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.*

# Heathfield House Nursing Home

Heathfield, Bletchington, Kidlington, OX5 3DX

Tel: 01869350940

Date of Inspection: 27 May 2014

Date of Publication: July 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 |
| **Management of medicines** | ✗ Enforcement action taken |
| **Safety and suitability of premises** | ✓ Met this standard |
| **Supporting workers** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✓ Met this standard |

## Details about this location

| | |
|---|---|
| Registered Provider | Heathfield House Nursing Homes Limited |
| Overview of the service | Heathfield House is a care home in Bletchingdon near Oxford that is registered to provide nursing care to older people, some of whom have dementia. |
| Type of service | Care home service with nursing |
| Regulated activities | Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>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 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 27 May 2014, 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 carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

### What people told us and what we found

During our inspection we spoke with seven people, three people's relatives and two visiting professionals. We also looked at five peoples care files and five staff files. We also spoke with nine care workers and the registered manager. There were 40 people living at the home at the time of our inspection.

We considered our inspection findings to answer questions we always ask;

Is the service safe?
Is the service effective?
Is the service caring?
Is the service responsive?
Is the service well-led?

This is a summary of what we found;

Is the service Safe?

We found that the service was not always safe. Medicines were not always handled appropriately. We noted that two people had medicines prescribed to them which were not documented on their medication administration records. We also noticed that medicines were not always safety administered. We checked the current medicine administration records (MAR) charts for six people. For four people we found that the records of medicines received into the home and the number of doses signed for on the medicine administration record (MAR) chart did not match. This meant the service did not have appropriate systems in place for the safe administration of medicines. We looked at

medicine audits for April and May 2014. We noted that the audit had systems in place to identify concerns in medicine stocks and records; however the audits did not identify these concerns.

Is the service effective?

We found the service was effective. People were supported in promoting their independence and community involvement. We observed that where possible people were encouraged to do things for themselves. Care staff told us how they promoted peoples independence. One care worker told us, "it's important we do not forget that although people here can be highly dependent it's important we encourage any areas of independence, no matter how small it may seem, it's still important".

Is the service caring?

The service was caring. People we spoke with felt their care needs were understood. One person told us, "I have no complaints; they know what I need and do it very well". Another person told us, "I would rather be in my own home, but they [staff] make things very comfortable". We saw that there was a wide range of activities for people to do. We saw that these activities were designed to offer individualised and meaningful stimulation. We observed a number of caring and positive interactions through our SOFI observation that clearly had a positive impact on people's mood.

Is the service Responsive?

We found the service was responsive. Support plans gave care staff clear guidance on how to meet people's needs and how to identify changing needs so the appropriate action could be taken. We saw through daily notes that this guidance was being followed.

Is the service well led?

We found the service was well led. People we spoke with felt the culture in the home had improved. One person told us, "it can be challenging, but it's very open and that's good". Another person told us, "communication is good, we know what's happening and that helps us do our job better". The provider had an effective system to regularly assess and monitor the quality of service that people received. We also found that People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. People we spoke with felt able to raise concerns and told us that the management were approachable available when needed.

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

## What we have told the provider to do

We have taken enforcement action against Heathfield House Nursing Home to protect the health, safety and welfare of people using this service.

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

We looked at this outcome because at our last inspection in December 2013 we found that people were not always treated with dignity and respect. The provider sent us an action plan. At this inspection we found that improvements had been made.
People we spoke with felt respected and involved. One person told us, "I feel very respected, staff treat me very well". Another person told us, "no decisions are made about my life without me or my family being involved". One person's relative told us, "the staff are wonderful, they respect my father for who he is and let him be himself". We observed a number of warm and respectful interactions between care staff and people they were supporting.

People who use the service understood the care and treatment choices available to them. One person's relative told us, "they are very good here, my wife was very clear on what was available, it made the move much easier". Another person's relative told us, "they work very hard to make sure people understand the process, they keep me informed so I can support if needed with decisions". We saw through our SOFI observation that there were a number of positive interactions where people were given choice and had their preferences respected.

People expressed their views and were involved in making decisions about their care and treatment. We saw that people were involved in their care reviews. Where people were assessed to not have capacity we saw that relatives acted on their behalf. For example we saw that one person living with dementia chose to walk around the home at night. This person's family were involved in discussions around action to take to enable this person to do this safely.

People who use the service were given appropriate information and support regarding their care or treatment. We spoke with one person who was planning to return home. This person had been kept informed and offered the appropriate support to understand and be part of the process.

We found that people were supported in promoting their independence and community involvement. We observed that where possible people were encouraged to do things for themselves. Care staff told us how they ensured they promoted peoples independence. One care worker told us, "it's important we do not forget that although people here can be highly dependent its import we encourage any areas of independence, no matter how small it may seem, it's still important". We reviewed the care file of one person who had shown a preference to maintain contact with their local town. We saw that this person had been supported to visit the town and gone out for a meal.

**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

People we spoke with felt their care needs were understood. One person told us, "I have no complaints; they know what I need and do it very well". Another person told us, "I would rather be in my own home, but they [staff] make things very comfortable". One person's relative told us, "I can't believe the change, being here as made such a difference, she is much more confident and eating much more".

People's needs were assessed, these assessments informed care plans and risk assessments where appropriate. Each person also underwent a dependency assessment to ensure their level of need was understood. We reviewed the care file for one person who had multiple complex needs. We saw this person required support with day to day care tasks and could also present behaviours that may be classed as challenging. We found support plans gave care staff clear guidance on how to meet this person's needs and how to identify changing needs. We saw through daily notes that this guidance was being followed. When this persons needs changed the service responded. For example, we saw that this persons health had recently declined and the appropriate professionals had been involved in reviewing care plans to meet this persons changing needs. Care staff were able to describe these care needs and told us how they would support this person. This was in accordance with actions in their care plan. This meant that care and treatment was planned and delivered in line with peoples individual care plans.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We looked at the care file of one person who was living with dementia but wished to maintain their independence. There was guidance to care staff to prompt this person to ensure their independence was maintained. This guidance was supported by risk assessments along with pressure mat which alerted care staff when this person was out of bed. This helped care workers to keep this person safe whilst maintaining their independence. We observed the pressure mat was in use .Care workers were able to speak with us about how to support this person and how the pressure mat supports this person.

We saw that there was a wide range of activities for people to engage with. We saw that these activities were designed to offer individualised and meaningful stimulation. The

activities coordinator told us, "it's important to find that one thing that interests people, there is always something regardless of their capacity". We saw that life stories and discussion with relatives helped inform the activities that were being designed to ensure they remained meaningful to people. These activities included animal time, music therapy, games, bingo, and a 'creative  corner' for people that enjoyed crafts. We also saw that these activities offered a balance of home and community experiences. For example, we saw trips to local museums had been planned along with religious services that we saw people attended. This meant that peoples need to practice their religion were being met.

People's care and treatment reflected relevant research and guidance. We saw that where people were living with complex needs that care staff were encouraged to research appropriate documentation to better understand the impact of those needs on people life's. This information was the used to inform care plans.

People who use services were only deprived of their liberty when this had been authorised by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards. The provider was aware of the new high court judgement with regards to deprivation of liberty.

**Management of medicines** ✖ Enforcement action taken

**People should be given the medicines they need when they need them, and in a safe way**

## Our judgement

The provider was not meeting this standard.

People were not always protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

## Reasons for our judgement

We looked at this outcome as we saw improvement was needed around the storage of medication following our last inspection in December 2013. The provider sent us an action plan. We found that whilst improvements had been made to ensure medicines were stored securely, there were inappropriate arrangements for the handling, administration and recording of medicines.

At this inspection we checked the arrangements for storing, handling, administration and recording of medicines. We looked in detail at the medicine records for nine people living in the home.

Medicines were kept securely. We found that there were appropriate arrangements for storing most medicines, including controlled drugs. We noted that medicines were stored in a clinical room and a store cupboard. The clinical room contained medicine storage cabinets, two medicines trolleys and a medicine fridge. This room also contained a controlled drugs cabinet. All storage areas were locked when not in use.

Medicines were stored appropriately and the service had taken appropriate action when they had concerns. The temperature of the clinical room and medicine fridge had been recorded every day during May 2014, temperatures were within manufacturer guidelines. We identified that no temperature records of the store cupboard was maintained. We discussed this with the manager who informed us that the air conditioning unit had broken and a replacement had been ordered and would be at the home shortly after our visit. This meant that the service ensured medicines were stored appropriately and took appropriate action when concerns were raised.

Medicines were not always handled appropriately. We noted that two people had medicines prescribed to them which were not documented on their medication administration records. Both people's medicines were stored in medicine trolleys and the

service had no clear record of the stock of each medicine. One person's medicine had a prescription label which stated the medicine was received in January 2014. The other person's medicine only had their nickname recorded. This meant that these people were at risk of not receiving their prescribed medicines.

Medicines were not always safety administered. We checked the current medicine administration records (MAR) charts for six people. For four people we found that the records of medicines received into the home and the number of doses signed for on the medicine administration record (MAR) chart did not match. This meant the service did not have appropriate systems in place for the safe administration of medicines. The service was also unable to ensure that people received their medicines or that medicines could not be accessed appropriately.

Medicine records were not always accurately completed. We found one person had a medicine where one tablet had been signed as given and another signed as destroyed. Nurse's noted that four tablets were received and that two tablets were in stock. We counted this person's medicine and noted only one tablet was in stock. This meant the service did not have an accurate record of when medicines were administrated or disposed.
We looked at medicine audits for April and May 2014. We noted that the audit had systems in place to identify concerns in medicine stocks and records; however the audits did not identify these concerns.

**Safety and suitability of premises** ✓ Met this standard

**People should be cared for in safe and accessible surroundings that support their health and welfare**

## Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

## Reasons for our judgement

When we visited in December 2013 we noted that hoists were not stored properly and were left in inappropriate places, for example, obscuring a fire exit door on the first floor of the home. We also noted that areas of the home including a bathroom and corridor posed a risk to people and visitors. The provider sent us an action plan in response to our visit. We found that the provider had taken appropriate action.

We found the premises were being refurbished at the time of our visit. For example, we saw that a lounge on the ground floor was being redecorated and turned into a dining room. We noted that all equipment and tools used by maintenance staff were safely secured. This meant that while areas of the home were being refurbished, people were not put at risk during this process.

The provider had a plan of refurbishment for the home. We noted that the corridor on the ground floors of the home had new flooring, and that a bathroom on the ground floor had been refurbished. We also noted that the bathroom upstairs had been refurbished and turned into a sensory bathroom. We looked at the refurbishment plan for the home and noted that the provider had planned to change the corridor flooring on the first floor. The provider was also looking to install a new lift. Staff told us that a chair lift had been installed to ensure people could move between floors while the lift was being replaced. The manager also told us that a bedroom on the first floor was being converted into a lounge and dining space to provide people with a communal space if they could not go downstairs.

We noted that emergency fire routes were accessible and moving and handling equipment was not stored in corridors or around staircases. We saw that when equipment was used it was placed in rooms which were not being used. We also noted that fire doors were not restricted from closing, meaning that appropriate action was being taken in line with the home's fire risk assessments.

We saw that the design, layout and security of the premises safely met the needs of everyone who received care and treatment including those with disabilities. We saw that all visitors to the home signed the visitors' book to show they were in the building.

We saw that the design of the premises promoted people's dignity, independence and wellbeing. For example, people were able to access their rooms on the first floor of the home by a lift; people were able to move around the home freely and had a choice in where they could spend their time.

We saw that the risks to safety had been identified and managed. For example we saw that appropriate fire checks and water temperature checks were completed on a regular basis. We noted that risks regarding refurbishment work were identified. We noted that fixed wiring checks were being arranged to ensure all electrics in the home were safe.

**Supporting workers** ✓ Met this standard

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

## Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

## Reasons for our judgement

We looked at this outcome as we found improvement was needed regarding supporting workers at our last inspection in December 2013. We found that staff were not always being appropriately supervised and did not always receive appraisals. The provider sent us an action plan. We found that improvements had been made and we found that people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Care workers we spoke with felt supported, one care worker told us, "I get all the support I need the manager is always happy to listen". Another care worker told us, "the support is there when I need it and you get regular supervision". Care workers also felt that they received enough opportunities to develop. One care worker told us, "training opportunities happen all the time. We do the standard ones, but also anything specific we feel we need we just ask". People we spoke with felt that the care workers supporting them were well trained. One person told us. "they are all so patient; when they move me they make me feel at ease as they are confident in what they are doing".

Staff received appropriate professional development. We saw that all care workers had opportunities to attend training that was varied and relevant to their work such as, moving and handling, mental capacity and understanding dementia. Care workers were also able to work toward nationally recognised care qualifications.

Care staff received regular supervision. We reviewed the supervision records of 4 care workers and found that this was happening regularly. We saw that care workers were supported in a number of areas and were also able to raise their own issues. We also saw that care workers received an annual appraisal that identified training needs. The provider may find it useful to note that whilst supervision was happening, the system of recording supervision meant that the manager could not access the records if needed. Supervision was sealed in an envelope and given to the care worker.

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

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

## Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

## Reasons for our judgement

The provider had an effective system to regularly assess and monitor the quality of service that people received. We saw that there was a system in place to audit care files. We saw that improvements highlighted through these audits were updated and acted upon. We also saw that regular checks were done across a number of areas such as health and safety to ensure the quality of the service provided. We also saw that there was a system in place to ensure staff supervision and training was tracked to ensure it was up to date. This meant that people were being care for by care staff who had up to date training and appropriate support.

People we spoke with felt the culture in the home had improved. One person told us, "it can be challenging, but it's very open and that's good". Another person told us, "communication is good, we know what's happening and that helps us do our job better".

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. There has not been another satisfaction survey since our last inspection; however we saw that this year's survey was in the process of being sent. Relatives we spoke with felt able to raise concerns. One person's relative told us, "the manager is always available for a quick chat, it is very reassuring". Another relative told us, "you get the feeling when you share your opinion it will be listened to, you don't find that everywhere".

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. We reviewed the incidents and accidents file and saw that occurrences were being recorded.  The manager explained it was part of their role to look for trends. We saw that due to the high number of falls happening un-witnessed in certain areas of the home that the manager had decided to rearrange the layout of the ground floor. This was to ensure that care workers could more effectively identify people who may need support. This meant that information was being used to improve the service and ensure peoples safety.

The provider took account of complaints and comments to improve the service. We looked

at the compliant and comments file and saw a number of entries from people who were very happy with the care being provided. We saw that complaints were responded to in line with the stated policy. For example one person's relative had complained about the appearance of the carpet. The manager explained that this had been brought forward in the homes refurbishment programme.

**This section is primarily information for the provider**

## ✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

### Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

| **We have served a warning notice to be met by 31 July 2014**<br><br>This action has been taken in relation to: | |
|---|---|
| Regulated activities | Regulation or section of the Act |
| Accommodation for persons who require nursing or personal care<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Management of medicines**<br><br>**How the regulation was not being met:**<br><br>The registered person was not protecting some service users against the risks<br>associated with the unsafe use and management of medicines. (13) |

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

## 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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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

| | |
|---|---|
| Phone: | 03000 616161 |
| Email: | enquiries@cqc.org.uk |
| Write to us at: | Care Quality Commission<br>Citygate<br>Gallowgate<br>Newcastle upon Tyne<br>NE1 4PA |
| Website: | www.cqc.org.uk |