# Inspection Report

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

# Head Quarters

Unit 3, Meadow Lane, St Ives, PE27 4LG

Tel: 01480308216

Date of Inspections: 13 December 2013
12 December 2013
11 December 2013
10 December 2013
09 December 2013

Date of Publication: February 2014

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

| | |
|---|---|
| **Cooperating with other providers** | ✓ Met this standard |
| **Staffing** | ✗ Action needed |
| **Assessing and monitoring the quality of service provision** | ✗ Action needed |

## Details about this location

| | |
|---|---|
| Registered Provider | Cambridgeshire Community Services NHS Trust |
| Overview of the service | 'Head Quarters' is the main administrative office for Cambridgeshire Community Services (NHS) Trust (the trust). It is also the location registered with the Care Quality Commission from which it organises its local community nursing teams. These are teams of district nurses, staff nurses and health care assistants. These staff deliver the trust's community nursing service in the Luton, Cambridgeshire and Peterborough areas to patients living at home and in other residential settings. The community nursing service delivered in the Cambridgeshire and Peterborough area is the subject of this inspection. |
| Type of services | Community healthcare service<br>Dental service<br>Rehabilitation services |
| Regulated activities | Diagnostic and screening procedures<br>Family planning<br>Personal care<br>Surgical procedures<br>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 announced 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 9 December 2013, 10 December 2013, 11 December 2013, 12 December 2013 and 13 December 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 received feedback from people using comment cards. We reviewed information given to us by the provider, reviewed information sent to us by other regulators or the Department of Health, talked with other regulators or the Department of Health and took advice from our specialist advisors. We were accompanied by a specialist advisor.

During our inspection we visited the trust's headquarters from which its community nursing service is organised. In addition, we visited two teams of community nurses based in different parts of the Peterborough and Cambridgeshire area.

### What people told us and what we found

At our inspection dated 4/5 February 2013 we told the trust that it needed to make improvements to its community nursing service in the Peterborough and Cambridgeshire area. The report of this earlier inspection visit has been published. A copy of the report can be found on our website by entering the words 'HQ The Priory' in the appropriate search box.

At our inspection visit between 9 December 2013 and 13 December 2013 we checked what improvements had been made by the trust.

We received comments from a total of 18 patients. All of these people gave positive feedback. Patients told us staff were courteous, reliably completed planned visits and delivered good quality nursing care. A patient said, "The staff have always been conscientious in all of their dealings." Another patient said, "The care I have received has been excellent. Staff are friendly. They always listen to my concerns and help me."

We found that the patients whose care we reviewed had received safe and sufficient nursing care.

However, we found that the trust had failed to take appropriate steps to safeguard the health and safety and welfare of patients by ensuring a sufficient number of suitably qualified, staff were employed at all times. This was because it had not completed a reliable assessment of the number of community nursing staff it needed that was based

upon an accurate assessment of how its current resources were being used to meet patients' needs.

We also found that the systems and processes used by the trust to identify, assess, resolve and monitor risks to protect community nursing patients and staff were not robust. We found that senior managers did not have all of the information they needed to accurately check how well the community nursing service was operating in the Peterborough and Cambridgeshire area. This meant that patients could not be fully confident that the trust's community nursing service would be able to reliably respond to their needs for safe nursing care.

As part of a themed national inspection of children who are about to use adult healthcare services we spoke with the service manager of the trust's community nursing team and with the transition health coordinator. We asked them about the support they provided to young people aged between 14-18 years who were transitioning into adult healthcare services. We found the provider had a multi-disciplinary approach in promoting a seamless transition from children's to adult services. We found that strong working links had been developed both within the trust, between different health disciplines such as special needs school nurses and therapists and across agencies. Our judgement in relation to this part of the trust's provision are reported below in the section for Outcome 6. We found that children who were about to use healthcare services for adults had been safely supported through this transition.

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 01 March 2014, 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

**Cooperating with other providers** ✓ Met this standard

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

### Our judgement

The provider was meeting this standard.

Patients' health safety and welfare were protected when more than one provider was involved in their care, treatment or when they moved between different services. This was because the trust worked in cooperation with others.

### Reasons for our judgement

We spoke with the service manager of the trust's community nursing team and the transition health coordinator, about the service they provided to support young people aged between 14-18 years, transition into adult care services. We also spoke with the team manager of the local authority social care transitions team and looked at some service information.

Young people's health, safety and welfare was protected when more than one provider was involved in their care and support, or when they moved between different services. This was because the trust worked in co-operation with others. The service manager explained that the transition health coordinator post was developed with Cambridge County Council, three years ago as a response to support the smooth transition from children's to adult care services.

The transition health coordinator role signposted young people, their families and relevant professionals to appropriate services. While they did not work specifically with individual young people, they became involved with complex situations, when difficulties arose around transition arrangements. An example of this was when a young person required a piece of equipment to transition with them into adult social care services. The policy in place about equipment and transition arrangements lacked clarity, resulting in confusion and the young person being without the equipment they required. The transition health coordinator was able to step in and resolve the problem. As a result of this situation the policy document was reviewed and amended to help prevent a similar mistake from happening again.

We were shown a draft copy of an information leaflet the trust had developed advising about the role of the transition health coordinator. The trust may find it useful to note that when we talked with some families and professionals from other agencies and organisations, there was a lack of understanding about the role of the transitions health coordinator.

The local authority social care team manager and the transitions health coordinator told us how they worked together. We saw that a clear system and pathway of working across the two agencies had been developed. We saw from this pathway that both agencies had a role and responsibility in working together to support young people and their families through the transition period. We were told that when the local authority had identified a young person had reached transition age, this was communicated to the transition health coordinator so that joint working between the two agencies could begin.

The transition health coordinator told us they had access to the local authority's electronic care records. This enabled them to check any contact details held about the young person and information about their assessed needs. This ease of access to information enabled the service to be effective and responsive to needs because it had up to date information. The transition health coordinator told us, "I can check which social care professions are involved and record it on our system, this then makes health colleagues aware of who is involved with the young person's care."

The transition health coordinator told us the electronic records they used enabled other health professionals to have direct access to healthcare records. This included doctors and school special needs nurses. In addition, it involved other healthcare professionals supporting a young person such as the speech and language therapist, physiotherapist and occupational therapist.

The transition heath coordinator told us when they received information from the local authority, this then triggered them to start developing a 'Children's Health Action Plan' (CHAP). We saw a sample of CHAP's and saw how the system worked and enabled health professionals involved to access the document to input or review information. The special needs school nurse involved the young people and their families. An action plan was then produced that clearly set out the young person's health care needs, what action was required, by whom and when. This information was also shared with the local authority and informed the young person's social care assessment enabling a comprehensive approach to assessment and support.

The transition health coordinator told us, "The school nurse is the person that is in a good position to coordinate and involve families." The service manager shared with us their concerns about young people who attended mainstream school or were home taught. They told us, "This group of young people are at risk of experiencing a poor transition as they are far less known to services."

We asked the transition health coordinator who reviewed the CHAP's information to check the process was working effectively. They told us this had been an administrative task and that this person had recently left the trust. The trust may find it useful to note without an identified person to continually monitor the CHAP'S, this could impact on the effectiveness of the transition arrangements put in place for young people.

The transition health coordinator told us they attended various meetings including strategic meetings where they could influence commissioners and policy developers. Commissioners have responsibility for funding arrangements and decisions. They also attended meetings with the local authority transition team where they acted as the 'bridge' between the two agencies, shared information and provided advice and guidance.

We saw how the provider was proactive in their approach in working collaboratively with others. The transition health coordinator told us how they had completed a piece of work with doctors in the community. This involved them providing advice and guidance about

the transition needs of young people with complex health care needs and clarifying the nature of their role.

**Staffing** ✖ Action needed

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

## Our judgement

The provider was not meeting this standard.

There were insufficient community nursing staff employed by the trust In the Peterborough and Cambridgeshire area. The trust did not have sufficient capacity to enable it to safely meet patients' needs for care.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

At our inspection dated 4/5 February 2013 we raised concerns about staffing levels in the trust's community nursing service in the Peterborough and Cambridgeshire area. We told the trust it had to make improvements. On 4 December 2013 the trust informed us that as a result of the outcome of the auditing phase of the action plan, a recommendation was being made to the trust's board to formally declare that staffing levels were not sufficient to meet CQC standards set out in regulation 22 (outcome 13 - staffing). We were told by the trust that the assurances it had given us were no longer valid because it had not been able to provide enough community nursing hours in Peterborough and Cambridgeshire. It said that this was the case even though it was nearly fully staffed, had prioritised the nursing care it provided and had introduced more efficient working practices.

The trust said that it had reached this conclusion after accurately determining the minimum number of community nursing staff it needed to provide a safe level of nursing care. We found that parts of the analysis upon which the minimum number had been set was not reliable. We saw that individual local managers had submitted information to the trust that had been inconsistent and so could not be used to generate an accurate account of the minimum staffing level required.

At our inspection dated 9 December 2013, all of the 18 patients who gave us feedback were positive in their comments. They said that the community nurses had called to their homes as planned and provided them with all of the nursing care they needed. We reviewed key parts of the community nursing care that 10 patients had received. We found that with minor exceptions all the patients had received nursing care that was appropriate for their individual needs. A patient said, "The nurses are kind and caring. I always feel a sense of relief when they enter my home because I know they will sort out any problems I have in a professional way. I cannot speak highly enough of them."

However, we found that the trust did not have robust systems to effectively manage staffing arrangements in its community nursing service. Documents and records showed

that in the two teams we visited the trust's commitment to recruit to vacant posts had not been fully effective. There were 7.67 whole time equivalent vacant posts. Some of these vacant posts had been unfilled for more than two months. In addition, we noted that between 8 November 2013 and 8 December 2013 (inclusive) 222 community nursing shifts (6.9% of the total) had not been delivered.

The trust said that the number of vacant posts and unfilled shifts was within 'the tolerances and assumptions' it used to operate the service. However, staff told us that as a minimum the posts and shifts in question needed to be filled to enable the service to run on a sound basis. They considered that the reduced resources available to them placed undue pressure on staff, made it more difficult to retain staff and increased the risk of mistakes being made. They said that the recruitment system was not effective because it could not match staff turnover. In addition, they said that most of the unfilled shifts had occurred because the trust did not have effective arrangements for using temporary bank and agency staff. These are staff who are not based in the service but who can be called upon as and when necessary. Staff told us and records confirmed that that there were not enough bank and agency staff available and so requests for them often went unanswered.

The trust said that it had carefully prioritised the work that community nurses completed. However, community nurses consistently told us that routinely they spent between 10% and 20% of their time delivering 'non-core' nursing care. This area of provision reduced the amount of time that community nurses had to spend completing core duties, managing risk and completing training.

There was only limited evidence to show that the trust had consistently responded to reports from the managers of the teams about low staffing levels to help prevent them from happening again. For example, we saw that the trust had developed a monitoring form called the Quality Early Warning Trigger Tool. This was being completed each month by community nurse managers. Outcomes were being actioned and risk assessed locally and results collated centrally for trust-wide oversight and monitoring. Scores over 16 and red rated were reported to the board via the clinical operations board. We noted that in November 2013 the tool showed that in Peterborough there was a red rating that meant there was a 'major concern' about the number of times the minimum staffing level set by the trust had been breached. The overall risk rating was amber showing that there was a 'moderate concern'. This had been calculated by combining a range of scores some of which did not relate directly to staffing matters. However, there was no evidence that the continuing risk resulting from inadequate staffing levels had been noted by the trust and no clear account of any action having been taken to address the matter.

We found additional problems related to the community nursing teams being overstretched. Community nurses said that they routinely worked unpaid overtime so that they could complete all of their clinical work and as many administrative tasks as possible. One of them said, "(There are) huge staff shortages leaving the remaining staff working nine hour days and being paid for seven and a half hours." They told us that often they had to balance providing essential nursing care for patients against the need to complete records required by the trust. We saw evidence of the results of this when we examined five sets of the records that community nurses were required to complete if they had concerns about a patient's wellbeing. Three of the records were not completed correctly so that they gave an incomplete and misleading account of the concern. This reduced the trust's ability to risk assess and manage patients' care so that they were kept safe. Another problem was that community nurses had not always had the time necessary to complete all of the training which the trust said they needed to work efficiently and to care for patients in the right way.

The trust told us that it planned to introduce improvements that would address all of these problems and in so doing would release more time for its community nurses to provide care for patients. However, the plans submitted to us did not have any timescales within which they would be completed. In addition, there was no system of 'milestones' so that progress could be checked effectively. These omissions limited the trust's ability to assure us that it had reliable plans that would deliver the required improvements.

In summary, the trust did not have robust arrangements to plan, monitor and evaluate staffing arrangements in its community nursing service. The trust was not able to reassure us that it had used a dependable system to calculate the number of staff it needed to employ in its community nursing service. A part of this shortfall was that it had not effectively addressed problems that reduced its existing capacity that related to vacant posts and unfilled shifts.  This reduced the trust's ability to deliver the staffing resources it needed to meet patients' needs for care through its community nursing service.

**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.

Some of the trust's systems were not effective to ensure that it could identify, assess and manage risks to the health, safety and welfare of patients who needed community care. This was because the board had not been provided with all the information it needed to check that its community nursing service could reliably meet patients' needs for care.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

## Reasons for our judgement

The trust's board is responsible for making sure that the trust is run in an efficient and effective way to meet patients' needs for care. There were a number of committees to which the board had delegated certain functions. These included the Quality Improvement and Safety Committee.

We had received information of concern prior to our inspection in relation to staffing numbers in the trust's community nursing service. It was said that there were not enough staff to reliably provide appropriate care for patients. The trust told us that it was working towards increasing these numbers across the Peterborough and Cambridgeshire area and had developed an action plan to achieve this result. We examined how the trust's action plan had been implemented and monitored. We were told that the plan had been checked by senior staff so that any concerns could be reported to the Quality Improvement and Safety Committee and to the board.

We spoke with four board members regarding the action plan. They said that either they had not been aware or had gradually become aware during the summer months of 2013 that the action plan might not be successful. We asked if a risk assessment had been completed for circumstances that could lead to a failure to deliver the action plan. The trust told us that risks were articulated and shared publically using the Board Assurance Framework and that a specific risk assessment regarding the potential for failure to deliver the plan had not been undertaken.

Documents showed that the progress of the action plan had been considered at meetings of Quality Improvement and Safety Committee in August and October 2013. They also showed that updates had been included in various Quality Reports that had been submitted to the board. These reports indicated that the action plan was on schedule for delivery by the end of November 2013. However, we noted that the Quality Report for

November 2013 also stated that there had been an increase in demand for the service. It said that this exceeded the capacity of the service given its current staffing numbers. Additional information had been provided by the chief nurse who had reported to the board on community nursing staffing levels, capacity and the work underway to address the challenge both internally and externally with commissioners and other providers.

The minutes of the board meeting that the trust held in private in October 2013 also indicated that the board had received a report that there were not enough community nurses to meet demand. In addition, it anticipated that there might still not be enough capacity in December 2013. However, the minutes did not indicate that board members had challenged the assurance they were being given that the action plan was on target, despite continued reports of pressure on the service.

We were told that risks relating to the community nursing service had been highlighted to the board since 2008. Therefore, the progress of this action plan and previous actions to resolve these risks needed a greater and more consistent level of oversight by senior managers. This was necessary to ensure they were appropriate and were effectively monitored to reduce the risk.

We examined the trust's system for investigating and resolving complaints. We found that the trust had received very few complaints during the course of the 12 months preceding our inspection. One theme or trend had been found and this had been acknowledged at board level. We were advised of the actions that had been taken to reduce the risk of the concern happening again.

In addition, we examined the system for reporting incidents to determine if they had been dealt with correctly so that lessons could be learned. Records showed that there had been only a limited number of serious incidents relating to the community nursing service and these had been investigated correctly. However, we noted that there were only a small number of reports relating to low staffing numbers in the community nursing service. Staff at local level told us that this was because they did not have time to complete incident reports for this category of concerns. Senior managers said that the low number of reports relating to staffing levels comnined with the only limited number of complaints assured them that the community nursing service was properly managed and evaluated. However in fact, the impact of under reporting was to reduce the trust's ability to have a clear picture of all aspects of the care it provided for patients.

In summary, we found that key systems used by the trust to monitor its community nursing service were not robust. The board's oversight was based on inconsistent and incomplete information. This had resulted in inaccurate assessments being made of how many community nurses the service required to maintain compliance with staffing numbers. This meant that patients could not be fully confident that the community nursing service would be able to reliably respond to their needs for safe nursing care.

**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<br><br>Personal care<br><br>Treatment of disease, disorder or injury | **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Staffing** |
| | **How the regulation was not being met:**<br><br>There were insufficient qualified, experienced and skilled community nursing staff employed by the trust. This was because the trust had not completed a reliable assessment of the number of community nursing staff it needed that was based upon an accurate assessment of how its existing resources were being used to meet patients' needs. This resulted in the trust not having sufficient capacity to enable it to respond effectively to patients' needs for care. Regulation 22. |
| Regulated activities | Regulation |
| Diagnostic and screening procedures<br><br>Personal care<br><br>Treatment of disease, disorder or injury | **Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Assessing and monitoring the quality of service provision** |
| | **How the regulation was not being met:**<br><br>The trust did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients. This was because the board had not been provided with all the information it needed to check that its community nursing service could reliably meet patients' needs for care. Regulation 10 (1) (a) (b) 2 (b) (v) 3. |

**This section is primarily information for the provider**

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 01 March 2014.

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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete. |
| ✖ **Enforcement action taken** | If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people. |

## How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact -** people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact -** people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact -** people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

## Glossary of terms we use in this report

### Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

| |
|---|
| Respecting and involving people who use services - Outcome 1 (Regulation 17) |
| Consent to care and treatment - Outcome 2 (Regulation 18) |
| Care and welfare of people who use services - Outcome 4 (Regulation 9) |
| Meeting Nutritional Needs - Outcome 5 (Regulation 14) |
| Cooperating with other providers - Outcome 6 (Regulation 24) |
| Safeguarding people who use services from abuse - Outcome 7 (Regulation 11) |
| Cleanliness and infection control - Outcome 8 (Regulation 12) |
| Management of medicines - Outcome 9 (Regulation 13) |
| Safety and suitability of premises - Outcome 10 (Regulation 15) |
| Safety, availability and suitability of equipment - Outcome 11 (Regulation 16) |
| Requirements relating to workers - Outcome 12 (Regulation 21) |
| Staffing - Outcome 13 (Regulation 22) |
| Supporting Staff - Outcome 14 (Regulation 23) |
| Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10) |
| Complaints - Outcome 17 (Regulation 19) |
| Records - Outcome 21 (Regulation 20) |

### Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

## Glossary of terms we use in this report (continued)

### (Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

### Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

### Responsive inspection

This is carried out at any time in relation to identified concerns.

### Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

### Themed inspection

This is targeted to look at specific standards, sectors or types of care.

## Contact us

| | |
|---|---|
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| Website: | www.cqc.org.uk |