Inspection Report

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

The Seven Dials Medical Centre

24 Montpelier Crescent, Brighton, BN1 3JJ

Tel: 01273773089

Date of Inspection: 04 November 2013

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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
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	The Seven Dials Medical Centre
Registered Manager	Dr. Peter Meade
Overview of the service	The Seven Dials Medical Practice is a partnership of four General Practitioners (GP's). The practice the situated in the city centre with good public transport links. It has about 8 000 registered patients and provides general medical services plus a range of additional services such as family planning and minor surgery. The practice also provides a range of specialised clinics including Drug Misuse, Diabetes, Asthma and Heart Monitoring.
Type of services	Doctors consultation service Doctors treatment service
Regulated activities	Diagnostic and screening procedures Family planning Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 November 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

We spoke with the practice manager, two GP's (one of who was the registered manager), a practice nurse, a health care assistant and a receptionist to understand how the practice worked. We also spoke with eight patients (one of who was a member of the Patient Participation Group) to help us understand their experience.

We found that patients were involved in planning their treatment and care. A patient said, "I've had lots of health problems lately. The GP has explained things clearly and I've been there when they make referrals so I feel involved."

Patients were treated with respect and their privacy was maintained. A patient told us, "I'm treated with respect and I'd soon complain if I wasn't."

Patients' and other records showed that risks to their health and well-being were managed. Patients were referred to specialist health care professionals when needed. Patients could get urgent appointments and there were adequate facilities to manage medical emergencies.

A patient told us, "It's very clean and hygienic, particularly the toilets which I think is important." We found relevant government guidance in relation to infection control was being followed.

There were systems to ensure suitable staff were employed. Appropriate background checks were undertaken and GP's and nurses' professional registration was verified.

There was an annual patient survey carried out by the Patient Participation Group and there were arrangements for the practice to monitor standards of quality and safety.

A patient summed up their experience as, "It's well organised, clean and gives you confidence."

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

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.

Patients' views and experiences were taken into account in the way the service was provided and delivered in relation to their care.Their privacy and dignity was respected.

Reasons for our judgement

Patients who used the service understood the care and treatment choices available to them. The patients we spoke with all told us that the GP's and nurses explained their findings with them and involved them in making decisions about their care and treatment. One patient said, "I've had lots of health problems lately. The GP has explained things clearly and I've been there when he makes referrals so I feel involved." Another patient commented, "The GP is excellent. I want to know about the whys and wherefores. I want to know what's going on with my body. Ignorance is death but they go into everything for me."

Patients were given appropriate information and support regarding their care or treatment. We saw that there were posters displayed along with information leaflets for patients to take away in the waiting rooms. These covered a wide range of health topics and were a readily accessible resource for patients. Patients we spoke with told us they felt the GP's and nurses gave sufficient information to support their decision making and management of their health. One patient said, "The GP went out of their way to explain diabetes to me. They explained what to watch for, how to deal with it, when to call an ambulance or the surgery. They went out of their way to reassure me."

Patients expressed their views and were involved in making decisions about their care and treatment. We were shown entries in patients' notes which recorded those patients had been given options about the care required, along with discussions on the relative merits of each option. Two patients who had been referred to hospital explained that they had been given a choice of hospital. A patient told us, "I always come in with an idea myself and this helps. They are always willing to discuss what you want."

We found there was appropriate information available regarding the services available and access arrangements. We saw a copy of the practice information booklet which clearly explained the personnel and services on offer, including specialist clinics. It contained information on opening hours and how to make appointments, and other relevant

information. The practice also had a comprehensive website which detailed similar information to the booklet, and news and notices. We observed this practical information was also displayed in the practice waiting rooms.

The practice ran a Patient Participation Group (PPG). We saw that minutes of the PPG meetings and these could also be found on the practice's website, along with terms of reference and other information. The minutes showed that the PPG assisted in disseminating key messages to patients. For example, missed appointments had been highlighted at an earlier meeting, and a GP reported that there had been an improvement since this happened. The PPG also produced a regular newsletter and we saw copies of this. One of the main activities of the PPG was to plan and administer the practice's annual patient survey. We spoke with a member of the group and they told us how they spoke with patients in the waiting room to gather their views so they could be fed into the group's activities. We were told that some difficulties were experienced in generating interest in the PPG. None of the patients we spoke with were aware of the PPG. This meant that there was a forum to enable patient participation in the running of the service, although it was not widely known by patients.

We observed that all staff spoke with patients in a kind and respectful manner. Conversations at the reception desk with patients, both in person and over the telephone, were conducted sensitively so they could not be easily overheard. A receptionist told us that if a patient requested or if the staff felt more privacy was required there was a private area where patients could be taken. We saw this facility. A patient told us, "I'm treated with respect and I'd soon complain if I wasn't."

We saw that all consultations were performed in private in a room with the door shut. All staff we spoke with were aware that a shut door meant no entry and we saw staff respected this. We also saw that in addition examination couches could be shielded by curtains. All the patients we spoke with confirmed that consultations were held in private and there were no interruptions. We saw notices displayed that advised patients a chaperone could be provided and what role they would perform. All chaperones, some of whom were receptionists, had undergone training for this role. Patients we spoke with told us that chaperones were routinely offered, and provided for medical examinations and treatments when required. We observed patient records were stored securely. This demonstrated that patient's privacy and dignity were respected.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

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

We were shown the practices computer based patient notes. We saw that important safety information was flagged up on opening a patient's file. For example, we were told that a patient who was a Jehovah's Witness and did not want blood products had this information included here. We saw a variety of alerts on the records we viewed. We also saw that important information such as past medical history; current problems, medicines and allergies were summarised and easy to see. We saw that there was a record of each consultation recorded. The system also highlighted if patients were due any interventions, for example medication reviews, screening or other investigations and health advice. We saw that the system had highlighted that advice regarding smoking should be given and the records confirmed this had happened. A patient said, "I use different doctors but the information gets shared." This showed that patient records helped protect them from unsafe or inappropriate care.

Patients who were requiring end of life care or had complex needs were identified by clinical staff. We were shown the register that was maintained of these patients. We spoke with the receptionist that administered the register who explained the processes in detail and we noted this included liaison with out of hours services. We saw that there were multi-disciplinary meetings held every four to six weeks to discuss the needs of this patient group. This meant were arrangements to ensure that patients with particularly complex needs were identified and their care was planned and regularly reviewed by health professionals involved in their care.

Two patients explained in detail how they had been referred to a hospital specialist when this was needed. Another patient told us their spouse had been referred to specialist stroke nurses. We found there was system to ensure that any investigation results, including the outcome of consultant appointments were seen and reviewed by a GP promptly. A patient said, "My doctor always gives my results." Another patient commented, "They follow up on scans and remind me of 'flu vaccinations." This showed that patients were referred on to specialists when needed, and that investigations and specialist input

were followed up.

There were systems to ensure patients medicines were managed safely. Prescriptions were written using a computer system. This system automatically alerted the prescriber if they were prescribing outside of normal usage. There was a system for obtaining repeat prescriptions which we saw was working and the manager told us that urgent prescriptions could be obtained. Patients could order repeat prescriptions on-line. A patient told us the system "Works well." We spoke with a patient who had been invited in to have their blood pressure checked before a further repeat prescription was issued. They told us, "They are hot on making you have a yearly consultation for your BP before another 'script. That's fine, it's a precaution."

There were arrangements in place to deal with foreseeable medical emergencies. We saw training records which showed that clinical staff had undergone training in resuscitation and the management of anaphylaxis's (an extreme allergic reaction) and they confirmed this with us. We saw that there was adequate emergency equipment including a defibrillator, medicines, a nebuliser, oxygen and a first aid kit. The nurses told us they were responsible for checking equipment and medicines to ensure they had not expired and were working. We saw records that showed this equipment was checked regularly to ensure it was ready for immediate use.

We found that the practice had adequate access and facilities for disabled people. The practice manager was conducting a disabled access audit and we were shown evidence that the audit was almost completed. The practice was situated in a listed building so it was acknowledged that there were limits on any modifications that could be made. However, we saw that there was ramped access to the building. We saw there were disabled toilet facilities. There was a ground floor consulting room which was available for any of the clinical staff to see and treat people who could not manage the stairs down t to the main consulting rooms. A patient who had a disabled spouse told us, "We use the level access room." We also saw that the waiting room area had a loop system installed for people who used hearing aids.

The practice had clear information about its opening hours and access arrangements both in and out of normal working hours. The practice's opening hours and arrangements for making an appointment were displayed in the reception areas, on the practice website and in the practice information booklet. We noted that there was an early evening surgery once a week. Out of hours cover was provided by a specialist provider. Details of how to contact this service were recorded on an answerphone message and were also displayed outside the practice. Patients we spoke with knew how to access this number, one said, "I'd ring the practice number and follow the instructions." Emergency appointments were available on the day and we saw patients using these appointment slots. Appointments could also be booked in advance. A patient said, "What I like about this practice is you can be seen on the day or book an advance appointment."

All the patients confirmed that they could get an urgent appointment but some felt that getting a routine appointment with their preferred GP was more difficult. One said, "They can always fit you in on the day but appointments in advance are slightly more difficult." Others commented that advance appointments could be booked, "More or less," and "I can usually be booked in a reasonable time." However, another patient said, "Appointments are my biggest bugbear. If it's an emergency you can usually get an appointment but not necessarily with your own GP. Otherwise it can be up to two weeks. I don't bother with the out of hours service; I'd go to A and E." Patients we spoke with

mentioned that reception staff tried hard to fit appointments in to meet patients' needs. For example one patient told us they found early morning appointments difficult due their arthritis, so reception staff had booked her appointments later in the day. This showed that people could always get an emergency appointment but found it more difficult to get a routine appointment with their preferred GP.

Patients we spoke with were satisfied with the care and treatment they received. One patient said, "Everything was done correctly. The receptionists couldn't have been more helpful getting stuff sent to the pharmacy and delivered. I was impressed." Another patient told us, "It's a good practice, I've stayed although I've moved further away." A further patient commented, "It's improved a lot, the patient reception interface is much better; you are made to feel more welcome." Finally a patient summed up their experience as, "It's well organised, clean and gives you confidence."

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.

Patients were cared for in a clean, hygienic environment.

Reasons for our judgement

In 2010 the government issued advice to all providers of health and social care entitled, 'The Code of practice on the Prevention and Control of Infections and Related Guidance.' Patients were protected from the risk of infection because this guidance had been followed.

We saw there was a policy for infection prevention and control (IPC) and that it was updated annually. There was a designated lead for IPC. The lead had received training for this role which was regularly updated. We saw training records to confirm this. All the staff we spoke with were aware who the IPC lead was. This meant there was appropriate IPC guidance and leadership.

All staff received training in IPC including hand hygiene and we saw this recorded in training records. Staff confirmed that they had this training regularly. Patients we spoke with told us that GP's and nurses washed their hands or used hand sanitizer before they examined or treated them. A patient told us, "Come to think of it they wash their hands, but the gel is on their desk." We saw there were supplies of hand sanitizer throughout the surgery, adequate hand washing facilities and supplies of personal protective equipment such as gloves. This showed that staff had appropriate training in IPC and applied this to their work.

There was an annual audit of IPC and we looked at the last year's audit. We noted that no major issues had been identified at the last audit. This meant that there was appropriate monitoring of IPC issues.

The majority of patient equipment in use was disposable after a single use. A nurse said, "Nearly all the stuff we have is use and chuck." We were told that instruments used in minor surgery were all disposable. The nursing staff explained to us that that equipment, such as blood pressure cuffs, that was not disposable was cleaned using disinfectant wipes. However the provider may find it useful to note that some GP's were not aware that the cleaning of some low risk equipment between patients was necessary.

We found that the practice had clear cleaning schedules which we looked at. The practice manager checked cleaning standards, but these checks were not logged. However, we

saw that when an issue was identified a written record was made and retained and that a copy was passed onto the cleaning staff for action. We observed that the practice was clean and well maintained. Patients we spoke with also felt standards of cleanliness were satisfactory. One patient said, "It's very clean and hygienic, particularly the toilets which I think is important." This meant patients were cared for in a clean, hygienic environment.

The GP's had access to specialist advice on the investigation, diagnosis and treatment of infections from consultants at a local hospital trust. The GP's we spoke with told us they found this service useful and there were no problems getting advice when needed.

We were shown the system used by reception staff for handling and sending patient specimens such as urine samples. This ensured that the samples were handled safely and did not present a risk of infection. We saw records that showed staff were vaccinated against Hepatitis B. We saw actions to take in the event of a needle stick injury were displayed. A GP had recently sustained such an injury and was able to describe the actions taken which reflected that of the guidance. We were also told that post exposure prophylaxis treatment for HIV was available through the Occupational Health Department or A and E. This meant there were systems to reduce the risk of infection for staff while doing their jobs.

We found that clinical and domestic waste was segregated. We saw that there were appropriate arrangements for the disposal of 'sharps' (this includes items such as needles and blades) and for other waste that had the potential to cause harm, such as cytotoxic waste. We saw all hazardous waste was securely stored while awaiting collection by a contractor licensed to do this. We saw that receipts for waste collection were given and retained. This meant that there were robust systems to manage hazardous waste.

We observed that there was patient information on reducing the risk of infection displayed in waiting rooms. This included immunisation programmes for shingles, influenza and child vaccinations. The practice had a system for inviting those patients due, or eligible for vaccination in for an appointment. Patients we spoke with confirmed that they received these invitation letters. This meant patients were given information on how to reduce the risk of infective illnesses.

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Patients were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

There were effective recruitment and selection processes in place. We looked at the files of two reception staff who had been recruited since the current regulations were introduced. The manager told us the vacancies were advertised at the local job centre or on a commercial web-site. We found that there job descriptions and person specifications for the role. We saw there was a recruitment process that included an application and interview. We saw adequate references had been received on the staff files we looked at. Proof of identity was provided as part of the process for obtaining access to computer systems, but the provider may find it useful to note copies were not retained. Once appointed we saw staff had a contract which made clear their contractual rights and responsibilities and had an induction programme.

The practice had access to an Occupational Health (OH) Department. We saw that new staff were assessed by OH to ensure they were mentally and physically fit to do their job. There was also the provision to refer staff to OH if they had health problems that would affect their work. We saw that a pregnant member of staff had undergone a maternity risk assessment which ensured they could safely carry out their duties. This meant there were systems to ensure that staff were, and remained, fit to carry out their role.

Nurses and GP's must have current registration with the relevant professional bodies (Nursing and Midwifery Council, General Medical Council) in order to work with patients. We found the manager had a system for checking that nurses and GP's had renewed their annual registration. We also saw evidence that professional staff were completing the required continuing professional development their registration required. Patients we spoke with confirmed that they felt confident in the skills and abilities of the clinical staff. This meant that nurses and GP's were appropriately registered with their professional bodies.

Appropriate background checks were undertaken for clinical staff. GP's at the practice were required to be on a 'performers list' maintained by NHS England. Being on this list enabled them to practice as a GP and also meant that all necessary background checks, including barring orders or relevant criminal convictions, had been completed. We saw that the practice manager had a system to carry out an annual check to ensure GP partners remained on this performers list. We also saw records that showed any locum GP's

employed were checked to ensure that they were included on the performers list.

Nurses and health care assistants had a Criminal Records Check when they joined the practice and a nurse confirmed this had happened. These checks preceded the current Disclosure and Barring Service (DBS) which are an employer's check to ensure candidates were not barred from working with vulnerable people or have criminal convictions that would make them unsuitable for their job. As these checks were conducted some time ago the practice manager told us they were considering the frequency of repeat checks. The registered manager took action in the 48 hours following our visit and determined annual checks would be required and initiated the process for carrying them out.

Reception staff signed a declaration that they had no criminal convictions but there were no checks made with the DBS. There was no risk assessment process in place to establish if a DBS check might be appropriate. The registered manager took action in the 48 hours following our visit and completed risk assessments for all staff at the practice which was forwarded to us. This assessment demonstrated that no further DBS checks were required. This meant that that the provider had a process to determine if non-clinical staff required background checks to be performed.

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 patients receive.

Reasons for our judgement

Patients who used the service, their representatives were asked for their views about their care and treatment and they were acted on. We saw that an annual survey was carried out by the Patient Participation Group (PPG) in 2012 and 2013. Three patients we spoke with confirmed that they had seen copies of the survey forms available in reception. One patient said, "The things are on reception, asking you to fill in forms; I have seen them." The results, analysis and action plans from these surveys were available to view on the practice website. We found that actions had been implemented. For example, there were issues about the flow of practice information and it was agreed the newsletter would be reviewed. We saw copies of the revamped newsletter. A member of the PPG told us, "Everything was very positive. I don't know what they could do to make it better." There was also a suggestion box situated in the entrance area, but the practice manager told us this was very rarely used.

Commissioners of services had set quality standards using the Quality Outcomes Framework (QOF) for the practice. We saw that QOF performance data was monitored by the practice manager using an electronic system. We saw that current QOF performance, and necessary actions for improvement were discussed at practice meetings. This showed that the practice was monitoring quality standards using an agreed and recognised set of standards.

We were told there was a range of staff meetings including meetings for reception staff, and GP's and nurses. We saw minutes of these meetings. We noted that a wide range of issues were discussed and that staff were able to express their opinions and contribute to decision making. We saw that relevant information, including actions needed to improve, was given by managers. A receptionist said, "We talk about what's gone wrong, what needs changing." This meant there were opportunities for staff to be updated and to express their views on the quality of service provided.

The provider had arrangements to identify, assess and manage risks to the health, safety and welfare of patients and others. We found that relevant risk assessments were performed. For example we saw a fire risk assessment and found that a sample of the

control measures such as the provision of fire extinguishers and checking of fire alarms were in place. We also saw there was an assessment for the Control of Substances Hazardous to Health (COSHH) and that cleaning materials were locked away as this assessment required. We saw that safety alerts generated by bodies such as the National Patient Safety Agency were reviewed, acted upon and disseminated to practice staff. For example we saw that an alert about a medicine had resulted in a search of patients' records to identify that medicine and an e-mail had been forwarded to all staff to advise them of the alert. GP's we spoke with confirmed that they received notice of alerts via email.

There was a complaints system which included the handling, investigation and the identification of lessons learnt. We saw records where the learning points were made explicit and saw records of practice meetings where these were discussed. We also found there were incident reporting arrangements which staff were aware of and we saw they had been used. We saw incident reports where any lessons learned were identified. However, the provider may find it useful to note that while these systems were effective for managing individual significant events, there was no system for analysing and discussing significant events and feedback overall. Therefore there was no robust way of ensuring any themes and trends would be identified and that relevant learning would be effectively disseminated to all staff.

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.

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