dementia however the Trust had identified that they had work to do in terms of the ward environments and had identified "creating dementia friendly environments" as an action from the Dementia Action Alliance action plan which they had submitted.

Are the views of patients with dementia taken into account?

On the wards, there were a variety of leaflets available which provided information to patients and their family members about their care and treatment in hospital. This included information about vascular dementia and delirium. Staff on the ward and the management team told us that they involve advocates when patients do not have family and lack the capacity to make significant decisions themselves.
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.
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:

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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)

(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.