# Inspection Report

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

# Filton Blood Centre

North Bristol Park, Filton, Bristol, BS34 7QH

Tel: 01179217200

Date of Inspections: 29 January 2014
28 January 2014

Date of Publication: February 2014

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

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|---|---|
| **Respecting and involving people who use services** | ✓ Met this standard |
| **Consent to care and treatment** | ✓ Met this standard |
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Cleanliness and infection control** | ✓ Met this standard |
| **Supporting workers** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✓ Met this standard |

## Details about this location

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|---|---|
| Registered Provider | NHS Blood and Transplant |
| Overview of the service | Filton Blood Centre in Bristol provides specialist scientific and laboratory services, which the Commission do not regulate. The service collects whole blood and blood component products from voluntary donors and then delivers these to the NHS and other UK health services as directed. We regulate and inspect this part of the service.<br><br>This inspection was carried out in the Southmead Blood Donor Centre, a permanent site based in the grounds of Southmead Hospital, and one mobile blood donor session. |
| Type of services | Acute services with overnight beds<br>Blood and Transplant service<br>Diagnostic and/or screening service |
| Regulated activities | Diagnostic and screening procedures<br>Management of supply of blood and blood derived products<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 28 January 2014 and 29 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 staff and reviewed information given to us by the provider.

### What people told us and what we found

This inspection looked at the services provided from the Blood Donor Centre based within Southmead Hospital and one mobile blood donor session in the community. We were checking that the donor care processes for people who were donating blood (referred to as donors) was safe.

We spoke with 12 donors, eight donor carers, three qualified nurses and other senior managers.

We found that donors were involved in making decisions about donating, consented to donate and were well looked after during the donation procedure. The health and welfare of donors was paramount and donors were provided with sufficient post-donation information to know what to do if they were unwell. There were stringent procedures in place to ensure that recipients of whole blood and blood component products were not placed at risk of receiving unsafe products.

There were standard operating procedures for all staff to follow for the entire whole blood or blood component donation process. This ensured that infection prevention and control measures were in place. Blood donation was carried out in premises that were fit for purpose.

Donors were looked after by donor carers and qualified nurses who were well trained and supported to do their job. NHS Blood and Transplant had robust measures in place to monitor the quality and safety of the service and used donor feedback to review and amend service delivery.

You can see our judgements on the front page of this report.

## More information about the provider

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

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

## Our judgements for each standard inspected

**Respecting and involving people who use services** ✓ Met this standard

**People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run**

### Our judgement

The provider was meeting this standard.

People were fully informed about the way the service was provided and delivered. People were provided with sufficient information to make an informed choice about participating in donation services.

### Reasons for our judgement

We spoke with five donors at the donor centre and seven donors who attended the mobile blood donation session. Those attending the donor centre were regular platelet donors. They told us "I made the decision to change from being a blood donor so that I could help more patients and donate more often", "I know the drill but every visit the staff check that I am happy to donate. The staff are very professional and courteous" and "I have had to cancel some appointments but the staff are very good at re-arranging my appointments".

The donors who attended the mobile blood donation session either had timed appointments to donate or had 'walked-in' to donate. All donors were welcomed and given the Welcome Booklet to read. Those who had never donated before were registered and an explanation was given as to what would happen. New donors were given another booklet to read which explained the blood donation pathway.

We found that donors were informed and understood the procedures that were taking place. There was a range of leaflets available for them to provide additional information about the procedures. We saw leaflets in respect of the tests that would be carried out on donated blood, sickle cell & blood donation, over-volume donation, platelet donation and the frequency of male donation.

There were also leaflets in respect of feeling faint, bruising, the haemoglobin and iron, finger prick test (explaining why decisions may be made that donation cannot go ahead) and an 'after you have given blood' card. This card gave donors advice about drinking plenty of fluids, not undertaking any strenuous exercise and instructions to leave the donor site plaster in place for a minimum of six hours. We saw these after-care cards being given to donors at the mobile blood donor session.

Donor carers and qualified nurses told us that it was always important to explain clearly what was going to happen, even for regular donors. They said "There is a lot of written

information for donors but we answer questions when we can", "If I have any queries during a donors health screen, I can ask the nurse to speak to the donor" and "Donors are volunteers, therefore it is very important that they are respected and seen on time".

**Consent to care and treatment** ✓ Met this standard

**Before people are given any examination, care, treatment or support, they should be asked if they agree to it**

## Our judgement

The provider was meeting this standard.

Before people proceeded with donation they were asked for their consent and the provider acted in accordance with their wishes.

## Reasons for our judgement

All donors had to provide written consent before donation of whole blood or blood components could proceed. Those donors who attended the donor centre had to complete and sign their donor health check (DHC) form upon arrival. Whole blood donors in the centre and those donors who attended a booked appointment at a mobile blood donation session, had to hand their completed forms in on arrival. The mobile session had supplies of spare DHC forms for those donors who did not have an appointment or who were new donors.

Each donor had a private and confidential health screening consultation and were asked further questions based upon the information they had provided on the DHC. Donors had to again give written consent, signed in the presence of a member of NHS Blood and Transplant staff. Donors consented to say they had read and understood the welcome booklet, were not at risk of infection, agreed to their blood being tested, were aware of the donation process and agreed to their blood being used for the benefit of others.

All donors we spoke with, (apart from those who were new blood donors) were fully aware of the nature of the procedures that were going to happen. They told us "Even though I am a regular donor I am asked several times to give my consent", "I wouldn't be here if I didn't agree to donate a pint, but I know they have to ask me" and "I realise they have to continually check and make sure I am happy to proceed". Donor carers we spoke with told us that they had to check consent during the health screen and then again when the donor was on the couch.

We asked what would happen if donor carers had concerns that a donor appeared to lack the capacity to give consent despite having signed their consent form. They told us they would seek the advice of the qualified nurse. The nurse told us if they had the same concerns they would defer the donor. The nurse told us about occasions when first time donors who were students may have been coerced into donating blood by their peers, but had willingly consented. An explanation of why the person was not able to donate would be given. If necessary, concerns would be raised with the clinical support team within NHS Blood and Transplant and the person's GP (if known).

**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's safety and welfare was ensured because the donation process was planned and delivered in such a way as to protect them and those who benefitted from donated blood supplies.

## Reasons for our judgement

Each time donors attended the donor centre or a mobile blood donation session, they had to complete a donor health check (DHC) form. The DHC asked questions about the donor's medical history, any medicines they take or have previously taken, and recent travel abroad. Donors were asked a number of questions about their lifestyle: these were relevant to blood safety. These checks ensured that the whole blood or blood component product they donated was safe to be received by the recipient.

Donors told us "When we arrive we are given the form to complete", "I fill in the same information every time I donate (every fortnight). It seems excessive, however I have to sign to give my consent on the form", "I am sent the form about a week before the donation session" and "There are sometimes different questions on the form so I have to read it carefully. Staff check the details with me again during the health screening".

All donors had a confidential health screening consultation with a donor carer prior to donating whole blood or blood components (for example platelets). Information on the DHC was checked and the donor was given the opportunity to ask further questions. Donors at the mobile blood donation session and those donating whole blood in the donor centre were advised to drink 500mls of water prior to the donation starting as research had shown this to be beneficial to post-donation recovery. Those donors who were donating platelets were provided with drinks and snacks throughout the procedure, as this could take between 70-80 minutes.

The donor carers referred to the qualified nurse when they had medical queries. We saw that the donor carers were not present during the donor/nurse consultation in order that matters could be discussed in private. At the mobile blood donor sessions, health screening was undertaken in a screened booth. In order to provide some privacy for the confidential discussions, the radio played to mask the personal conversations.

A finger prick test was completed using a single-use lancet (a needle) and pipette (a tube to suck up a drop of blood). The blood drop was tested for haemoglobin (the oxygen carrying capacity of the blood). If the haemoglobin (Hb) level was low the donation would

not proceed. If the Hb level was border-line, a sample of venous blood would be taken with donor consent, and a more precise test was completed. These measures ensured that the donation of blood was not detrimental to the health and welfare of the donor.

When donors were ready to donate, the donor carer rechecked the personal details and consent again and then supported the donor to be comfortable on the donor couch or chair. The donor site was rigorously cleaned using an antiseptic chloraprep wand and a non-touch technique. A sterile needle was inserted into a vein in the donor's inner elbow and connected to a sterile blood collection pack (a single use closed system). The blood was collected by an automated agitator, which also weighed the donation. Donor carers told us that once a collection pack had been removed from sealed packaging, it had a shelf life of 1.5 hours. At the end of the procedure, the sterile needle was removed and a pressure dressing applied.

Platelet donors in the donor centre were connected to machinery for the period of their donation. The machines separated the platelets off and then returned the other blood components to the donor. The donor carers monitored both the donor and the machinery during the procedure. One donor carer told us, after the first return of blood to the donor, they had to ensure that the procedure was going well.

Following donation donors were offered refreshments and observed in the 'tea table area' to ensure there were no ill effects. In the mobile blood donation session we noted that two donors had become unwell following donation. One donor had become unwell and fainted, whilst the other had started to re-bleed from the donor site. Donor carers dealt with both incidents calmly and efficiently.

There were systems in place to ensure that whole blood, blood component donations and test tube samples could be traced back to the donor if needed. Bar-coded adhesive labels that met the Blood Safety and Quality regulations 2005, were attached to the DHC forms, blood packs and test tubes and there were stringent administrative systems in place to reconcile all blood donations. Blood products were placed in large insulated bags, collected from the blood centre and the mobile blood donation sessions at agreed times and delivered, along with the relevant paperwork to the laboratory in the NHS Blood Bank, Filton.

All qualified nurses and first aiders received basic life support training. Refresher training was completed on a yearly basis. The donor centre and mobile blood donation session had a pocket mask and a first aid kit as part of their equipment. Any medical emergencies would be dealt with via a 999 call for ambulance service assistance.

**Cleanliness and infection control** ✓ Met this standard

**People should be cared for in a clean environment and protected from the risk of infection**

## Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

## Reasons for our judgement

We spoke to donors in both the donor centre and the mobile blood donation session. They did not raise any concerns with us about cleanliness and infection control. They did make the following comments: "I see the staff washing their hands frequently or using the hand gels", "I have never had a problem with infection at the injection site" and "They rigorously clean the injection site each time" (the injection site is the venpuncture site).

We looked around the donor centre and found it to be clean, tidy and well organised. The storage areas were clean and tidy and clinical equipment was clean and appropriately stored. The centre was cleaned in the evenings when no donors were donating. On the Tuesday and Thursday when the centre was open for longer hours, cleaning staff visited to remove clinical and domestic waste. The centre had designated hand washing facilities, with liquid soap and paper towels. Supplies of sanitising hand gels were located on the tables by each of the donation couches. Signage was displayed in respect of hand washing techniques. The guidance was in line with the national patient safety agency 'clean your hands' campaign.

Cleaning logs were kept for the donor centre and had to be completed at the beginning and end of the day. There were twice daily tasks that had to be completed (work surfaces, named equipment and the couches), weekly tasks (named equipment) and monthly cleaning tasks (named equipment). The cleaning logs were reviewed and signed off by the donor carer supervisors.

At the start of a mobile blood donation session, a venue assessment was completed by the session supervisor, and signed off by the qualified nurse. This included a check on the cleanliness of the premises. All venues were required to have toilet facilities and hand washing facilities. Where premises were not suitably clean or sanitary, facilities services could be called in or the session cancelled.

Donor carers and nurses did not routinely wear gloves (personal protective equipment (PPE)) when undertaking venepuncture but had access to supplies of gloves if needed. Donor carers would put on gloves if a donor started to bleed after the needle had been removed from their arm, or they had to deal with other body fluids. All staff who worked for

NHS Blood and Transplant were offered screening and advice regarding the hepatitis B virus immunisation programme.

The donation couches and surrounding items of equipment and machinery were cleaned in between donors use and prepared for the next donor. Sanitizing wipes were used to clean all items. The couches were cleaned at the start of the mobile blood donation sessions during the set up procedures and then in between each donor.

The centre manager and senior nurses had lead responsibility for infection control and prevention in the donor centre and mobile blood donation sessions. All donor carers and qualified nurses received infection control training as part of their annual mandatory training. This was confirmed in our discussions with donor carers and qualified nurses.

Infection control audits were completed regularly on a national basis. We were shown a re-audit report called 'Effectiveness of donation related infection control procedures' dated June 2013. The audit had re-looked at hand hygiene practice and had found that 98% of staff were compliant with the hand hygiene requirement. Compliance with arm disinfection was 97%.

Following donation, samples of all blood supplies were tested for a number of specific infections, for example HIV and the hepatitis B virus. Donations were screened for the West Nile Virus (WNV) on a discretionary basis. Donors had to consent to the tests being carried and could not donate blood without that consent being given. These precautions were in place to safeguard the recipient of that blood product.

**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 by staff who were supported to deliver the service safely and to an appropriate standard.

## Reasons for our judgement

Donors we spoke with in both the donor centre and the mobile blood donor session made positive comments about the donor carers who looked after them. They said "The staff are all very competent", "I am very impressed with the staff and their kindness" and "I have got to know the staff really well during the years I have been donating here. They are all very committed to us as volunteers".

All donor carers we spoke with, in the donor centre and the mobile blood donation session, confirmed that their training was up to date and "training opportunities were good". They told us that they had access to all the documentation and standard operating procedure guidance to do their job.

New NHS Blood and Transplant blood collection staff had a comprehensive six week induction training programme to complete. This included workbooks, training sessions, competency checks and support from a mentor (an experienced donor carer allocated to support them in their learning). Two newly appointed qualified nurses were supported by the area lead nurse and the trainer with their induction learning at the blood donation session. One nurse told us "I have had very good support to learn the job".

When donor carers or qualified nurses had a break from their role, they were required to review any updated standard operating procedures before undertaking any tasks. This ensured that they were working within agreed procedures.

An electronic training matrix was maintained by NHS Blood and Transplant. All staff (donor carers and qualified nurses) had an annual performance and development review, reviewed at key times during the year. Mandatory training for all staff included fire awareness, health & safety, infection prevention and control, equality and diversity, safeguarding of adults and children, conflict resolution, information governance and moving and handling. The centre manager and the donor session managers maintained an overview of the matrix and could identify when individual staff members were due for refresher training. This ensured that training always remained in date. The matrix highlighted staff who were due refresher training, 30 days prior to expiry.

Training was provided by a mixture of online learning sessions and practical training sessions. Qualified nurses also completed basic life support training and the administration of lidocaine (anaesthetic medicine). Skills based training included venepuncture training and this was revalidated every two years.

Donor carers and qualified nurses we spoke with said they were well supported to perform their roles and got on well as a team. Team briefs were held at the start of every day in the donor centre and at the start of a donor session. Team meetings were held on a regular basis.

**Assessing and monitoring the quality of service provision** ✓ Met this standard

**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 in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

## Reasons for our judgement

We spoke to donors in both the blood centre and the mobile blood donor session. They told us "We have been given the donor helpline telephone number if we want to make comments about the service", "At the end of every session we are asked if there are any comments we want to make", "I see there are some comment cards on the table (mobile donor session) but I don't feel I need to complete one" and "Everything seems to work like clockwork and procedures are well thought out".

Comments made on donor satisfaction survey forms were reviewed by the centre manager and discussed with the team staff. Good feedback was collated and fed back to the team staff and this was confirmed by those donor carers we spoke with. A discussion would be had with any donor who had made comments that required a response. Any information received by the national contact centre was responded to within five working days, by the relevant manager and any corrective and preventative actions were taken.

Staff surveys were completed on an annual basis. The results from the 2013 survey had not been collated by NHS Blood and Transplant, but we looked at the outcome of the 2012 survey. This showed what things the service had improved on, and where the areas for improvement were. As a result of the survey the top three priorities were identified along with actions plans on how the improvements were going to be achieved. Donor carers and qualified nurses we spoke with confirmed that there was an annual survey and they were notified of the outcome and progress in making improvements. A 'Bright Idea's' scheme enabled staff to make suggestions that would improve the NHS Blood and Transplant's efficiency and effectiveness.

An annual cycle of audits was completed to ensure that the blood donation services remained safe for the staff to work within and met the donor's needs. The audits covered both the blood centre and the mobile donation sessions. The quality management team monitored any adverse events, accidents and incidents and classed each into one of three key categories (critical – actual harm, major – potential for harm and other – contradiction to policy and procedure).

The quality management audit system also looked at the control of documents and management of equipment. Alerts were sent 30 days before any equipment was due for servicing and maintenance inspections were completed on a six monthly basis, for the equipment that required this level of servicing. Service level agreements were in place for all equipment in the case of mechanical breakdown.

Change control measures were always put in place when introducing any significant changes. An example given was when a new type of single-use lancet for the finger prick test was introduced. There was a programme of staff training, a roll-out of use and an evaluation of the product.

NHS Blood and Transplant was also audited by other regulators for compliance against the Blood Safety and Quality Regulations 2005, the Human Tissue Authority (HTA) and the Medicines and Healthcare Products Regulatory Agency (MHRA). The MHRA completed their last audit in July 2013 and visited the donor centre and one of the donor sessions. Four 'other' (contradiction to policy and procedure) areas of non compliance were identified and the quality team were able to report what corrective actions had been taken.

Audits were completed in respect of infection control, venue assessments for the mobile blood donation sessions and completion of documentation, to name some examples. Where shortfalls were highlighted, corrective and preventative action plans were put in place and audits were repeated.

Monthly clinical governance meetings were held and attended by the centre manager or a qualified nurse and the area donor sessions manager. Information was shared between other centres and there were discussions around work load planning, training, quality and any clinical events.

There were strict standard operating procedures in place for the setting up and running of mobile donor sessions. A loadmaster (the staff member who was charged with ensuring that health and safety was adhered to and the standard operating procedures were followed) was identified for each set up. We observed these procedures being followed. There were standard operating procedures for the staff to follow to calibrate machinery (the agitator and the heat sealer) used during the donation process. All consumable products used during the donation procedure had to be documented and donor carers showed us how these were completed at the various stages of the process.

## 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.

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|---|---|
| ✓ **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:

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|---|
| 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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