Care Quality Commission

Inspection Report

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

Merridale Medical Centre - RP Tew

Merridale Medical Centre, 5 Fullhurst Avenue, Leicester, LE3 1BL

Tel: 08444778891

Date of Inspection: 08 October 2013

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

Standard	Result
Respecting and involving people who use services	✗ Action needed
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safeguarding people who use services from abuse	✗ Action needed
Complaints	✗ Action needed

Details about this location

Registered Provider	Merridale Medical Centre - RP Tew
Registered Manager	Dr. Rachel Clarke
Overview of the service	Merridale Medical Centre is a GP practice in Leicester City. It offers general and enhanced services, including minor surgical procedures and family planning. The practice is based in a large new building with an on-site pharmacy and space used by other health and social care providers.
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Family planning Surgical procedures Treatment of disease, disorder or injury

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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 8 October 2013, talked with people who use the service and talked with staff.

What people told us and what we found

We spoke with five patients during our inspection. Everyone we spoke with was satisfied with the service they received. Comments patients made included: "No bad comments definitely," "We're quite satisfied with the practice" and "It's a good service. "

We found the practice had no formal procedures for staff to access translation and interpretation services. This meant staff were using different methods to access information in patients' first languages.

There were systems in place to ensure patients had access to health advice and treatment from appropriate professionals. Some patients did not understand the roles of different health professionals because the practice had not provided enough clear information.

We found the practice needed to improve their systems for protecting people from abuse. This was particularly lacking in relation to vulnerable adults.

We found there was a clear complaints policy and procedure. Most patients were aware of this. Managers were aware they needed to improve their analysis of complaints to ensure they recognised any themes and any learning from complaints. We found the practice did not effectively co-ordinate complaints where patients were complaining about more than one provider.

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

What we have told the provider to do

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.

Patients' views and experiences were not always taken into account in the way the service was provided and delivered in relation to their care.

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

Reasons for our judgement

Patients did not always understand the care and treatment choices available to them. We spoke with five patients. One patient did not understand why appointments were offered with other health professionals such as the practice nurse or nurse practitioner when they wanted to see a GP. We saw that this issue had also been raised by patients on the NHS Choices website. We found that the receptionists had information to help them to decide who to make appointments with. There was no clear information for patients about why they might be offered appointments with healthcare professionals other than a GP. This meant patients were not clear about the appointments and the choices they had when attending the practice.

Patients expressed their views and were involved in making decisions about their care and treatment. Three of the five patients we spoke with were members of the Patient Participation Group (PPG). This is a group set up to represent the views of patients and raise concerns or suggestions about the service. The PPG members we spoke with told us their views were listened to by the receptionist manager who attended their meetings: "She takes everybody's point of view on board." However, members could not describe any formal mechanism for ensuring people with decision-making responsibility listened to their views. One patient told us: "The availability of appointments is troublesome at best." Although it had been discussed at PPG meetings, in this member's view: "The access problem has never been properly dealt with." They had found this frustrating and considered the PPG to be a: "Paper exercise."

It was clear from our interviews with staff that the appointment system had been recognised as an issue and action had been taken to address it. This included introducing a new landline telephone number for patients to make contact. However, patients we spoke with told us they still experienced difficulties making appointments, particularly with GPs. Feedback about action taken to resolve issues was not always given and the

effectiveness of action was not assessed. This meant patients felt frustrated because they were not kept informed or felt they had not been listened to.

Patients were given appropriate information and support regarding their care or treatment. There was a range of information available to patients in the waiting areas. This was organised by patient group, for example with separate boards for young people and carers, so patients could quickly identify information relevant to them. Health advice and information was available on the provider's website. We spoke with five health professionals. They told us they had access to different sources of patient information. This meant patients were supported because they had access to information rom a range of sources.

The practice had recently made a decision to remove patients from their list if they were living outside the local area. This was because there were a lot of new patients registering with the practice and they could not meet the rising demand. One patient had contacted the Care Quality Commission with concerns about this decision. Whilst we found the practice had responded appropriately to individual patients' concerns and complaints about the decision, we found there had been very little information made available to patients about this. A letter that had been sent to all affected patients did not offer support to patients or suggest where they could seek advice and information. This meant patients had to seek alternative care without any acknowledgement of the inconvenience this might cause or any reassurance about how continuity of care would be ensured.

Patient's diversity, values and human rights were respected. However, the provider had not taken effective action to provide interpretation and translation services. The practice had good information about the diversity of their patient group. Of more than 14,000 patients registered with the practice, 616 were Polish and a significant number were from other black and minority ethnic (bme) backgrounds. Four of the five patients we spoke with were from bme backgrounds. None of the people we spoke with felt they had been discriminated against due to their ethnic background or religious beliefs. Comments included: "We haven't encountered any problems." One patient said they sometimes had difficulties understanding what the GP was telling them. They said they asked the GP to write it down and they would ask a friend to translate it later. Some leaflets about the service were available in other languages including Polish and there was a link on the website to information about the NHS and GP services, in a range of languages. However, most patient information was not available in other languages or formats. One patient commented: "They don't have very much in other languages."

The five health professionals we spoke with told us they accessed translation and interpretation services differently. This included using internet translation services, using local translation services and asking patients to call friends to interpret over the phone. Patients did not have access to information in an appropriate format because the provider did not have effective systems to access translation and interpretation.

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 patients' safety and welfare.

Reasons for our judgement

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We spoke with five patients during our inspection. Everyone we spoke with was satisfied with the service they received. Comments patients made included: "No bad comments definitely," "We're quite satisfied with the practice" and "It's a good service." Some of the patients we spoke with had been registered with the practice many years. Everyone we spoke with told us the care and treatment they received from the two permanent GPs was good. Comments from patients and staff showed that one GP in particular was very well respected and patients tended to request appointments with them.

Care and treatment was planned and delivered in a way that was intended to ensure patients' safety and welfare. Prior to our inspection, we had received a complaint about maternity services, so we asked staff about care of pregnant women. We found that all health professionals followed the same protocols for giving advice to pregnant women and referring them to appropriate secondary care services, such as midwives and specialist maternity clinics. This helped to ensure patients received consistent care.

Health professionals at the practice had areas of expertise and specialism. Receptionists had information about these specialities so they knew who to make appointments with. For example, one of the GPs ran a minor surgery clinic and one of the nurses managed the care of patients with diabetes. One of the five health professionals we spoke with felt they were not properly supported to provide specialist care, treatment and advice to patients. This could have meant patients did not receive the best care for their conditions. We spoke with managers about this and they told us changes were planned to improve specialist care for this particular patient group.

We saw that the provider had procedures for reporting incidents and near misses where patients had received or were at risk of receiving unsafe care. All incidents reported through these procedures were discussed at practice meetings. Notes from the practice meetings did not show what action was agreed as a result of discussions or show if any additional support was offered to staff to avoid future occurrences. Managers had identified that these procedures needed improvement to ensure all staff could learn from such events where appropriate.The provider may find it useful to note that patients were at

risk of poor care because systems for identifying errors were not always effective.

Two patients told us about occasions when their care and welfare had not been protected. One patient had made a complaint and the complaint was still being investigated at the time of our inspection. We looked at medical records for the other patient. They indicated that a serious diagnosis had possibly been missed. There was no evidence this had been reported or investigated in accordance with the provider's procedures. Managers agreed to further investigate the apparent missed diagnosis, using their normal procedures.

There were arrangements in place to deal with foreseeable emergencies. We saw there were written instructions about how to deal with possible emergencies. These were easily accessible on the walls in waiting areas and reception. All the staff we spoke with knew who first aiders were, knew how to identify a medical emergency and where the emergency equipment was kept. Relevant staff had been trained to deal with medical emergencies. Patients and staff were protected from the consequences of foreseeable emergencies because the provider had effective systems to deal with them.

Cooperating with other providers

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Patients' health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others. Two of the patients we spoke with had experienced care and treatment co-ordinated by the practice. One patient told us the practice had co-ordinated their care well, with the GPs passing on information from specialist doctors. The other patient told us about communication problems between the practice and other healthcare providers such as district nurses. This had made it difficult for them to get prescribed medicines and medical supplies when they needed them. Patients' experience of care shared by multiple providers varied.

From speaking with staff, we found that systems for sharing information with other healthcare professionals were very informal. Many different teams used rooms at the practice, so individuals were often on the premises for informal discussions about patients. All staff we spoke with, including a staff member working for another provider, told us that relationships between practice staff and other health and social care providers were very good. Health care professionals used the same computer system so could share information about patient care through that system.

There were very few formal systems to support health professionals to share information either about patients or about service provision. Notes from clinical meetings showed that other providers were sometimes invited, but there was no explanation of which providers would be invited or how frequently. One health professional employed by another provider told us about regular meetings with a GP to discuss patients. This was the only example of regular meetings between providers. The provider may find it useful to note that the lack of formal systems could result in a risk to patients' health, safety and welfare.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Patients were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

Patients were not protected from the risk of abuse because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Only one of the patients we spoke with felt they could comment about this standard. They felt concerns about their child had been dealt with appropriately. The patient told us: "They (the GP) answered all my questions."

All of the staff we spoke with told us they had done training in safeguarding children. This is training to support people to identify and report any concerns about potential abuse. We saw training records for only five staff of a team of more than 20. The provider's child protocol stated that clinicians should be trained in child protection every year and other staff every three years. The protocol did not state what level of training each staff role should complete. The provider did not keep any records of the training expected of each staff role and the training completed. This meant patients may not be protected from the risk of abuse because some staff may not have received training to help them to identify or respond to situations where patients may be at risk.

The staff we spoke with were aware of what to look for to identify safeguarding issues involving children and vulnerable adults. They were able to give examples of when they had reported or been involved in identifying risks. All of the staff we spoke with knew who the practice leads for safeguarding were. They were confident the leads would take appropriate action if they reported any concerns to them. Staff could identify risks and knew how to report concerns.

We spoke with the practice lead for safeguarding children. They talked confidently about their role, their responsibility within the practice and their multi-disciplinary work. They confirmed that all concerns about children's safeguarding were reported to them, but that all staff had a responsibility to report directly if reporting to them would cause a delay or further risk.

The provider had a copy of local multi-agency procedures for safeguarding vulnerable

adults. They had no internal policies or procedures for protecting vulnerable adults from abuse. There was no written requirement for staff to have completed safeguarding vulnerable adults training. One of the staff we spoke with was unsure whether they had ever done this training. Vulnerable adults were not protected from the risk of abuse because the provider had no internal guidance for staff and some staff had not been trained to respond to concerns about vulnerable adults.

The provider responded appropriately to any allegation of abuse. The two GPs we spoke with knew that any child with a protection plan would be easily identified by a flag on their electronic medical records. The lead for safeguarding children was responsible for arranging for such flags to be added. Other staff were not aware of the system for identifying patients known to be at risk or to present a risk to children or vulnerable adults. Patients may not be protected because not all staff were aware of the system for recording and identifying known risks.

We looked at the medical records for a child with a protection plan. We saw there was an alert available to staff looking at the record so they could see the child had a protection plan. Confidential details of the protection pan were kept separately, in accordance with the provider's protocol, to ensure only staff who needed details could access them. The practice manager showed us how the electronic records system could be used to prepare reports showing all children with a protection plan.

There was no similar system for identifying vulnerable adults at risk of abuse.

Complaints ✖ Action needed

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

There was not an effective complaints system available. Comments and complaints patients made were not responded to appropriately.

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

Prior to our inspection, two patients had contacted the Care Quality Commission (CQC) with complaints about this service. Both had made formal complaints to the provider. During the course of our inspection, another patient told us about a complaint they had made. They were not satisfied with the provider's response. We talked to managers at the service about all three of these complaints as well as their response to complaints in general.

Patients were made aware of the complaints system. This was not always provided in a format that met their needs. Four patients we spoke with either were aware of the complaints procedure or were confident they could find it if they needed it. Another patient where English was not their first language told us: "I don't know how to make a complaint. I would try and speak with my GP about this." We found there were several copies of the complaints procedure available in the waiting area, for patients to take away. The complaints procedure was also prominently displayed on the provider's website. The procedure was not available in any format or language other than written English. Patients knew how to complain because the provider made their procedure available, although patients who did not speak or read written English might have difficulty using it.

Patients were given support by the provider to make a comment or complaint where they needed assistance. The complaints procedure included a statement that patients could ask a friend to complain on their behalf. Details of the health ombudsman were included for patients who were not satisfied with the provider's response. Most of the staff we spoke with were aware of the complaints procedure. Staff told us they would ask the practice manger to contact any complainant who was unwilling or unable to put their complaint in writing. We found from speaking with managers and GPs, that complainants were generally offered opportunities to meet with someone to discuss their complaint. We looked at the investigations of the three complaints patients had told us about and found evidence that the complainants had taken the opportunity to discuss their complaints. Patients could make complaints in different ways and be confident their complaints would be dealt with in accordance with the provider's procedure.

One GP told us they would record any complaint from a patient on their medical records and discuss with the practice manager. This showed not all staff were aware of the provider's complaints procedure and meant patients were at risk of discrimination because their complaints were kept on the personal medical records.

Patients' complaints were fully investigated but records did not show whether patients were satisfied with outcomes. We looked at the records relating to the complaints reported to us by patients. We found the records provided a full description of the investigations but did not provide the outcome, whether the complainant was satisfied or any learning from the complaints. Some staff told us complaints were always discussed at practice meetings to ensure learning was shared. Other staff told us complaints were not discussed at practice meetings. One GP we spoke with was not aware of one of the complaints we had heard about. Patients' complaints were investigated but there was not always a clear resolution. Records did not show whether complainants were satisfied with the outcome of investigations.

Where different services were involved in delivering care or treatment the provider did not take appropriate action to co-ordinate a response to the patient raising the complaint. One of the complaints patients told us about involved another provider. The practice had advised the patient to use the other provider's complaints procedure. There was no evidence the practice had taken any action to co-ordinate a response. The complaint records described the practice's investigation of complaints about their service but did not provide any information about the complaints about the other provider. The practice manager told us that they had contacted the other provider to forward the patient's complaints, but had been advised the patient would have to submit a separate complaint. Patients did not receive a co-ordinated response to complaints involving more than one provider. This meant any issues relating to joint working between providers may not be adequately addressed.

We asked for and received a summary of complaints patients had made and the provider's response. We saw a review of complaints from 2012. The review included information about the number of complaints received and broad reasons for the complaints. The review lacked any analysis or evidence that complaints were used for learning and service improvement. Three of the thirteen complaints had no outcome recorded. The practice manager had identified that improvements were needed for the useful analysis of complaints. We saw evidence that some staff groups received detailed information about complaints and any associated improvements to the service. Patients could be confident some changes were made as a result of complaints, but the provider's procedure did not ensure this for all complaints.

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 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:** The provider had not made suitable arrangements to ensure that patients were enabled to make, or participate in making, decisions relating to their care or treatment. (17)(1)(b) The provider did not always, involve patients in decisions relating to the way in which the regulated activity is carried on in so far as it relates to their care or treatment.(17)(2)(f) The provider did not take care to ensure that care and treatment is provided to service users with due regard to their linguistic background (17)(2)(h)

Regulated activities	Regulation
Diagnostic and screening procedures Family planning Surgical procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse** **How the regulation was not being met:** The provider had not taken reasonable steps to identify the possibility of abuse and prevent it before it occurs. (11)(1)(a) The provider did not respond appropriately to all allegations of abuse. (11)(1)(b)

This section is primarily information for the provider

Regulated activities	Regulation
Diagnostic and screening procedures Family planning Surgical procedures Treatment of disease, disorder or injury	**Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010** **Complaints**
	How the regulation was not being met: The provider did not have an effective system in place responding appropriately to complaints and comments made by service users. (19)(1) The provider did not bring the complaints system to the attention of patients in a suitable manner and format. (19)(2)(a) The provider did not ensure that any complaint made was, so far as reasonably practicable, resolved to the satisfaction of the patient. (19)(2)(c) The provider did not take appropriate steps to coordinate a response to a complaint where that complaint related to care or treatment shared with, or transferred to, others. (19)(2)(d)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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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