Inspection Report

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

Yorkshire Ambulance Service NHS Trust HQ

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Date of Inspections: 24 January 2013
23 January 2013
22 January 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Yorkshire Ambulance Service NHS Trust
Overview of the service	Yorkshire Ambulance Service is the main provider for emergency ambulance and patient transport service across Yorkshire and the Humber. It has locations and ambulance stations across the county of Yorkshire and provides services to all sections of society.
Type of service	Ambulance service
Regulated activities	Diagnostic and screening procedures Transport services, triage and medical advice provided remotely 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 22 January 2013, 23 January 2013 and 24 January 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and talked with stakeholders.

What people told us and what we found

We spoke with 16 people who had been transported to hospital by emergency ambulance and 14 people who had used the Patient Transport Service to transport them to and from hospital out patient appointments. People spoken with told us they were happy with the care and treatment they had received from the ambulance staff. One person commented; "I really appreciate the service and everything they do for me." Another person told us; "They explained everything and checked I was happy with what they were doing."

We found there were effective systems in place to reduce the risk and spread of infection. We visited six ambulance stations across the county and spoke with over 30 members of ambulance service staff working in a variety of roles to gain their views. Staff spoke of how they enjoyed their work and how they took a pride in providing people with a good service in spite of the pressures they felt.

The provider may find it useful to note that most of the ambulance road staff we spoke with told us they rarely had time to carry out the necessary checks of their vehicles to make sure they had sufficient stocks of medications and other equipment at the start of a shift. Senior managers and directors told us they recognised the challenges highlighted by the staff and said these were issues that the Board and Executive team were fully aware of and were addressing. They told us they had already taken significant action with other developments under way.

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

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone

number on the back of the report if you have additional questions.

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

As part of our inspection we spoke with people who had been transported to hospital by emergency ambulance to find out if they were asked for their consent before they received any care or treatment and whether the ambulance staff had acted in accordance with their wishes. To do this we visited three Accident and Emergency (A&E) departments in different parts of the county and spoke with 16 people who had been transported to hospital by the Yorkshire Ambulance Service. All the people spoken with were complimentary about how the ambulance staff had asked them about their symptoms and listened to them. One person told us; "They explained everything and checked I was happy with what they were doing." Another person said; "They listened to me, and then told me what they were planning to do, and I consented to everything."

We reviewed the provider's policy for obtaining consent dated July 2012 which took into consideration relevant clinical guidance including capacity to consent to examination or treatment. The service also had a policy relating to consent for conveyance and non conveyance to hospital, and consent processes for death and dying. This meant the service had clear procedures in place to be followed to obtain consent, to act on the wishes of the person or to act in the best interest of the person to meet their needs in different circumstances.

We spoke with ambulance staff who described how they assessed people's care and treatment needs and how they explained to people about what action they intended to take to make sure the person was in agreement. Staff spoken with explained they would respect a person's wishes where they had capacity to decline consent for the recommended course of action and described how they would discuss the risks involved with declining transport to hospital and advise them to ring their GP, or to dial 999, if their condition worsened.

We saw prompts for consent was included in the essential information within the patient report form records. There was also a mental capacity assessment tool contained within

the record to be completed if capacity was in doubt. We saw one had been completed on the day of our inspection. Staff spoken with confirmed the completion of this assessment tool was regular practice within the service. We reviewed a sample of the patient report forms used by ambulance staff to record their assessment and the action taken to meet people's needs. We saw that where people with capacity had not consented to the recommended course of action, such as being transported to hospital, this was recorded on the report.

Ambulance staff demonstrated a good understanding of how to assist people who did not appear to have capacity to consent to care and treatment. Staff understood that sometimes a lack of mental capacity could be temporary; for example, if someone was very drunk or had an injury which affected their ability to make an informed decision. Staff told us they would act in the best interest of someone who was unable to make a decision for themselves.

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We spoke with 16 people who had been transported to hospital by emergency ambulance to find out about their experience of the service. All the people spoken with were very happy with the care and treatment they had received. One person commented; "It was a brilliant service." The person went on to explain; "When I rang 999 the lady on the phone was very good and stayed on the phone until the ambulance staff arrived. It was very reassuring."

We also spoke with 14 people who had used the Patient Transport Service (PTS) to transport them to and from hospital out patient appointments. The majority of people spoken with told us they were happy with the care and treatment they had received from the ambulance staff. One person commented; "I really appreciate the service and everything they do for me." Another person told us; "They always help me in, right inside my home, and make sure I'm safe." However, four people told us they regularly experienced long delays in waiting times to return home after their hospital appointment. One person reported waiting over four hours to be taken home. Two people commented on the use of taxi services instead of ambulances and the standard of service not being as good. One person told us; "One taxi driver that came was driving unsafely and using a mobile phone while driving." Another person commented; "It depends who the taxi driver is and what experience they have had before picking me up. They can be grumpy."

We discussed these issues about the PTS with the senior management team. They told us these issues had already been identified and the PTS was undergoing a "Transformation programme" to improve the service. We saw details of this programme which began in June 2012 and is planned for completion during 2013.

We spoke with ambulance staff who described how care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. All the ambulance staff spoken with described how the needs of the people needing to use the service were their first priority. Staff spoke knowledgeably about how they assessed people's health needs and made clinical decisions about the most appropriate action to be taken.

Staff described how various clinical pathways had been developed to meet the individual

needs of people presenting with different symptoms. The pathways were flow charts used by the ambulance staff to ensure the person received the treatment and care they needed from specialist services as quickly as possible, or at a later date. Examples of the pathways included: stroke; mental health; heart problems; falls; and alcohol and substance misuse services.

We reviewed a sample of the patient report forms used by ambulance staff to record their assessment and the action taken to meet people's needs. We saw information was recorded about the person's symptoms and the observations and assessment carried out by the ambulance staff. The report also provided information about the course of action taken. This information was passed to the staff in the A&E department or other specialist service on arrival to support the continuity of care.

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.

People's 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

We saw evidence that the service worked in co-operation with other agencies to put systems and processes in place to protect people's health, safety and welfare as they moved between different services

During our inspection we spoke with the hospital staff in the three A&E departments we visited. The hospital staff confirmed they worked well with the ambulance staff on a daily basis and said communication was good between the two services. One senior hospital staff member commented; "The Yorkshire Ambulance Service is an excellent service." We saw ambulance staff handing over the care of the person they had transported to the hospital staff and found they provided clear details of the person's medical condition to support the continuity of care for people.

We saw evidence of joint working between the service and acute trusts across the county to develop clinical pathways to meet the individual needs of people presenting with different symptoms. We saw the Yorkshire Ambulance Service clinical pathway development framework and information on how they worked with providers to do this. We saw minutes of multi-agency meetings set up to develop clinical pathways which had representation from the Yorkshire Ambulance Service. Ambulance road staff spoken with where knowledgeable about the clinical pathways and we saw they were in daily use within the service.

Senior hospital staff spoken with confirmed they worked in co-operation with the ambulance service to further improve people's experience of care and treatment. They gave examples of joint working to develop clinical pathways and to implement new systems to improve care handover times to reduce the length of time an ambulance needs to stay at a hospital once the person has been transported. This is so the vehicle and crew are not held up inappropriately causing delays in them being able to respond to emergencies.

A locality manager described how the Yorkshire Ambulance Service were also working closely with local police services to develop joint working in city centres during peak times when people were out socialising in bars and clubs. He told us this way of working was

proving successful as often both services were required to attend incidents. Co-ordinating their response led to improved outcomes for people who needed the services and for staff providing the service.

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 had been followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

During our inspection we found there were effective systems in place to reduce the risk and spread of infection. We visited six ambulance stations in different parts of the county: Leeds, Huddersfield, Pocklington, Rotherham, York and Northallerton. We looked around the stations, inside vehicles at the stations, and spoke with station managers and ambulance road staff about infection control.

All the people we spoke with who had used the emergency service or the PTS told us they were happy with the cleanliness of the ambulance transport they had travelled in. One person commented; "It was spotless." Another person said; "It looked clean and tidy to me." A person who used the PTS told us; "Sometimes the floor is a bit dirty but that is understandable in this weather."

In the stations we visited we found that communal areas were clean and tidy and hand wash and paper towels were freely available. Information about correct hand washing techniques was displayed prominently beside wash basins. Cleaning equipment, such as mops, were available and appropriately stored. In two of the stations we visited we saw a record of deep cleaning of the sluice room on display on the wall. These had been signed as completed for most weeks over the past year; however some weeks were not signed. This corresponded with when the cleaning staff with responsibility to do this job had been on annual leave. The provider may find it useful to note that there was no system in place to cover this task during staff absence to ensure effective infection control measures are maintained.

Ambulance staff told us of ways in which they maintained standards of hygiene within vehicles and on equipment; for example, by using freely available sanitising surface wipes to wipe down areas such as handrails and stretcher handles. Staff also told us how the introduction of many types of single use equipment, such as forceps and bag valve masks, had helped to reduce the potential for cross infection between patients. Staff demonstrated a good understanding of what infection control measures to carry out if bodily fluids spilled into an ambulance.

We saw vehicle washing facilities were readily available in the stations. We observed vehicles being washed externally to remove the dirt that had accumulated due to gritting in

the snowy weather conditions. Most of the vehicles we looked at internally were clean and tidy. However the provider may find it useful to note that a few of the emergency ambulances had information leaflets and flowcharts stuck to the walls using adhesive tape. We saw there were black marks on the walls where leaflets had been removed but there were remains of adhesive which had attracted dirt which could harbour infection.

We saw there was an infection and control policy in place which made reference to related policies and guides such as hand hygiene, waste management, vehicle cleaning cabinet monthly checks and sluice room equipment cleaning log. There was a system in place to ensure that vehicles were given a regular deep clean. We saw the deep cleaning schedule was displayed inside the vehicle in all but one of the vehicles we inspected. We checked and found this vehicle had been deep cleaned within the agreed timescale and this was in the record held in the office.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

During our inspection we spent time at Trust headquarters reviewing staff rotas and other relevant documentation and spoke with senior managers and directors in relation to this outcome. We reviewed staff rotas and saw there were sufficient staff and an appropriate skill mix to meet the demands of the service. We saw the service had a workforce plan which identified a schedule of recruitment and training for an additional 70 staff during 2012 with ongoing and further recruitment and training planned to reach an agreed establishment of front line emergency staff of 2106 by June 2013.

We also visited six ambulance stations across the county and spoke with over 30 members of ambulance service staff working in a variety of roles such as: paramedics; technicians; ancillary staff; clinical supervisors; and locality managers, to gain their views. Staff spoke of how they enjoyed their work and how they took a pride in providing people with a good service in spite of the pressures they felt. One member of road staff commented; "I love my job." Another member of staff told us how the staff worked well as a team and pulled together to make sure the service was covered. However another member of staff told us; "There is so much work to do and we have to do it all at once. I'm loosing the will to live."

The provider may find it useful to note that most of the ambulance road staff we spoke with told us they rarely had time to carry out the necessary checks of their vehicles to make sure they had sufficient stocks of medications and other equipment at the start of a shift. One paramedic told us; "The staff working out on the road have to put a lot of their own time in for the service to run properly. I try to come in 20 minutes early in my own time to make sure I can check the vehicle before I start work." Not having protected time to carry out these essential checks may put lives in danger for example, if equipment is found not to work properly or stocks of single use equipment have not been replenished when it is needed

We discussed this with the directors who told us they recognised the challenges highlighted by the staff we had spoken with. The Executive Director of Standards and Compliance explained; "The demand for the emergency services has been increasing year on year, creating a significant challenge to the service to keep pace with this." He described how the service has managed this by increased resources, such as through overtime and through sub-contracting arrangements for example, to match demand

changes. He went on to describe how workforce changes planned from February 2013 would significantly reduce the reliance on overtime would provide greater capacity to manage such situations within normal working arrangements.

All the people spoken with who had used the emergency ambulance service said they were happy with the response times of the service. Some commented on the information and support they were given by the call handler which they found reassuring. People using the PTS were also complimentary about the ambulance staff with comments such as; "They are all lovely;" "They are very helpful indeed;" and "My husband says they are heroes." This indicates that there were sufficient staff to ensure people using the service experienced a response appropriate to meet their needs.

Overall, we judged there were enough qualified, skilled and experienced staff to meet people's needs and action plans were in place to provide greater capacity in the workforce.

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

During our visits to the six ambulance stations across the county we spoke with over 30 members of ambulance service staff. Staff confirmed they were up to date with their mandatory training in areas such as moving and handling and infection control. However, the provider may find it useful to note that the majority of staff spoken with told us they had difficulty in accessing training and supervision due to work pressures and the need to prioritise operational work. One member of staff explained; "Training is always put to the bottom of the pile. It sometimes gets cancelled because of operational pressures when staff are needed on the road." Another member of staff told us; "A lot of training is now done through a work book but we are not given time to complete it as there is no free time during a shift."

We spoke with the Head of Leadership and Learning about staff having time to undertake training. He confirmed staff should be given time to undertake training during work time and said they could request "Down time" to do this. He acknowledged this was difficult during busy periods. He also informed us that when staff attended their statutory update training they received 12 hours pay for 8 hours attendance. The intention of this is to fund four hours for staff to complete their training work books. We saw evidence that planning for training for the coming year was already taking place. This took into account the need for flexibility in the training delivery to reflect known periods of peak demand. We reviewed staff training records and found systems were in place to record staff training and recall staff when updates and refresher training was required.

During our visits to the ambulance stations staff told us about a new clinical leadership structure had recently introduced into the service. Locality managers described how the new system would provide stronger clinical leadership and support to the operational staff. A clinical supervisor role had been introduced to take responsibility for providing clinical support, guidance and carrying out annual appraisals for 15 staff members they were allocated. However, the provider may find it useful to note that the clinical supervisors we spoke with felt they had not been able to carry out this role since their appointment due to work pressures. Many of the staff we spoke with told us they had not yet met with their clinical supervisor. One member of staff commented; "New staff are not given the support they need. I had to ask for a supervisor." Another member of staff said; "Although my mandatory training is up to date I don't think my wider training and development needs are

listened to or considered as there is no time."

We spoke with senior managers and directors about the comments made by staff. They told us they recognised the challenges highlighted by the staff and said these were issues that the Board and Executive team were fully aware of and were addressing. They told us they had already taken significant action with other developments under way. They described how the clinical supervision model had been entirely re-designed with a clear new framework and expectations on supervision and support. They told us clinical supervisors had been recruited and had been trained for the new role, including attendance at a university leadership course. The Executive Director of Standards and Compliance explained that although the new model was in place, it had been completed at a busy time for the service due to winter pressures. It was expected that the new model would be fully operational within the coming weeks.

We saw that the clinical leadership changes were still subject to project management. We saw the minutes of a meeting of the project group which showed the clinical supervision model would continue to be monitored, including the time spent by individual staff with their supervisor and staff feedback until the process is fit for purpose.

Overall, we judged people were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard and action plans were in place to provide stronger clinical leadership and support for staff.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

As part of the inspection we reviewed the arrangements in place for managing and responding to complaints. We saw there was a policy for managing complaints and concerns in place. Information outlining the complaints system was available via the trust's website and information on how to complain was also available at headquarters, in ambulance stations and vehicles. This information was also available in languages other than English and it could also be made available in large print, Braille or on audiotape. This meant the provider brought the complaints system to the attention of people in a suitable manner and format.

All complaints received were categorised into low, medium and high risk and were recorded on to an internal system. Initial triage of a complaint helped to determine how best to investigate it. For example, clinical complaints would have input from appropriately qualified staff. We saw evidence that, wherever possible, all relevant information was gathered in relation to the matter being complained about and complaints were fully investigated. Where appropriate, we saw that the provider took steps to coordinate a response to a complainant. Depending on the severity or the sensitivity of the issue, this may also have involved a personal visit.

The senior managers and the station managers described the process in place to share information with ambulance road staff on common themes so that lessons learned from complaints helped them to reduce the impact of unsafe or inappropriate care and treatment. We saw there was a system in place for statistical reports and information about complaints to be discussed at a senior management level to provide updates on significant events and provide assurance on action taken to effectively learn from adverse events.

We discussed this process of learning from incidents and complaints with two station managers. They confirmed there was a process in place and the information was disseminated to all of the ambulance staff by various means to ensure lessons are learned and reduce the likelihood of similar incidents happening again.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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.

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