Inspection Report

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

Crofton Care Partnership

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Tel: 01329663984

Date of Inspection: 06 February 2014

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

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

Details about this location

Registered Provider	Crofton Care Partnership
Registered Manager	Mrs. Petula Williams
Overview of the service	Crofton Care Partnership provides personal care and support for people in their own homes.
Type of service	Domiciliary care service
Regulated activity	Personal care

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 6 February 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We visited two people in their homes with care staff and we spoke with six other people who use the service and a person's relative. People we spoke with told us they received the care and treatment they had agreed to and this was accurately described in their care plans. We found that staff understood how to respond to people's decisions and people told us that staff were respectful and acted in accordance with their wishes.

People we spoke with were satisfied with the care they received from the provider. A person said "I have always felt safe with them all (staff) and they always know what they need to do". Another person said "they are real carers, I feel at ease with them and safe, I trust them". We found that staff had a good understanding of people's needs and how to care for people safely. Some people told us they would prefer to see the same staff more frequently.

We found that the provider had procedures in place to safeguard people from the risk abuse and that they acted on their concerns to promote people's safety and welfare.

People told us they were satisfied with the provider's staff. However, we have asked the provider to make improvements to ensure staff are adequately supervised and appropriately trained to carry out their role effectively.

People told us they were asked for their views on the quality of the service they received and we found that the provider used monitoring systems and information to make improvements to the service.

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 14 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

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 received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

People or their representatives signed their agreement to the provider's terms and conditions of the service and this explained the responsibilities of the provider and the person in the delivery of the service. People we spoke with told us that they were given sufficient information about the service and this was discussed with them prior to commencement. This meant that people were given sufficient details about the care and treatment available in order for them to make an informed decision.

People's needs were assessed prior to the commencement of the service and a care plan was developed with the person, their representatives and social services as applicable. A person's relative told us "yes we have a care plan and my relative and I discussed this with the manager and it accurately reflects their needs and what is delivered". Other people confirmed that care was delivered in line with their agreed care plan. We saw that people or their representatives signed their agreement to the care plan and their consent to share information with other named people and/or professionals. This meant that people or their representatives received the care and treatment they had agreed to.

We discussed with the provider and manager how they supported people who lacked the mental capacity to make decisions about their care and treatment. They told us that people's care and treatment was discussed with their family or representatives and other relevant people. For example, where a home care package was not meeting a person's needs their care plan was reviewed with their family, the community mental health team and adult services to make a decision in the person's best interests. We saw the records that confirmed the provider had acted to support the person's best interests.

We visited two people in their homes along with care staff, and we spoke with six people by phone. We observed that staff asked people what they wanted, for example; what they would like to eat and whether they required any other support. A person we spoke with said "they ask me about my choices, for example I go to bed at the time I want to". A person's relative said "they always ask what care they would like, whether that's a bath,

shower or hair wash and if there is anything else they can do". This meant that people were supported by staff that gave people choices and respected their decisions.

Staff we spoke with demonstrated they knew what to do if a person refused care or treatment and this conflicted with the person's care, welfare or safety needs. For example, a staff member said "I try to encourage people and offer choices, like a strip wash if they don't want to shower, I always report my concerns to the office and these are acted on". Another staff member said "you can't force people, you must respect people's personal choice - I plant the seed of what may be good for them and if they decline I let the office know". A staff member told us about a situation where a person's family had requested care was delivered in a way which conflicted with the person's safety and wishes. They said "I was asked to move someone in a way that could cause harm to the person and me; I called the office and was told to act safely and in line with the person's wishes, not the family member". This meant that people were supported by staff who knew how to respond to people's decisions about their care and treatment.

The provider told us that if a person told them that they had made a Do Not Attempt Resuscitation (DNAR) decision then this would be recorded on their care file. We noted that people were not routinely asked about their advance decisions as part of their care planning. The provider might like to note, that whilst people may not have chosen to make advance decisions, because people had not been asked they could be at risk of not having their important decisions communicated when required.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We visited two people in their homes with care staff and we spoke with six other people who use the service and a person's relative. We reviewed the care plans of five people and we spoke with staff.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.
We looked at the electronic records of people's needs assessments and saw that these included information about the support people required and any risk issues. Paper care plans were then developed that recorded people's individual needs and the support required to meet them and these were kept in people's homes. People we spoke with told us that their care plans accurately reflected their needs and the care that was delivered.

We visited a person with care staff and observed that they delivered care as agreed, for example; that the person was assisted with moving and handling to meet their personal care needs. Staff recorded the care they delivered in people's care plans. A staff member said "we always write in the folder and check this first before we do anything" and a person we spoke with said "they (staff) usually read the care plan so they know what to do". Another person said "they (staff) have it all written down and they look at this". This meant that care was delivered to meet people's assessed needs.

Most people we spoke with told us that the staff supporting them varied. A person we spoke with said "it would be much better if I could have the same care staff more often or for at least a week at a time as I never know who is coming". Another person said "staff vary, although I like to see the same staff". Some people told us that their preference for the same staff had been accommodated as far as possible. The provider told us that they were monitoring the number of different care staff that people saw and were allocating calls in designated areas to improve continuity and accessibility.

People we spoke with told us that their needs were adequately met by the range of staff that supported them. Staff we spoke with told us they were informed of any changes in people's care needs by the manager or office staff and that they used the daily records and care plans to ensure that care continued to meet people's needs. A staff member said

"I have never arrived blind yet" and another staff member said "they (office) have never not told me if there is an issue with a person". This meant that whilst some people did not always see the same staff, they experienced a continuity of care as a result of communication between those that provided it.

Whilst people we spoke with told us that their preferences and choices were respected by staff who delivered care. We noted that care plans did not always reflect people's preferences and abilities. The provider might find it useful to note that where care plans did not reflect people's individual preferences they may be at risk of inappropriate care.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We saw that risks had been assessed in relation to people's moving and handling, environment and care delivery needs. The Barthel Index was used to assess people's level of functioning in relation to daily living activities and this was reassessed on review to monitor and update people's changed needs.

We saw that some actions to minimise risks were identified on the care plan, for example; the care plan for a person who was at risk of pressure areas stated they should have cream applied following their shower. However, the provider might like to note that it was not always clear that preventative actions had been identified because they were not recorded in detail. For example; we saw that a person who became aggressive at times did not have a specific risk assessment in place. There was no record of a risk assessment or management plan for a person who had a sling placed permanently beneath them, although they told us this could cause discomfort. Whilst staff we spoke with demonstrated they had a good understanding of the risks to people's safety and welfare and how to act to support them safely, the provider might find it useful to note that where actions to minimise and manage risks were not clearly recorded people's safety and welfare may not be adequately protected.

We saw examples of where people's care plans had been regularly reviewed. The review included checking that the person's needs were met within the times and visits allocated and any changes required. People's satisfaction with the service was also discussed at review. Staff we spoke with told us that the manager acted when they raised concerns or notified them about people's changed needs and their care plans were promptly reviewed. People we spoke with told us that their care plans were accurate and that their needs were periodically reviewed by the manager. This meant that people's care plans were kept up to date in recognition of people's changed needs.

People we spoke with told us that staff were 'reasonably' on time, with most people accepting that times could vary when staff were unavoidably delayed. All the people we spoke with said that staff spent the agreed time with them and this was sufficient to meet their needs. People we spoke with were satisfied with the care they received. A person said "they are very good, they seem to know what to do and they fit it all in". Other people told us they were 'happy' with the service and a person said "it was a lovely relief to have them - I am very lucky".

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We spoke with four staff members about how they protected people from the risk of abuse. A staff member told us "I would notice changes in people's personality and any signs that their welfare or wellbeing was at risk, I would call the office and not record this in their care plan at home because other people may have access to this". Staff we spoke with told us who they would report any concerns to, including external agencies. We saw that the provider had an up to date policy and procedures on safeguarding adults at risk which included a reporting procedure.

We saw that the provider had introduced safeguarding training that included a taught session and a recorded assessment of staff knowledge that met the requirements of the Common Induction Standards (CIS). Training included; understanding the background to adult safeguarding, recognising indicators of abuse and knowing what to do when there are concerns.

We noted that one staff member we spoke with had not completed training in safeguarding adults at risk of abuse since 2011 and they told us "we just touched on this". Another staff member had not completed training since coming into post in July 2013. We looked at some of the training records which showed that not all staff supporting people in their homes had either completed training or had recent training (last three years) in safeguarding vulnerable adults. We noted that 'recognising the signs of abuse' was included as part of the induction process. Whilst we saw that the staff training requirements were being addressed, the provider might find it useful to note that; where the provider had not ensured that staff knew and understood the relevant safeguarding information and processes, people may not be adequately protected against the risk of abuse

The provider told us that the local authority multi agency procedures for raising concerns

and reporting abuse were available on-line in the office. We saw that the staff handbook contained some information on abuse that included; what abuse may be and how staff should respond to and report their concerns. We discussed an example of how the manager had acted to support a person who they considered at risk and this included discussing their concerns with adult services.
This meant that people were supported by staff that had access to information about responding to abuse and this was acted on.

People we spoke with told us they felt safe with the provider's staff. A person said "I have always felt safe with them all" another person said "we have not had any information about abuse, but we are aware of adult services and we would call them if we were concerned".

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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 looked at the records of five staff that provided support and personal care to people using the service. This included three staff that had been recently employed (six months) and two staff who had been employed for over one year. We spoke with four staff about how they were supported in their role.

Staff Induction was delivered in two parts over two separate days. The manager told us that the first day of induction covered "the way we work and our expectations". We saw that this included; a welcome to the agency, 'your employment', health, safety and hygiene, confidentiality and paperwork. We were told that the second day was focused on the delivery of care in the community and the staff handbook and included dementia care. In the staff records we reviewed we saw that three out of the five staff had not been recorded as having completed day two of the induction. Staff we spoke with told us they had either attended a two or a one day induction. It was therefore not evident that all staff had completed a full induction prior to working unsupervised.

We saw that the staff handbook included information about; the principles of care, health and safety, moving and handling, Infection control, adult abuse, and food safety. Staff we spoke with told us that they used the handbook for reference. Whilst we saw that staff were given introductory information about the learning requirements covered by the Common Induction Standards (CIS) staff were not required to complete a recorded assessment of their knowledge and understanding in all the learning outcomes as required in the CIS. We saw that all staff had completed, moving and positioning and hoist training and some staff had completed safeguarding training which did require staff to evidence their competence, knowledge and understanding in these areas. This meant that it was not evident that staff fully completed induction training that satisfied the relevant standards in the sector to ensure that staff were signed off as fully inducted and ready to practice.

The records showed that not all staff had completed the appropriate training for their role which met the recognised standards in the sector. For example, not all staff had completed training in; health and safety, food hygiene and nutrition, safeguarding

vulnerable adults, infection control training and dementia care. For example, a staff member employed for six months had not completed health and safety and food hygiene training and they had not had previous experience in a care role. Another staff member who had been employed for six months had not completed; health and safety, food hygiene or safeguarding training and they told us "I had a bit of care experience in the past". We looked at the appraisal records of two staff members and saw that one staff member had identified the need for health and safety and food hygiene training in February 2013 and this was not recorded as having been completed. Another staff member had identified the need for refresher training in food hygiene and health and safety in their appraisals of January 2013 and January 2014 and these had not been completed. This meant that staff were not effectively supported to achieve the appropriate training for their role.

We saw that regular observations were carried out by the manager to assess the quality of care staff delivered and this included; their appearance and presentation, their care skills and abilities such as; communication, delivering care respectfully, their ability to complete care plan tasks, their record keeping and general observations/comments. Staff we spoke with told us they carried out shadow shifts to introduce them to people and learn about their individual needs and requirements. The manager told us that new staff complete shadow shifts "as many times as they need to". This meant that people were supported by staff who knew their needs and were assessed as competent in some aspects of their role.

The provider's supervision policy stated that staff would have a recorded supervision session every other month and the handbook stated this would take place 'one to one' in the office and cover; performance, knowledge and skill development and any personal matters affecting work. We noted that whilst staff had regular formal contact with their manager through community reviews (observed practice) the supervision structure described in the provider's supervision policy and staff handbook was not delivered as described.

Staff we spoke with told us that they were regularly observed by the manager but they did not receive supervision as described in the policy. Staff told us they felt supported by managers and that they could contact them for advice and support. A staff member said "the managers are always there at the end of a phone" another staff member said "they (managers) have proven to me that if I have any concerns they would deal with it - they are brilliant". This meant that whilst staff felt they were supported, because supervision was not delivered in line with the policy, people could be at risk of receiving a service from staff that were not adequately supervised in their role.

People we spoke with told us they were satisfied with the provider's staff. A person said "I have never seen anything that tells me they are not properly trained". Another person said "they (staff) are all very nice and helpful, I am very happy with them".

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 to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We looked at the responses from a recent satisfaction survey carried out by the provider. At the time of our inspection they had received a 40% return. People were asked to agree or disagree and comment on statements about the qualities and abilities of staff and the quality of the service they received. We saw that responses were mostly complimentary and some comments had been made to suggest improvements or concerns. The provider told us that they would collate the information and inform people and staff of the findings and actions by the end of March 2014.

We saw that people were also asked about their views and comments on the service at their care plan reviews. People we spoke with told us they were asked for their feedback. One person told us they had raised a concern about a staff member and this had been rectified. This meant that people who use the service and their representatives were asked for their views about their care and treatment and they were acted on.

The provider told us about the care monitoring system used by the local authority and how this provided them with information to monitor and improve elements of their service. For example, data was produced on; punctuality of calls, the number of care staff people saw over time and the length of the visit. The provider told us how they had used this information to make improvements such as; re zoning geographical areas so that people experienced improved punctuality and consistency and staff had less travel time. This meant that provider gathered and used information from monitoring to improve the service.

The manager carried out regular observations of staff working with people. The observations included checking that care was provided in a respectful way. Staff told us that they were asked for their feedback during the observations and we saw the records that confirmed the observations took place as described. Whilst we found that the provider had a system in place to monitor the quality of care delivered by staff, the provider might find it useful to note that; where the monitoring and management arrangements to ensure that staff were adequately supported through training and supervision were not effective, people could be at risk of inappropriate and unsafe care and treatment and we have

addressed this elsewhere in our report.

Risks to the health, welfare and safety of people and others were assessed as part of the needs assessment process and this included; risks posed by people's environment and equipment and risks related to the delivery of care and whether any particular skills were required by staff. We noted that some risk assessment records were not dated as reviewed in line with the other care plan documents.

Staff we spoke with told us that they were informed of any risks prior to delivering care and they described examples of risks they had identified and acted on. For example a staff member said "there was no lighting to the entrance we used at back of the property, now there is a key safe in the front - they (provider) acted very quickly to sort this out". Another staff member told us about the risks to a person's welfare and safety through their behaviour and how they had reported this and their concerns were acted on to support the person safely. The provider told us that they communicated information about potential risks to staff through briefings sent out by e-mail or with pay slips. Briefings had included; information about scabies and risks caused through heat and adverse weather conditions. This meant that where risks to the safety and welfare of people and others were identified they were acted on.

We looked at an example of a complaint and saw that the complaint had been logged, investigated, responded to and recorded in line with the provider's policy and procedures. The provider told us that they encouraged staff to feedback information when people were dissatisfied and they attempted to resolve complaints quickly and informally wherever possible. People we spoke with told us that they had information about the complaints procedure and who they would contact if required. This meant that the provider had a system in place to deal with people's complaints and provided people with information about that system.

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 activity	Regulation
Personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: The arrangements for ensuring that staff were appropriately supported through training and supervision to deliver care and treatment to the appropriate standards were not adequate. Regulation 23 (1)(a).

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 14 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. 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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