Inspection Report

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

Tameside General Hospital

Fountain Street, Ashton Under Lyne, OL6 9RW

Tel: 01613316000

Date of Inspections: 15 May 2013
11 May 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Tameside Hospital NHS Foundation Trust
Overview of the service	Tameside General Hospital is an acute general hospital which is eight miles to the east of Manchester and serves a population of approximately 250,000. The hospital has 541 beds 61 of which are used for day case admissions. It provides a number of services including: accident and emergency, medicine, surgery,paediatrics, maternity, intensive care, high dependency and critical care.
Type of service	Acute services with overnight beds
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Termination of pregnancies 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'.

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 11 May 2013 and 15 May 2013, observed how people were being cared for and talked with people who use the service. We talked with staff, reviewed information sent to us by other regulators or the Department of Health and talked with other regulators or the Department of Health.

What people told us and what we found

We carried out this responsive inspection of the trust's emergency care pathway, risk management and incident reporting. We carried out the inspection after correspondence from the North Western Deanery and viewing a report of a review of urgent care commissioned by the trust raised concerns about patient safety and the quality of service provision in the accident and emergency department and escalation areas at the trust. We were told there was a culture of under reporting of incidents, problems of overcrowding and delays in ambulance handovers, poor implementation of discharge planning and a lack of regular team meetings for staff.

We spoke with people about their journey from accident and emergency to admission. We asked them about their understanding of what was happening and if staff had explained what was wrong with them, what treatment was needed and if discharge arrangements had been discussed. People told us "I can't fault anything." They told us staff had "put them at ease" and felt they had been given "excellent attention" when they arrived at the department. They told us that "everybody has been good" and that "the doctor talked me through everything'.

On both occasions we visited the trust the accident and emergency department was quiet. There were a number of beds available on wards and departments so escalation procedures were not operational. We observed the handover process for patients brought into the accident and emergency department by ambulance. We found that handovers took place in a corridor. This meant that the privacy of patients' confidential information was not always respected.

We found that the trust had an escalation policy in place and the designated escalation area was fully equipped to manage escalated patients if required. We were told by staff, patients and the review of urgent care commissioned by the Trust that the application of the escalation policy was not always consistent. This meant that there was a risk that people could experience unsafe and inappropriate care.

We found that three bed management and discharge planning meetings took place every day but consultant input to ward rounds was limited to three days a week. This meant that there had been improvements to discharge planning but more work was needed to implement and manage discharge processes consistently across the trust.

Staff told us that there had been an increase in meeting frequency between ward based and senior staff. Some staff told us that staff meetings were sometimes cancelled when the ward was busy. This meant that learning from incidents, adverse events and errors was not always shared.

We found that the trust had systems in place to assess and monitor the quality of services. However these systems were not always robust enough to ensure that all risks were identified by the trust and effectively managed. This meant that timely action was not always taken to protect people who use the services.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

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 not meeting this standard.

The provider was not meeting this standard. Patients rights to privacy and dignity were not always respected and upheld. Information and support helped patients to make decisions.

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 Report of the commissioned review documented that 'There is a significant problem of overcrowding and delays in ambulance handovers in the Emergency Department (ED)'. When we visited the accident and emergency department on 11th and 15th May 2013 the department was very quiet. We looked at how the layout of the accident and emergency department and the handover processes supported privacy and dignity for people who use the service. We observed the handover process for patients brought into the accident and emergency department by ambulance. Patients were handed over by paramedics to a nurse and doctor in a corridor between the major and minor injury areas. Details of the patients injury and treatment was relayed by the paramedic to the medical team, the patient was then triaged and transferred to either the major or minor treatment area. Whilst we observed that this was done as discreetly and quietly as possible this meant that patients' privacy and discussion of patients' confidential information was not always respected. We spoke to ambulance personnel who told us that in the majority of cases handover processes at the trust were quick. However, we were also told that at very busy times the handovers were sometimes delayed and ambulance teams had to wait for significant periods of time. We asked managers about how times of high activity were managed. We were told that board rounds were carried out in line with risk assessments to identify patients who could be moved from the accident and emergency department to either wards or escalation areas to manage the high activity in accident and emergency.

We looked at what systems were in place to make sure patients were receiving a planned discharge. We saw on both wards there were discharge procedures in place. Staff we spoke with were familiar with them. One staff member went through the process to show how discharges were managed. By following individual patient 'care pathways' (the record of assessment, treatment and support a patient receives from admission to discharge), we could see evidence of patient/family and other agency involvement in the planning of

discharge. This meant the sample of patients we looked at were being discharged with support systems in place. Consultant input to ward rounds was limited to three days a week. This meant that senior reviews of patients prior to discharge could be delayed and this affected bed management and discharge planning. There had been an improvement to discharge planning but more work was needed to implement and manage discharge processes consistently across the trust.

We saw that the department was clean and well maintained. An automatic door at the ambulance entrance was not operating correctly. A security guard was stationed at the door to ensure the entrance was safe and secure.

All cubicles had curtains in place to maintain dignity during treatment. When we visited there were three patients being treated in the resuscitation area, three in the major injury area and two in the minor's injury area. We saw that curtains were used when cubicles were occupied to maintain dignity and privacy.

The trust had a separate paediatric accident and emergency area. When we visited on 11th May 2013 the area was open. The area was clean and the waiting area was well stocked with toys. We saw that there were three curtained cubicles for paediatric patients and one examination room.

We visited the medical assessment units and wards 27 and 30 and spoke to patients who had been admitted from the accident and emergency department. Patients told us that they had been kept informed about what was happening and when and why they were being moved.

We observed care being delivered at the hospital. All the nurses and support workers we observed talked to patients in a kind and professional manner. We noted spontaneous interaction occurring between staff and patients. All of the patients we saw were well groomed and their clothing was clean and appropriate.

We saw that information leaflets were available on display units in the waiting and treatment areas for people to take away as needed.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

The provider was not meeting this standard. People were not always protected from the risks of unsafe or inappropriate care and treatment.

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

We visited eight wards and departments in the hospital, spoke to patients and staff and reviewed case notes. We observed care being delivered at the hospital. All the nurses and support workers we observed talked to patients in a kind and professional manner.

During our visit we looked at the care plans of twelve patients across eight wards and departments. Assessments and care plans had been completed and transfer documentation from the trusts accident and emergency department was mainly of a good standard. In one set of care plans we found that a patient transferred to the medical assessment unit from accident and emergency had no nursing notes only an electronic check- in sheet. We also saw that not all transfer times had been documented and discharge paperwork completed. This meant that the continuity of care and treatment was ineffective because care plans were incomplete. We discussed this with the trust managers who told us that additional administrative support was being sourced to ensure all relevant patient documentation was completed prior to patients being transferred.

We saw that the trust had designated the day surgery and endoscopy unit as the escalation area. The unit had 15 trolley beds in two separate bay areas. We saw that the bays were fully equipped with piped gases and suction equipment. The bays were separate to support gender segregation. One bay did not have a nursing station, the manager informed us that when the escalation area was in use each bay was staffed separately. Band five supernumerary nursing staff were rostered onto medical wards to staff the escalation area when needed. When we visited the trust we were told that the area had not been used for escalation for over two weeks. This meant we were not able to observe escalation processes whilst they were operational. Prior to our visit we were told by staff that the assessment and management of patients' transferred to escalation areas was variable. We had received concerning information from service users detailing incidents where patients' were treated in this area for long periods of time without any reassessment of their treatment needs. We were told that patients could be moved to different wards on up to four occasions before a risk or needs assessement was

completed. This meant that there was a risk that people could experience unsafe and inappropriate care because their individual needs were not always being appropriately assessed and monitored.

A system to assess patient's suitability for transfer to the escalation area was in use. We looked at the records of 15 patients who had been transferred to escalation in April 2013. We saw that risk assessments had been completed by medical staff that detailed a criteria that must be met before patients were transferred to the escalation area.

Bed management meetings were held three times a day with medical staff and trust bed managers. We attended a bed management meeting and saw that two matrons a specialist registrar and bed managers were in attendance. Bed availability and discharge activity were discussed at the meeting. During these meetings patients' length of stay in the escalation area was monitored and reviewed, if escalation had been utilised. We reviewed the data monitoring tool from April 2013 and saw that the average length of stay for patients in escalation was nine hours with a maximum of 29 hours.

We spent time talking with people about their experiences of the service. They told us that "everything about the admission had been a very positive experience" and "they were kept informed throughout about what was happening and what was going to happen".

We talked with nursing and medical staff as well as the paramedic staff bringing people into the department by ambulance. Nursing and Medical staff told us that the team worked well together and recent changes to management had made them feel more supported. Additional staff and a new e-rostering system had made things easier and working patterns more flexible.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

During our unannounced inspections on 11th and 15th May 2013 we saw that numbers of staff had recently been increased in the emergency departments. There was a consultant, two registrars, two F2 doctors, eight band 5 nurses and two band 2 nurses on duty. We were told that all of the four consultants who worked in accident and emergency had either a paediatric qualification or a specialist interest in paediatric medicine. This ensured that paediatric patients' were seen by appropriately qualified staff.

We spoke to the consultant who told us that there were always two registrars on duty in the department to supervise and support junior doctors and only F2 (second year) junior doctors worked in the department.

We saw that there was a list of on call speciality doctors available in the department. We were told that attendance by on call specialists was within one hour of the call out. The consultant explained that the ambulance notification came through to the major injury department and so specialty request calls were made before the patient arrived at the accident and emergency department.

When we visited on 15th May 2013 there were eight band 5 nurses on duty plus two band 2 health care assistants in the accident and emergency department.

The trust had used a number of quality indicators and nurse- to -bed dependency ratios to collaborate ward and department staffing levels. In January 2013 the trust board agreed to recruit to all vacant nursing posts.

We saw that there was an agreed establishment of 66.9 whole time equivalents (WTE) band 5 nurses in the accident and emergency department. Recruitment processes are in progress for 6.7 of these posts. This meant that there were eight band 5 nurses on each shift in the accident and emergency department .

The position in respect of all nursing vacancies at the time of our visit was that all band 2 vacancies had been filled. There were 26.57 WTE band 5 vacancies. 22 of these posts were filled on 22nd April 2013 and new staff were awaiting pre employment checks before

commencing in post.

The trust used an e-rostering system to allocate shift patterns and skill mix in each clinical area.

We visited the medical assessment unit. The unit had 52 beds available, 37 beds were occupied at the time of our visit. We saw that there was a ward manager, eight band 5 and eight band 2 staff on duty. We were told by staff that this was an adequate level of staffing for the current patient dependency. Shift reports showed us that the trust had covered all vacant shifts.

The Trust had an Escalation Policy in place. We looked at this policy and saw it detailed what staff should do when there was an increase in patient demand to ensure adequate support was made available. This included clear information about what to do about staffing levels in accident and emergency, it outlined in detail the level of risk when things occurred such as shortages of staff, and documented what actions should be taken.

When we visited the trust on 11th and 15th May 2013 the accident and emergency department was quiet. This meant that we were not able to observe the implementation of the escalation policy. We were told that during periods of high bed demand the trust relied on agency staff to fill vacant shifts in the escalation area. This meant that people using the service would not experience consistency and continuity of care.

We were told that people requiring medical beds were placed on other wards until medical beds were available (outliers). The arrangements for the clinical management of these patients was inconsistent. This meant that there was a risk that peoples' care needs would not be met by appropriately qualified staff with the right knowledge skills and experience when the trust was experiencing high bed demand.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider was not meeting this standard. Systems were not robust enough to ensure that all risks were identified by the trust and effectively managed

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

Prior to our visit concerns were raised by the North Western Deanery about the culture of incident reporting at the trust.

When we visited on 11th and 15th May 2013 we found that the trust had a paper incident reporting system in place. At the time of our visit a new electronic incident reporting process was being introduced. An electronic incident form was available on the trust internet and a dedicated incident email address had been opened to allow all staff to email a member of the quality and governance team to report any incidents or risks. We saw that a newsletter had been sent to all wards and departments in the trust in April 2013. This newsletter documented changes to the incident reporting processes and contact numbers for incident 'hotlines'.

We spoke to staff in the accident and emergency department and six wards. They told us they understood the reporting system and could describe the types of incident that should be reported and the process for raising concerns. We asked staff if they were able to assess the incident reporting book directly, all staff we spoke to knew where the reports were kept and said they could assesses them without asking their line manager. We asked staff if they received feedback from reported incidents and significant events. They told us that this was inconsistent. Sometimes feedback was provided in team meetings but on occasions feedback was not provided at all. A quarterly risk management report detailing the level and type of incidents reported had been submitted to the trust board for review. 1136 incidents had been reported in the January 2013 to March 2013 quarter. We looked at data provided by the National Patient Safety Agency that indicated that the trust had average reporting levels for incidents.

A report of a review of urgent care commissioned by the Trust raised concerns about patient safety and the quality of service provision in the accident and emergency department and escalation areas at the trust.

During our visit we confirmed that the trust had invited the Emergency Care Intensive Support Team (ECIST) to review the trusts internal patient pathways. The report highlighted problems with overcrowding and delays in ambulance handovers in the accident and emergency department, poor implementation of discharge planning and inconsistencies in the application of escalation processes.

When we visited the trust not all senior staff who worked in the accident and emergency department were aware of the content of the report or the timeframe for implementing the recommendations in the report.

Prior to our visit we were told by staff that the assessment and management of patients' transferred to escalation areas was variable. We had received concerning information from service users detailing incidents where patients' were treated in this area for long periods of time without any reassessment of their treatment needs. This meant that there was a risk that people could experience unsafe and inappropriate care because their individual needs were not always being appropriately assessed and monitored. The ECIST report also identified inconsistencies in the application of escalation policy and process. At the time of our visit a review of the escalation process had not been carried out by the trust to ensure all patents' received appropriate and effective care.

We spoke to staff who told us that there had been an increase in meeting frequency between ward based and senior staff. Some staff told us that staff meetings were sometimes cancelled when the ward was busy. This meant that learning from incidents, adverse events and errors was not always shared.

The director of nursing told us that, to improve clinical governance and risk management the medical director of the trust had reduced his clinical duties and a new deputy director of nursing had been recruited. A new deputy director of quality and governance had also, recently, been appointed by the trust to integrate and lead quality and governance. We were unable to directly assess the results of these changes.

The trust had a system in place to ensure risks are escalated, by staff, to the senior managers, medical leads and matrons. These risks were placed on departmental risk registers. All departmental and corporate risk registers detail the areas of concern, the level of risk and likelihood of occurrence, along with the actions taken to eliminate, reduce or control the risk. The trust's corporate risk register was last updated in March 2013. The trust provided reports and committee minutes which showed that departmental risk registers were updated and a system was in place to escalate risks to the corporate register. During our visit we saw that the risks identified by the ECIST report had not been added to the risk register or communicated to staff. This meant that risk reduction actions had not been taken to manage identified risks.

As part of our visit we saw that there had been an increase in audit programmes by senior staff. Outcomes from ward level audits were reported to the trust board. We also found case notes where not all transfer times had been documented in the accident and emergency department and discharge paperwork had not been properly completed. The trust were aware of this and told us that additional administrative support was being sourced to ensure all relevant documentation was completed prior to patients being transferred. This risk had not been documented in the departmental risk register.

The trust had systems in place to assess and monitor the quality of services. These

systems were not robust enough to ensure that all risks were identified, integrated and effectively managed by the trust. This meant that timely action was not always taken to protect people who use the services.

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 Surgical procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: Patients' rights to privacy and dignity were not always respected and upheld.
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider was not meeting this standard. People were not always protected from the risks of unsafe or inappropriate care and treatment.
Regulated activities	Regulation
Diagnostic and screening	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

procedures Surgical procedures Treatment of disease, disorder or injury	**Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider was not meeting this standard. Systems were not robust enough to ensure that all risks were identified by the trust and effectively managed

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 23 July 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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