

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

Dr Green and Partners

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

Details about this location

Registered Provider	Dr Green and Partners
Registered Manager	Dr. Joseph Santos
Overview of the service	Dr Green and partners practice from a modern medical centre. A wide range of GP services are offered by the practice including, chronic disease management, childhood immunisations and travel vaccinations and advice.
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

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Summary of this inspection

Why we carried out this inspection

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

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 23 January 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 and talked with staff.

What people told us and what we found

During our visit to Dr Green and partners we met with two GP partners. We also met with the practice manager. We spoke with six patients and with four members of staff.

Patients were involved in making decisions about their care and treatment. One patient told us that when a treatment was suggested by their GP they were asked "what do you think about that? Rather than just you will follow this, it's a discussion".

Patients received treatment that was intended to maintain their welfare. Patients were invited to attend for annual check-ups and reviews. One patient we spoke with told us about their annual review, they said "I get an annual health check. They take my blood pressure, check I am exercising and give me advice about alcohol intake".

The risk of infection had been reduced because current guidance had been followed.

Staff were supported to undertake training appropriate to their role and responsibilities. Staff received and appreciated feedback on their performance in their job.

The practice actively sought the views of patients. Annual satisfaction surveys were carried out and a patient participation group (PPG) was active. We saw that the practice responded to any patient comments posted on the NHS choices website.

Medical records and other records relevant to managing the service were maintained in good order and held securely.

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.

Patient's privacy, dignity and independence were respected. Patient's views and experiences were taken into account in the way the service was provided in relation to their care.

Reasons for our judgement

Patients were given appropriate information regarding their care or treatment. We saw that the surgery opening hours were contained on the practice website and in a patient information leaflet. The website and the leaflet also carried details of the services available and the names of the doctors who worked at the practice. The details on how to contact out of hours GP services were displayed in the waiting room, on the website and in the patient leaflet. This meant that patients were given appropriate information about the services available and how to gain access to GP services.

We spoke with six patients. All of them told us that they received explanations of their care and treatment, from both doctors and nurses, which they understood. They also told us they felt able to ask questions about their care and treatment. One patient we spoke with told us that they were able to ask their GP to help with an explanation of a letter they received from the local hospital. They said "I asked them could they put this in layman's terms. The doctor explained all the information I needed".

The patients we spoke with told us that when treatment options were available they were offered by the doctors. One patient we spoke with said "they [the doctors] have always given me the opportunity to debate the medical situation and look at possible outcomes". Another patient we spoke with told us the doctor had advised "you've got a test tomorrow. You can wait for the result or we could try this [a prescription]". One of the patient records we looked at recorded that the GP had advised treatment and given an option of medication. There was an entry confirming the patient declined the option of medication.

Patients were treated with respect and with regard to their privacy and dignity. We saw patients greeted politely and professionally by reception staff. The waiting room was separated from the reception area by a wall and fire door. This meant that patients in the waiting room could not hear phone conversations between reception staff and patients. We saw that surgery and treatment room doors were closed whilst patients were with a

doctor or nurse. The six patients we spoke with all said they were happy with the privacy they were given when they saw the doctor or nurse. The computer screens at the reception desk were positioned in such a way that patients could not see the information held for others.

We asked the six patients we spoke with whether they could access both routine and urgent appointments to see either a GP or practice nurse. Four of the six patients we spoke with told us they did not experience any difficulties in getting either routine or urgent appointments. However, two patients commented that they found obtaining a routine appointment with their preferred GP was difficult. All six patients said they could obtain urgent appointments. One of them told us, "if you've got an urgent appointment you don't mind who you see". The provider may find it useful to note that two patients we spoke with found access to appointments with their usual GP difficult.

Patient's diversity, values and human rights were respected. The surgeries were located on the ground floor. Wheelchair access was available to all surgeries and treatment rooms and there was a toilet provided with wheelchair access. Written information could be produced in large print for patients with a visual impairment. The practice had access to a language line for patients whose first language was not English and the website carried a translation facility. The provider may find it useful to note that specific provision for patients with a hearing impairment was not available.

Patients were able to obtain information and access services to encourage them to change lifestyle behaviours that were placing them at risk of poor health. We saw a range of health promotion materials displayed in leaflets in the waiting room. For example, advice on exercise and influenza vaccinations. Patients were encouraged to check their own weight and height. A machine was available in one of the treatment rooms. There was a poster promoting this service and advising patients to hand their results in to the GP or nurse when they went in for their appointment. One of the patients we spoke with said they had received health promotion advice about losing weight. They said "I have had dietary advice that was helpful". This meant that patients were encouraged and supported to reduce their risk of developing health problems.

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 patient's safety and welfare.

Reasons for our judgement

We spoke with six patients. Most of the patients were satisfied with the services they had received. However one patient expressed dissatisfaction with the follow up arrangements when they had been referred to hospital. They told us they had been disappointed that their GP had not contacted them to find out how their hospital treatment was progressing. However, another patient described the service they received from their GP as "the best I could get" and third patient said "I have every confidence in my GP. They are always very helpful".

We looked at the results of both a national survey of patients registered at the practice and the local satisfaction survey carried out in 2013. Both showed a high degree of confidence in the service received from the practice. The NHS choices website recorded that 94% of patients would recommend their GP.

We met with two of the GP partners during our visit. They told us about various initiatives the GPs had been involved in to further improve care and treatment for patients. For example, identifying patients who were long term smokers to give early advice on avoiding developing chronic obstructive pulmonary disease (COPD). We also discussed the efforts the practice was making to increase the frequency of checking the blood pressure of patients with diabetes. This was aimed at offering more active assistance and advice in reducing blood pressure for this group of patients with a long term medical condition. We were told it was too early to assess whether these initiatives were bringing about improvement in the health of these groups of patients.

Patients received care and treatment with regard to their safety and welfare. One of the patients we spoke with told us "I get an annual health check. They take my blood pressure, check I am exercising and give me advice about alcohol intake". We saw that medicine reviews were carried out every six months. The patients we spoke with who were taking regular medicines all told us they received a six monthly review of their medicines.

When patients attended their annual reviews we saw that every aspect of their care and review was recorded in their medical records. The content of the review reflected relevant research and clinical guidance. We saw that treatment guidance from the National Institute

for Health and Clinical Excellence (NICE) was held on the practice patient database. For example, the recording system used for asthma reviews followed the NICE guidance.

Patients were referred for specialist advice and treatment when appropriate and their referral was processed in a timely manner. Three of the six patients we spoke with had required referral to hospital specialists in the past. They told us that their GP had explained why they required the referral and had processed the referral quickly. One patient said "my referral to hospital was dealt with very effectively".

We looked at four electronic patient records and noted that these were in chronological order. The records included medical information, treatment given and medication being taken. Where needed, some information was recorded as an alert. For example, if the patient had allergies or an on-going medical condition. The system also had the facility to add messages in cases where urgent information needed to be highlighted or to remind the GPs to undertake medical reviews. Standard medical abbreviations were used throughout. This meant that patients could see any GP or nurse.

All of the medical records we looked at contained good quality copies of correspondence from other health care professionals. These were held in date order and easily accessible to the GP or nurse. This meant that the GPs and nurses could follow up on patient information received from other health care providers.

There were arrangements in place to deal with foreseeable emergencies. Three of the staff we spoke with had received training in basic life support. We saw certificates to confirm this training had taken place. The fourth member of staff had not been in their job long and had not had the opportunity to receive basic life support training. This member of staff was aware that they would be required to attend basic life support training in 2014. All four members of staff knew where the emergency equipment was kept. The practice emergency equipment comprised an emergency oxygen cylinder, a supply of emergency drugs and an automated external defibrillator (AED). We found that the emergency equipment was in working order and the emergency drugs were in date. One of the practice nurses we spoke with told us they checked the emergency equipment every week. The provider may find it useful to note that the weekly check of emergency equipment was not recorded.

We saw that the practice had a business continuity plan to maintain services to patients during an emergency. For example, the shortage of GPs or a loss of the water supply to the building. We saw that a fire evacuation policy and procedure was in place and that fire evacuation instructions were clearly displayed throughout the building. There was a record confirming that two members of staff were trained as fire marshals.

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 protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

The six patients we spoke with were all satisfied with the cleanliness of the practice. We saw that there was a cleaning schedule, supported by checklists, in place for the cleaners to follow on a daily basis. We saw that cleaning materials and equipment were stored safely in locked cupboards. Different colour mops, buckets and cleaning cloths were in use to reduce the risk of cross contamination between clinical and non-clinical areas. The practice was very clean and tidy on the day of our visit.

Surgeries, treatment rooms and toilets all had appropriate hand washing facilities. They were stocked with liquid soaps and disposable paper towels. We saw that all wash hand basins had hand washing guidance displayed near them. We saw a record of a meeting in 2013 where all staff had received a reminder on good hand hygiene. Dispensers of hand sanitizing gel were positioned around the practice with notices encouraging patients to use the gel before they saw either the GPs or nurses. Patients and staff were provided with the necessary equipment and materials to ensure the risk of infection from poor hand hygiene was minimised.

Systems were in place to identify, assess and manage the reduction of the risk and spread of infection. The practice held a control of infection policy that was comprehensive. There was a nominated lead member of staff responsible for control of infection. We saw confirmation that the control of infection lead had taken an update in control of infection in the last 18 months. A control of infection audit had been carried out in 2013 in accordance with the Department of Health (DH) code of practice. This meant that patients could be assured that the practice operated effective processes for control of infection.

We saw that the practice held a contract with an approved contractor for sterilisation of surgical instruments. There was an appropriate system in place for safe storage, collection and return of surgical instruments. Most instruments used were disposable and used only once.

The risk of contamination from clinical waste was minimised because the practice operated a system segregating clinical waste from general waste. We found that full bags of clinical waste were tied and taken to a secure bin awaiting collection. The bins for sharp

instruments and syringes were held off the floor in a safe place on worktops to prevent them being knocked over and presenting a risk of injury from sharp objects. We looked at practice records confirming that clinical waste was collected by a licenced waste carrier and the consignment notes showing that clinical waste was removed at agreed intervals by the carrier. This conformed to the hazardous waste legislation of 2005.

The practice had taken measures to reduce the risk of patients contracting infection from waterborne bacteria. A legionella risk assessment was undertaken by the practice manager. The assessment identified the practice as a low risk environment for the growth of waterborne bacteria. The practice manager told us they would order a test kit to take water samples for analysis to check the water quality.

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.

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

Reasons for our judgement

Staff felt well supported to carry out their roles and responsibilities and told us they were happy in their jobs. We spoke with four members of staff. All of them said they received good support from their manager and the GPs. One member of staff told us "If the practice manager is not around there is always a GP around to ask if you have a question" and "I love being with the patients and I like this job because every day is different". Another member of staff said "there is plenty of support here". One of the patients we spoke with said "the staff are just so helpful when you come in they are so pleasant".

Two of the members of staff we spoke with had been in their jobs for less than two years. Both of them told us they received induction training when they started. They told us they worked through an induction checklist and shadowed experienced members of staff when they first joined the practice. We saw copies of the induction checklist used. This meant that staff were prepared well to offer efficient and safe services to patients.

Staff received appropriate professional development. We spoke with two practice nurses who told us about a range of training courses they had completed. These included courses in managing diabetes, asthma and COPD. The nurses held their own training records and we saw that they completed training to support their registration with their professional body. One of the non-clinical staff we spoke with told us they had received training in basic life support and how to use the computer system. We saw some certificates confirming completion held in staff personnel files. The provider may find it useful to note that a master record of training was not held. Therefore, the registered manager could not be reassured that appropriate training had been undertaken.

Staff were supported by a meeting structure which enabled briefing on practice developments and an opportunity for them to raise matters which they felt important to discuss. We saw that minutes of staff meetings were maintained. One of the members of staff we spoke with said "if I miss a meeting I get sent a printed set of minutes". We saw that a variety of topics were discussed at staff meetings. For example, hand hygiene.

The provider had worked continuously to maintain and improve high standards of care by creating an environment where clinical excellence could do well. Staff received appropriate

supervision and appraisal. We were told, and we saw records confirming, that staff received an annual appraisal. One of the members of staff we spoke with said that their appraisal gave them the opportunity to "focus, stop and look at your next year". We saw that appraisals included reviewing performance in the previous year, identification of training needs and looking at objectives for the year ahead. A relatively new member of staff told us that they had met with the practice manager every fortnight to review their progress and that they expected to have a formal review after they had been in post for six months.

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 received. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients using the service and others.

Reasons for our judgement

Patients were asked for their views about their care and treatment and they were acted upon. We saw that the practice conducted annual patient satisfaction surveys and an active Patient Participation Group (PPG) was working with the practice. (PPG's work with GP practices to offer a patient opinion on the way services were delivered and a patient viewpoint on any proposed changes with the service).

The results from patient surveys were made available at the practice and published on the practice website. We saw that the practice acted upon the comments received from patients. For example, patients had commented they did not know the system to register as a carer. The practice took action to promote carer registration and registered carers increased threefold in one year.

We saw that the PPG had a dedicated information board in the waiting room and had published a guide on practice services. We spoke with a member of the PPG by telephone on the day of our visit. They told us how the group was active in encouraging patient involvement. For example, PPG members visited the practice to promote participation in the annual survey. The PPG member we spoke with said "I did a two hour shift on Monday getting patients to complete the questionnaire". We saw that the practice was seeking patient feedback on a proposal to introduce online appointment booking.

The practice audited the quality of clinical work. We saw an audit was underway identifying patients with diverticulitis (a digestive problem). The aim of the audit was to promote self-management when appropriate to avoid hospital admission when the disease "flared up". We saw that this audit was commended by the local health commissioners. Other audits were carried out. For example, audit of post-surgery infection following toenail surgery. This meant that the practice reviewed the care patients received and looked for ways to improve care.

The practice took part in reviews of care with other GP practices in Oxfordshire. We saw

that the practice had reviewed the use of outpatients department, emergency admissions and prescribing. The results were compared with other practices in Oxfordshire. One of the GPs we spoke with told us that the GP team were keeping a close watch on outpatient referrals as the practice showed higher than average referrals in 2012/13. They told us how each proposed referral was shared with another GP to ensure it was the right thing to do for the patient before the referral was sent to the hospital.

There was an up to-date-complaints procedure which was displayed and included on the website and in the patient leaflet. The provider took account of complaints and comments to improve the service. We saw that the practice logged complaints and the GPs reviewed complaints received. We saw that all complaints received in 2013 had been dealt with in accordance with the practice procedure. We looked at the action arising from one complaint which related to prescribing of antibiotics. We saw that the GPs had researched the guidance on prescribing antibiotics and recorded action to follow the guidance.

Significant events were recorded, discussed and there was evidence that learning had taken place arising from incidents. We saw that significant events were discussed at health team professionals meetings. We saw that one incident resulted in the practice purchasing a new piece of equipment to take oxygen readings for young children.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients using the service and others. There were a range of safety policies covering important aspects of safety and welfare. For example, handling medicines, dealing with blood-borne viruses, repeat prescribing and decontamination. Staff were aware of these policies and knew where to find them. Staff we spoke with who had been appointed in the last two years told us that their induction included familiarising themselves with health and safety policies.

We saw that vaccines were stored safely in purpose designed refrigerators and that the temperature of these fridges was monitored. The records of temperatures showed fridges operated at optimum temperatures. Hazardous substances were stored in accordance with manufacturer's instructions and safety data sheets were held. There were records of essential maintenance to building and plant having been undertaken at appropriate frequencies.

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

Our judgement

The provider was meeting this standard.

Patients were protected from the risk of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

Patient's personal records including medical records were accurate and fit for purpose. We saw that patient medical records were updated every time a patient attended the practice. The records included copies of test results, medication taken and dates for medication reviews. Copies of correspondence from hospitals and other health care professionals were attached to the medical records and were held in chronological order.

Records were kept securely and could be located promptly when needed. Access to patient records was controlled by unique password access and we saw staff removed their "password cards" when leaving a computer unattended. Manual patient records were kept securely in appropriate storage units. The area for storage of manual patient records was not accessible to the general public. Records relating to staff employment and other records relevant to the management of the service were held securely. We saw that records held by the practice manager in their office were kept in lockable drawers which were locked when not in use. The practice manager's office was in an area which was not accessible to patients. We saw that the door was closed on each occasion the manager left the office.

Staff records and other records relevant to the management of the service were accurate and fit for purpose. We saw that staff records contained full information relating to the employment process. These records also held copies of induction and appraisal meetings. Some training certificates were held centrally in staff records. The provider may find it useful to note that not all proof of completion of training was held in staff records. Management records were held in chronological order in ring binders labelled with a description of the subject of the contents. For example, we looked at a comprehensive health and safety file that was clearly indexed. The documentation we requested on the day of our visit was found promptly and made available to us in a well presented format.

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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