Inspection Report

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

Heatherwood Hospital

London Road, Ascot, SL5 8AA

Tel: 01753633566

Date of Inspection: 07 May 2013

Date of Publication: July 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Cleanliness and infection control	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Overview of the service	Heatherwood Hospital provides inpatient orthopaedic surgery and medical rehabilitation services on two wards. The hospital also has an outpatients service, a day surgery, and a minor injuries unit.
Type of service	Acute services with overnight beds
Regulated activities	Diagnostic and screening procedures 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

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 7 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other regulators or the Department of Health. We talked with other regulators or the Department of Health and talked with other authorities.

We reviewed all the information we have gathered about Heatherwood Hospital.

What people told us and what we found

We inspected Heatherwood Hospital as part of a responsive review of Heatherwood and Wexham Park NHS Foundation Trust. During our inspection, we visited Ward 4 (an elective orthopaedic ward) and Ward 8 (a stroke and medical rehabilitation ward); we spoke with 13 patients; and interviewed 10 members of staff including nurses and matrons.

Patients were very complimentary about the care they received at Heatherwood Hospital. They told us they felt involved in making decisions about their treatment and care and staff treated them with respect. We found patient care and treatment reflected relevant published research and guidance, including guidance issued by the National Institute of Health and Clinical Excellence (NICE).

There were systems in place to control and prevent the spread of infection. The facilities we saw were clean and cleaning schedules were used to inform the standard of cleanliness. Risks were identified, assessed, and reviewed to ensure patient safety. While some of the patient documentation we saw showed adequate record keeping, we found some patient records which were not regularly updated and some care plans which were not sufficiently detailed to enable staff to deliver the care required.

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ 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.

Reasons for our judgement

During our visit, we found staff respected patients' privacy. We spoke with 13 patients. They all told us staff respected their privacy and treated them respectfully. One person said "staff make sure I have enough privacy." We observed staff asking permission to enter when curtains were drawn around patients' beds. We heard one nurse ask a patient whether she needed help and observed the nurse wait for the patient to respond before providing assistance. One patient told us they did not like the lights to be on at night so staff always pulled the curtain closed for them.

On both of the wards we visited, we found patients were given appropriate information and support about their care and treatment. Staff were able to explain the processes they followed to assess and plan patients' care. We spoke with three nurses on Ward 4 who told us patients' care plans and needs were discussed with them before they were admitted, and again on admission to the ward. One nurse told us, "we ask so many questions. At pre-assessment patients are given a lot of information and we check on admission that they know what to expect." All the nurses we spoke with said they encouraged patients to ask questions about their care and treatment and to be involved in discussions about their care.

Patients we spoke with told us they were able to express their views about their care and felt involved in making decisions about their treatment. They felt staff listened to them and, when they had concerns, addressed them. One patient told us, "staff are good at explaining" and another said "If it's something I don't want to take the staff discuss options with me." A patient on Ward 4 who required urgent surgery told us clinical staff gave them sufficient information about the procedure including the risks and benefits of surgery and how long recovery could take.

The hospital was responsive to people's comments, concerns, and suggestions. On Ward 4, we saw a public noticeboard which included a heading of "improving the patient experience." It noted patient feedback which had raised concerns about an insufficient number of toilets. When we queried how this issue was addressed, staff explained the

hospital had converted a store area into additional toilets.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights. People's needs were assessed to ensure care and treatment was planned and delivered in line with their individual care plan. However, people's care plans were not always updated to reflect changes to their planned care.

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

Staff told us patients' needs were assessed before they were admitted and were re-assessed on admission. We saw evidence of this in the patient records we saw on wards 4 and 8. Patients said they were aware of their care plans and staff discussed their care needs with them. One patient told us "the staff all give a good standard of care" and another said "they have answers to all my questions." All the people we spoke with confirmed they were informed of their planned and on-going treatment, although one patient said "sometimes the talk is a bit technical for me." We saw nurses talking with patients about their treatment and the next steps they should expect. The conversations we observed included discussion of discharge arrangements and the support patients would need once they left hospital.

Patient records included initial assessment forms which were completed on admission to the ward and care plans. The care plans we saw on Ward 4 followed a care pathway, a standardised protocol, which set out the expected care and support patients would need as a result of a specific surgical procedure. The care pathway enabled staff to review patients' individual needs against the expected pathway for the surgery they needed and identify any problems early on. Additional care plans were used on Ward 4 where patients had other health or medical conditions which required specific care and support, for instance, diabetes.

In some of the patient records we looked at, care plans were updated between admission and discharge to reflect improvements in patients' conditions. However, some of the care plans we saw were not updated in this way. For example, on Ward 4 one patient told us they were diagnosed for an illness whilst in hospital and met a referral nurse, but we did not see evidence that their care plans were updated as a result. Although changes to care plans were not always documented, staff were aware of changes which were made to patients' care.

On Ward 8, the patient records we saw also included risk assessments for falls, mobility, and nutrition and dehydration. These were reviewed regularly; in some cases they were reviewed on a weekly basis. We saw evidence of multi-disciplinary notes and, where changes to care were needed, these were included in patients' care plans. However, there was one example where a patient's needs were not assessed correctly for mobility. This patient was generally independently mobile but their manual handling assessment stated they needed the assistance to move from their bed to a chair and to walk.

Patient records we saw included notes of discussion with patients about their discharge. One patient we spoke with told us "they have asked me all sorts of things about going home and we have arranged my bed to be moved downstairs." Another patient said "I don't know the plan for me going home, they haven't told me. My son and daughter have spoken to the doctor."

Staff we spoke with were knowledgeable about patients on their ward. Staff told us daily meetings were held on each ward at each shift change so they could update each other on the care and treatment needs of each patient. On Ward 4, we found care plans were updated daily. Staff told us they had time to read through care plans on each shift and they were able to keep up to date with patients' care needs as they changed. One nurse said "communication is good on the ward. We are a small environment, and we all work well together." All the staff we spoke with said communication worked well between the multi-disciplinary teams.

On Ward 8, we found care plans did not always reflect the changing needs of patients as they moved towards discharge. However, staff were able to tell us about patients' needs and changes to each patient's care; they said changes to care plans were discussed at staff handover meetings.

There were systems in place to ensure new members of staff could read and understand care plans. One new staff member told us they were provided with a list of abbreviations to ensure they understood patients' care plans.

We found patients were referred to specialists when required. One of the patient records we looked at on Ward 8 showed the patient had an assessment from a speech and language therapist (SALT) because they could not swallow properly. The assessment determined the type of food and drink the patient could safely consume. As a result of the assessment, there was a food and fluid modification plan so staff would know what foods the patient could eat and how the food should be prepared. When we spoke with the patient their relative, they were able to tell us what support they needed to eat and drink. What they told us reflected the arrangements which were documented in the SALT assessment. However, when we checked the patient's care plan for nutrition, it conflicted with the SALT assessment and the food and fluid modification plan. The care plan was not updated to reflect the changes made to the patient's diet as a result of the SALT assessment. This represented a risk that a member of staff might accidentally follow the instructions of the outdated care plan and thereby put the patient at risk of choking.

We found ward staff on both wards worked closely with other health professionals, such as occupational therapists and physiotherapists, to support patients' return to health. Patients made positive comments about their rehabilitation with one patient saying, "I'm very pleased with the physio." Ward staff told us communication with the multidisciplinary team was good and daily meetings included physiotherapists, occupational therapists, and social workers. They told us having staff from these different health professions ensured

patients' progress was regularly reviewed.

Patients' care and treatment reflected relevant published research and national guidance. Staff explained how they used National Institute of Health and Clinical Excellence (NICE) guidance for managing patients who had a stroke. The matron on Ward 4 explained how the hospital had revised its protocols in response to NICE guidance for the prevention of embolism (blood clots). We saw audit results which demonstrated a high level of compliance with the protocol. Staff were also able to explain the protocol for fasting prior to surgery. They said the protocol applied predominantly where patients had a spinal anaesthetic and included the provision of nutritional drinks or water prior to surgery to ensure adequate nutrition and hydration. Staff told us they could keep up to date with changes in clinical practice through the hospital's electronic computer database. The said it contained guidance documents, ward meeting minutes, and other useful information to enable them to carry out their work.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance was followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

Staff on Ward 4 were able to explain to us how patients were screened for infections, such as Meticillin resistant Staphylococcus aureus (MRSA), before being admitted. We were told patients were not admitted to the ward if they tested positive for MRSA and patients who contracted MRSA in hospital were moved to side bays to prevent the MRSA from spreading to other patients.

Patients told us they thought the wards, including toilets and shower rooms, were clean. One person said "it's marvellous, they dust and mop every day." Staff told us they had no concerns about the level of cleanliness on the hospital's wards and one nurse said, "I wish the cleaner did my home." We spoke with a manager from the cleaning services team. We were told staff had appropriate equipment available to eliminate a range of potential bacteria and cleaning staff were trained to use the equipment. We spoke with the cleaning supervisor who told us there was a programme of regular audits by the cleaning monitoring team. We saw audits which demonstrated a high level of compliance with cleaning protocols.

On both of the wards we visited we looked at patient bays, bathrooms and toilets, ancillary, and storage areas. These areas were clean. The provider may wish to note we found the shower room on Ward 8 included areas of water damage. The vanity unit below the sink was warped and stained by moisture. The flooring area where the vanity unit met the wall between the shower and entry door was cracked and hanging away from the wall. These areas could potentially harbour infectious material.

We observed cleaning taking place on all the wards we inspected. There was a daily and weekly cleaning schedule for cleaning staff to follow. The schedule was signed and dated by cleaning staff as each task was completed. We spoke with one cleaner who told us their manager carried out regular checks to ensure cleaning was completed according to the schedule.

Staff told us there was an infection control lead nurse who attended monthly meetings on infection control and who fed back the findings of those meetings to ward staff. We saw minutes of infection control meetings and minutes from staff meetings that discussed

infection control. Audit results for staff compliance with the hospital's hand hygiene and MRSA screening protocol was displayed on the ward and showed a high level of compliance.

The nurses we spoke with were able to explain the actions they took to prevent the spread of infection on the wards, including appropriate cleaning of mattresses. They said they had infection control training. Disinfectant hand rub was available at the entrances to both wards, at patients' bedsides, and outside of side rooms. On both the wards we visited, staff were seen to use disinfectant alcohol gel between patient contacts.

During out visit, we found that Ward 4 achieved a hospital award for infection control in August 2012. We found that the hospital maintained a high level of compliance for infection control audits carried out monthly by the hospital trust. Monthly cleaning audits were carried out by the matron for all the wards we inspected and we saw documentation of this. The cleaning services manager told us that when audits identified concerns, they were generally addressed within 48 hours of identifying the problem.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

There was a system for identifying and assessing risks to patients. Matrons told us risks were captured and recorded on a local risk register and monitored at divisional meetings.

Clinical protocols regarding venous thromboembolism (blood clots), hand hygiene, pressure ulcers, and falls were audited. Matrons told us they submitted their ward data in respect of these protocols each month and then received a report which enabled them to compare their results against other wards. We were told that results would be displayed and discussed at staff meetings and action would be taken if improvements were required. The matron on Ward 8 gave us an example were improvements were being made as a result of these audits. A falls audit found a need to reduce the number of patient falls. As a result, falls data was being analysed to identify trends which might contribute to an increase in patient falls. There was also on-going liaison with the lead nurse for older peoples' care to develop an action plan to reduce the frequency of falls.

Matrons told us audits were also carried out on all wards to ensure the accuracy of patient records. As a result, a need to improve the scoring of risk assessments was identified. A hospital audit found that nurses scored some risk assessments more accurately than healthcare assistants. It was decided that the assessments should only be carried out by nurses. However, we did not find audits of care plans or systems in place to ensure the quality of care plans. The matron told us there was a process for checking the quality of care plans which was due to start later in the month. We were told that lead nurses and matrons would audit care plans monthly.

Results from audits undertaken by the infection control link nurse were fed back and collated by the infection control team. The matrons at the hospital received a report from the infection control team. Any concerns identified by the report were discussed at the matrons meeting to ensure they were addressed. For example, as a result of concerns about patients developing blisters from one type of wound dressing, Ward 4 was involved in a trial and audit of different wound dressings. A trial of a different dressings was implemented for both trauma and elective orthopaedic patients. The use of these dressings was then rolled out across the trust with the involvement of theatres, surgeons

and the tissue viability nurse.

Patients who used the service were asked for their views about their care and treatment. The hospital gathered feedback form patients through use of the NHS "family and friends" test. All patients were given a card to complete on their discharge to enable them to give feedback on the care they received at the hospital. We were told the results were collated each month and a report with a report of their findings was sent to the director of nursing and ward matrons.

Staff were able to explain the system of monthly meetings held to assess, review and audit tasks and documentation. We were told there were monthly ward meetings in which issues such as complaints were discussed and reviewed. There was evidence of learning from incidents. The hospital used an electronic system, called datix, to record and report on incidents or near misses. The matrons told us they attended monthly clinical governance meetings for the relevant trust division that they were part of. These meetings received information from audits undertaken, complaints and incident reports. Action plans arising from these were reviewed. We were told about an example where learning from an incident had resulted in the design of new documentation for patients having epidural pain relief which had been implemented on the surgical ward.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment resulting from patient records which were not always updated or complete.

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

In the patient records we saw, patients had a completed initial care and treatment assessment. In most cases the assessment was detailed and included information about the patient's medical condition and initial diagnosis but this was not always the case. In three sets of patient records on Ward 8, documented care plans setting out detailed arrangements for patients' care were not always in place. Staff completed evaluations of care they provided but the care they provided was not reflected in patients' care plans. As such, it was not clear whether the care given to patients matched their needs.

In one set of patient records we found that details of the initial assessment and the reason for the patient's transfer to the ward was not documented. The initial assessment which we found in the record was not signed or dated by the person who completed it. The patient's records showed there were 12 occasions where different members of staff had cared for this patient with incomplete information because the initial assessment was not updated.

Another set of patient records on Ward 8 included a care plan which noted the patient had diabetes. There was no risk assessment or care plan setting out how the patient's condition should be managed whilst in hospital. The records for a different patient noted that the patient required supervision when eating but the level and type of supervision was not defined. For example, there were no instructions telling staff exactly what type of support or assistance the patient needed when eating. Staff recorded supervision was provided but there was no information as to what the supervision actually involved.

We looked at four patient records which were completed by the hospital's multidisciplinary team, including records completed by physiotherapists and occupational therapists. These had clear documentation of consent to treatment, clear expectations and goals, and progress against those goals.

Patient confidentiality was maintained in respect of patient records. Patient records were stored securely in the ward office. Where patient information was kept at the end of beds or outside side rooms, these were placed so that details were not visible to others.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person did not ensure patients' needs were assessed to ensure care was planned and delivered to meet patients needs. Regulation 9 (1)(a)(b)
Regulated activities	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The registered person did not ensure that people were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of maintenance of: an accurate record in respect of each person including appropriate information and documents in relation to their care and treatment provision. Regulation 20 (1)(a)

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

This section is primarily information for the provider

The provider's report should be sent to us by 31 July 2013.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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