Inspection Report

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

Providence Surgery

12 Walpole Road, Boscombe, Bournemouth, BH1 4HA

Tel: 01202395195

Date of Inspection: 18 February 2014

Date of Publication: March 2014

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Requirements relating to workers	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Providence Surgery
Registered Manager	Dr. Mufeed Ni'man
Overview of the service	Providence Surgery is a practice based in Boscombe, Bournemouth. It has a branch surgery at Strouden Park, Bournemouth. There are approximately 9,400 registered patients. It is owned by two GP partners, who work there alongside several salaried GPs and a qualified doctor who is training as a GP. In total there are approximately 7.5 whole time equivalent doctors. The practice is supported by practice nurses, a healthcare assistant, a practice manager, receptionists and administrative staff.
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures 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 18 February 2014, observed how people were being cared for and talked with people who use the service. We talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

We spoke with two people who used the surgery and seven staff. These included the practice manager, the registered manager, two other doctors, and three other staff.

People's privacy, dignity and independence were respected. People said they were treated with respect and involved in making decisions about their care.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People expressed positive views about their care and treatment and said they could get appointments, although this was not always with their preferred clinician.

People using 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.

People were cared for, or supported by, suitably qualified, skilled and experienced staff. However, the practice had not undertaken the appropriate checks before staff started work to assure itself that new staff were safe to work with children and vulnerable adults. Not all the recruitment information required by the Regulations was available.

The practice had an effective system to assess and monitor the quality of its services, and to manage risks to people's health, safety and welfare.

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 03 April 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

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's privacy, dignity and independence were respected.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People's diversity, values and human rights were respected.

Staff treated people with consideration and respect. Both people we spoke with told us that staff treated them respectfully. We observed throughout our visit that staff spoke politely with people using the service, both face-to-face and on the telephone.

The practice ensured people's privacy. We saw that consultations took place in individual rooms with the doors closed and we were unable to hear details of consultations in progress. Consulting rooms were equipped with screens to place around examination couches, for privacy during examinations. A notice displayed by reception stated, "If you need to discuss something in a more confidential environment then please make the receptionist aware". Receptionists spoke discreetly with people and the reception staff we spoke with understood their duty to keep people's personal information confidential. They confirmed that they had undertaken information governance training, which explained their responsibilities for keeping personal information confidential. The practice used a computerised clinical record system and we saw that access to this was restricted to authorised staff. We saw that old paper clinical notes were stored in a locked room.

The practice accommodated the needs of disabled people. We saw that the ground floor of the building was wheelchair accessible and that most of the consultation rooms were downstairs. The practice manager confirmed that people who were unable to manage climbing the stairs to the first floor were seen downstairs. The front door was wide enough for wheelchairs, although it was not automatic. The reception desk was lowered to a height suitable for people using wheelchairs. There was a toilet adapted for people with mobility needs. There was limited disabled parking at the front of the practice.

The provider and practice manager reported that the practice had a significant proportion of people whose first language was not English. They confirmed that the practice used

telephone and face-to-face interpreting services, as well as translation facilities, if these were required. We spoke with a doctor, who confirmed that these were readily available and was able to give us examples of how they took account of people's gender and cultural diversity when they were treating people. The provider and practice manager also commented that the practice staff had a range of first languages other than English. We saw posters and written information in Polish and English in the waiting room and at reception.

People expressed their views and were involved in making decisions about their care and treatment. One person told us, "They explain things to me" and said that they were involved in decisions about their care. Clinical staff explained how they involved people in treatment decisions. The clinical notes we viewed showed that people had been involved in decisions about their treatment.

Both people we spoke with told us that appointments were generally long enough. For example, one individual said their appointments were "long enough for me to tell them", although on one occasion they had felt rushed.

People had access to general information about their health and about services available at the practice. There was a range of health promotion and information leaflets and posters on display in the waiting area. The practice opening hours were clearly displayed at reception, as were details of local out-of-hours primary care facilities. The practice had a website with information about the staff, services available, opening times and useful telephone numbers. This had a facility for online appointment booking and repeat prescription requests, provided people had obtained a PIN number from reception.

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

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

Both people we spoke with were positive about the care and treatment they received. For example, one said their GP was "a nice doctor". They said that they were pleased that tests, such as blood tests, could be done at the surgery, "rather than going to a strange place I don't know". They also told us their doctor referred them for specialist care when this was required.

The surgery kept computerised clinical records. The system prompted clinicians to enter clinical data completely and correctly, alerting them when important data was missing. We saw that the system alerted clinical staff to aspects of people's medical conditions, treatment and social circumstances of which they needed to be aware. For example, it flagged up adverse drug reactions and risk issues such as child protection plans. This meant that staff could ensure they treated people safely.

We examined several electronic clinical records covering consultations with several clinicians. Notes were appropriate and comprehensive, with clear management plans.

The surgery had procedures to ensure that new patients were treated safely. People received a registration pack that contained a form for them to record details of their medication, allergies and medical history. The registered manager and practice manager stated that the practice aimed to register the person on the clinical record system within 48 hours, if not on the same day. This information was then available when they saw their doctor. They explained that the practice had found this system more effective than inviting people for new patient health checks. Reception staff were familiar with the process for registering new patients. This included checking documents to prove people's identity, and visa checks where appropriate.

We noted that the patient list was drawn from an area of transient population and high deprivation. The practice sought to make it easier for people to access services by providing as much in-house assessment as possible. This reduced the need for repeat attendance or hospital visits. There was a range of in-house services, including diagnostic

ultrasound, blood monitoring for people on warfarin, addictions counselling, minor surgery and MRI scans of limbs. One of the doctors had a specialist interest in orthopaedics. All of the doctors were trained to at least Part 1 of the Royal College of General Practitioners certificate in substance misuse, with several holding Part 2 accreditation.

Repeat prescribing was managed safely with written or online requests for medicines. This was monitored daily by the duty doctor. Prescriptions for hazardous medicines such as warfarin were issued only as 'acute' items to prevent re-issue without monitoring. One person told us they had to see their doctor every so often to review their medicines before further repeat prescriptions were issued.

Clinicians liaised with external services, such as health visitors, district nurses and the palliative care team to ensure people's needs were met. The registered manager confirmed there was a fortnightly clinical meeting for clinicians including district nurses and health visitors to communicate regarding particular individuals' care. They and another doctor independently confirmed that the registered manager checked all referral letters before they were sent, to ensure that the referral was appropriate.

The surgery operated a flexible appointment system. Each day a duty doctor was available for immediate access urgent appointments. Reception staff triaged the urgency based on people's perceived need and did not ask them for clinical details. The duty doctor was not available for routine appointments. Half of the remaining appointment slots with the other doctors were pre-booked and half booked on the day, including appointments for telephone consultations. People told us they were generally able to get an appointment, although this was not always with their preferred doctor. A receptionist said that in an emergency they were always able to ask the duty doctor if they could add an extra appointment slot.

There were arrangements in place to ensure people received urgent medical assistance when the practice was closed. When we rang the surgery outside opening hours we found there was an answerphone message informing people of which service they should contact according to the circumstances. Details were also displayed on the practice website. In addition, the surgery offered extended opening hours on Monday early evenings.

There were arrangements in place to deal with foreseeable emergencies.

The practice manager told us that staff had regular training in basic life support. Staff we spoke with confirmed this. We saw the computerised patient record system highlighted particular risks to people's health and welfare, such as allergies.

The practice held appropriate emergency drugs, including an anaphylaxis kit. These were regularly inspected according to a schedule and their expiry dates were monitored.

We found that the practice had neither oxygen nor an automated external defibrillator, which is a piece of equipment used to restart someone's heart. The provider informed us following our visit that they had ordered this equipment. This meant they had made arrangements to have available all the equipment they might need to deal with a medical emergency.

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

We did not speak with people who used the practice about safeguarding children and vulnerable adults. However, we discussed safeguarding with staff, including two doctors. One of these doctors was the practice safeguarding children lead.

People who used the practice 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.

Staff received training in safeguarding children and vulnerable adults and this was refreshed periodically. The safeguarding lead for children and the practice manager informed us that both of the safeguarding leads, and some of the other doctors, had undertaken safeguarding training at level three (the highest level). Other doctors and clinical staff had level two training, and reception and administrative staff were also trained in safeguarding children and vulnerable adults. The safeguarding lead and practice manager also said they had been in contact with the clinical commissioning group with a view to organising face-to-face safeguarding adults training for the whole practice. All the staff we spoke with said they had undertaken training in safeguarding children and vulnerable adults and that this was updated periodically. We saw that three staff files for staff recruited in the past year contained evidence of safeguarding training.

The practice had policies and procedures in place for safeguarding children and vulnerable adults. They set out how staff should respond when they suspected a child or vulnerable adult was at risk of harm. The provider may find it useful to note that the vulnerable adults policy gave contact details for a neighbouring local authority in a flowchart for notifying a concern for a vulnerable adult. It also contained some out of date contact details in a list of who's who for safeguarding vulnerable adults in primary care. However, we found that current details of local agencies involved with safeguarding children and vulnerable adults were available to staff. For example, they were displayed in the reception office.

Staff working at the practice understood how to recognise and respond to safeguarding concerns. Both doctors we spoke with displayed a clear understanding of safeguarding issues they might encounter when treating children and vulnerable adults and were clear

about how to escalate safeguarding concerns. They commented that they were readily able to discuss safeguarding children queries with the health visitor, who was based in the same building. All the staff we spoke with were able to describe potential signs of abuse and the process they should follow in event of a concern, in line with the practice policies for safeguarding children and vulnerable adults.

The staff team regularly discussed safeguarding matters. Minutes of clinical meetings showed that staff discussed various aspects safeguarding children and adults. For example, meetings had addressed reporting adult safeguarding concerns and what should be recorded in children's records in order to facilitate safeguarding work, should a concern arise in future.

Both doctors told us that GPs did not routinely attend child protection conferences because of diary constraints, but submitted written reports to these meetings. They said that the health visitor usually attended the conferences in their place.

Requirements relating to workers ✖ Action needed

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was not meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff. However, the practice had not completed the appropriate checks before staff started work to assure itself that new staff were safe to work with children and vulnerable adults.

Not all information required by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was available.

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 did not speak directly with people who used the practice about the requirements relating to workers.

We examined recruitment files for four staff, including three who had started working at the surgery after 1 April 2013. Three of these files did not contain all the information required by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. For example, they did not contain proof of identity including a recent photograph, nor references from previous employment in health or social care. The practice manager explained that two staff members did not have references because they were already known to the provider. Consequently, the provider had not ensured that all information required by the Regulations was available.

Following the inspector, the provider informed us that they were updating staff files with photographs and CVs.

Appropriate checks were not undertaken before staff began work. Three of the files we examined were for clinical staff. For two of these clinical staff, who had started working at the practice in early September 2013, we saw evidence of the appropriate Disclosure and Barring Service (DBS) clearance dated late November 2013, after they had started work. The provider was unable to confirm that the staff only had unsupervised contact with people after they had received their DBS clearance. This was in contrast to the practice DBS recruitment policy, which stated: "A clear statement is included within the vacancy information packs that a DBS check will be required prior to a job offer".

In addition, another file for a receptionist contained no record of DBS clearance. The provider had not assessed the risks associated with not obtaining DBS clearance for non-

clinical staff. Consequently, the practice was unable to demonstrate that it had assured itself that new staff were safe to work with children and vulnerable adults before they started work.

Following the inspection, the provider told us they would not allow new staff to work alone with people until the staff had received DBS clearance.

We checked the professional registrations for all the doctors and nurses working at the surgery and found that all were appropriately registered. The doctors were all included on the national performers list. The national performers list shows that GPs practising in the NHS are suitably qualified, have passed relevant checks such as DBS checks, and have up to date training and appropriate English language skills. This all showed that doctors and nurses working at the practice were appropriately qualified and registered to work.

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.

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

The provider took account of complaints and comments to improve the service. People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

We asked to see records of complaints and examined paper trails of three complaints. These had each been handled appropriately and resolved. The practice had a complaints procedure and publicised this on the practice website. The registered manager confirmed that they investigated complaints against doctors and discussed these with the individual doctor concerned. Where there were useful learning points, these were shared with the clinical team. We saw minutes of practice meetings that confirmed this.

Additionally, a virtual patient participation group was in operation to obtain people's views about the practice through online surveys. The practice manager commented that they found it challenging to recruit people to the patient participation group. They said they thought this reflected the locality served by the practice, which has a transient population. We saw the findings and action plan from the last patient survey in early 2013 and noted that the practice was acting on the feedback received. For example, the registered manager and practice manager told us how the practice now organised appointments so that people were more likely to be able to see their chosen doctor for routine appointments. Additionally, the practice had introduced an online system for people to request appointments and routine prescriptions.

The staff we spoke with told us they were happy working at the practice and felt well supported by management. For example, a doctor commented that the registered manager "always has the time to talk to you about things" and said, "The ethos at the practice here is lovely. It's so easy to get a second opinion on things". Staff said that they were readily able to raise issues for discussion at practice meetings. For example, one staff member told us, "We're not judged in the slightest. Everybody's point of view is respected". Time at the quarterly staff meetings was allocated for learning. For example,

we saw that speakers had attended to deliver sessions on allergies and on mental health.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. There were fortnightly meetings for clinical staff and quarterly meetings for all staff. Minutes showed that agendas considered varied aspects of service quality, such as referrals, handling letters and processing results. They also discussed sudden deaths and learning from significant events. We examined the significant events folder. This was clearly presented, with analysis of incidents and clear action plans with checklists for actions to be completed.

The practice undertook audits of the care and treatment it provided. It participated fully in the Quality and Outcomes Framework (QOF), a national scheme that measures how well surgeries perform against various clinical indicators, for example in the management of chronic diseases. We noted that QOF scores were around the average for practices in Dorset. Individual doctors ran occasional supplementary audits as part of their professional revalidation requirements and the results of these were shared if useful.

We noted that the practice undertook warfarin blood monitoring in-house for people taking warfarin to reduce the risk of blood clots. Local clinical guidelines required that this was audited annually. The provider may find it useful to note that there was no written protocol available for dosing and that when we initially spoke with staff they expressed some uncertainty about when to refer abnormal test results to a doctor. Doctors later assured us that all abnormal results were referred to GPs to determine what dose of warfarin the person should take.

The registered manager monitored referral quality and reviewed all referrals. Selected referrals were also bench-marked against neighbouring practices as part of a local clinical commissioning group scheme. The registered manager also monitored prescribing and reported that the practice had achieved significant budget savings in the past financial year. We noted that the practice had reflected on a relatively high level of accident and emergency attendances by people registered with the practice and had been considering strategies to reduce this.

There was a fridge for storing medicines and vaccines that needed to be refrigerated. We saw that records of daily temperature checks, to ensure that the fridge was operating within a safe temperature range, were complete. The medicines had not reached their expiry date. The practice stored a minimum of other drugs.

From visual inspection we saw that the premises were clean. A staff member showed us completed daily checklists for several months, showing that staff checked each day to ensure that the premises were kept clean. We saw that there was a dedicated storage cupboard for the colour-coded buckets and mops. We noted that the practice used outside cleaning contractors.

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 Family planning Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010** **Requirements relating to workers**
	How the regulation was not being met: The provider had not awaited the results of Disclosure and Barring Service checks before staff started working alone with people to provide care and treatment. This meant that their recruitment procedures did not ensure that no person was employed for the purposes of carrying on a regulated activity unless that person was of good character. Regulation 21(a)(i) Not all information required by The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 was available. Regulation 21(b)

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 03 April 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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