Inspection Report

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

Smallcombe House

Oakwood Gardens, Bathwick Hill, Bath, BA2 6EJ

Tel: 01225465694

Date of Inspection: 25 November 2013

Date of Publication: January 2014

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

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

Details about this location

Registered Provider	The Salvation Army Social Work Trust
Registered Manager	Mrs. Ena Caddy
Overview of the service	Smallcombe House provides care and support for a maximum of 32 older people. The home is managed by The Salvation Army Social Work Trust. The home is located close to the city of Bath.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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 25 November 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

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

What people told us and what we found

At the time of our inspection, there were 26 people living at Smallcombe House. We used a number of different methods to help us understand the experiences of people using the service. For example, observations and looking at records. This was because some people had complex needs or memory loss which meant it was difficult for some to be able to tell us about their experiences. One person said "they couldn't be nicer to me. Another person told us "I'm quite settled here and have no real complaints."

We spoke with people and staff and observed how people were respected and involved in Smallcombe House. One person we spoke with told us "staff are very respectful when helping me with my personal care." We observed staff knocked on doors and asked permission before entering rooms and spoke kindly and appropriately with people. The home employed a full time chaplain and was in the process of employing a full time activities coordinator.

People told us they felt safe with carers and their needs were met in the way they preferred. One person told us "staff come when I press my buzzer and are all nice. I don't wish to be anywhere else but here." Staff told us they spent a lot of time talking with people and their families and by doing this got to know individual likes, dislikes and preferences. We observed people had risk assessments and management plans in order to meet their health and welfare needs.

Staff demonstrated a good understanding of infection control risks. The kitchen and laundry areas were clean and tidy and systems were in place to minimise infection risks to people. We observed cleanliness in people's bedrooms and some communal areas had not been well maintained. For example we saw debris and stains on floors and light pulls. The provider did not have appropriate systems in place to assess, detect and control the

spread of infections in all areas of the home.

All the staff we spoke with said senior staff and the manager were approachable and would listen to any concerns. Staff told us they had received regular supervision which they found helpful to their roles. Staff said there were opportunities to obtain further qualifications relevant to their roles. This included National Vocational Qualifications (NVQ).

The provider had systems in place to assess and monitor the quality of the home. We saw minutes of separate care staff and managers' meetings. Staff told us they understood the importance of making comments on behalf of people who lived in the house. We saw minutes of general house meetings involved people, relatives and staff. The manager told us these forums gave people, relatives and staff additional opportunities to express their views and experiences. We saw records which showed health and safety was discussed with all staff. This meant systems were in place to manage risks to people's safety and welfare.

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

What we have told the provider to do

We have asked the provider to send us a report by 12 February 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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

More information about the provider

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

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

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

We spoke with five people and one relative of a person living at the home. Some people had memory loss which made it difficult for them to tell us about their experiences. We spoke with four staff and the manager and made observations to see how people were respected and involved in their care.

People told us, "I'm satisfied, I want to stay here for the end of my days" and "I couldn't wish to be in a better place." One person's relative said "generally, everything is fine and mum has not expressed any displeasure about her care." Three people we spoke with could express what was important to them, including how they liked to be supported to maintain their independence. One person we spoke with said "staff are very respectful when helping me with my personal care. The girl today was very nice; she asked me what I would like help with and how I would like her to go about it."

We saw activities available for people in the communal areas in the home. One person told us "there are things going on here but I choose not to join in. There is a nice lounge and I know sometimes they get singers or a band in." We saw stocks of books, craft materials and games. The manager confirmed a new activities person had been recently appointed but had not yet started in post. The manager said because of this there were less organised activities than usual available for people within the home and local community. The home employed a full time chaplain who provided spiritual services throughout the week and a service on Sunday's. The manager told us it was people's personal choice to attend or not. This meant people's religious beliefs were treated with dignity and respect.

The five staff we spoke with all told us they talked to people when providing care and offered choices with all they were doing. For example, staff told us when supporting people with personal care; they always checked with the person what they wanted to do for themselves. This ensured people felt involved with their care and remained as independent as they were able. Staff told when providing personal care, privacy was respected by ensuring doors were closed, curtains drawn and the person was kept

covered as much as possible. One member of staff told us they always checked if people wanted help styling their hair, choosing jewellery or putting make up on. This meant people were cared for in a respectful and dignified way that promoted their independence.

We saw people walked about all areas of the home including in and out of office areas. We observed people were spoken to kindly and appropriately and were welcomed by care and ancillary staff wherever they went. We observed one person become confused and anxious with information whilst on the telephone. We saw staff spoke to this person calmly and gave information repeatedly until the person was reassured. We observed staff knocked on people's doors and asked permission to enter before doing so. We were invited into the bedrooms of three people and saw they were personalised with pictures and paintings. We saw beds and chairs were positioned facing windows and people told us they appreciated being able to see the grounds and views.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke to five people, four care staff and one visiting health professional. We made observations and looked at records to see how care was planned and delivered to people. People in the home had varying levels of dependency with most people requiring support with their personal care and mobility. One person told us "the young staff are very inexperienced but on the whole are good at helping me"

People told us they felt safe with carers and their needs were met in the way they preferred. One person told us "staff come when I press my buzzer and are all nice. I don't wish to be anywhere else but here."

We spoke to four staff to find out how they understood about people's care needs. Staff told us they spent a lot of time talking with people and their families and by doing this got to know individual likes, dislikes and preferences. For example, food and drink, and when people liked to get up or go to bed. Staff said they were informed of any changes in care needs by the supervisor at the start of each shift. Staff told us if they were unclear about anything they looked at people's care plans and spoke with the care supervisor. Staff told us they were responsible for recording the care they had provided and any other issues directly into people's care plans at the end of shifts. This meant the provider had appropriate systems in place to ensure care for people was appropriate and safe.

We observed staff spoke with people kindly and appropriately and took time to engage with people in conversations. For example, we observed one person being supported to transfer from a wheelchair to a chair. We saw this person was encouraged and supported to move safely between the chairs at their own speed. This meant care provided promoted the welfare and safety of people.

We looked at the care records of four people. We observed people had individual risk assessments and management plans to meet their health and welfare needs. For example, each person had a malnutrition universal screening tool (MUST) and a pressure risk assessment (Waterlow). This meant the provider referred to appropriate published guidance to support the care and welfare needs of people.

The manager told us one person's care needs related to end of life care. We saw records which showed this person had regular checks and repositioning. All the staff we spoke with demonstrated an understanding of this person's care needs. We observed this person appeared relaxed, clean and comfortable. We looked at this person's care records and saw the end of life section and pain assessment had not been documented. We spoke to the manager about this and they confirmed these assessments would be completed the following day, including consulting with the person's family and GP.

In all four care plans, we saw instructions which would have enabled staff to provide care safely and appropriately for people. For example, in one person's care plan we saw details regarding the person's ability to use their walking aid. These instructions clearly stated which areas of the home the person had difficulty walking, why and what actions staff should take to minimise risks and provide appropriate support. This meant this person's individual needs had been assessed and actions planned which minimised the potential for unsafe or inappropriate care.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not cared for in a clean, hygienic environment. People were not fully protected from the risk of infection because appropriate systems were not in place to monitor and audit cleanliness and infection control risks.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with the manager, two cleaning staff and one senior care staff whose responsibility was to act as lead for infection control for the home. We made observations and looked at records to see how the service monitored and maintained cleanliness and infection control.

The manager told us three cleaning staff had been employed, for 20, 25 and 35 hours per week. Cleaning staff worked seven days a week and were responsible for cleaning all areas of the home apart from the kitchen. The manager told us three kitchen staff had responsibility for cleaning the kitchen. The manager said they also employed two laundry staff working in total, 30 hours per week. The manager said one senior care staff had recently been nominated as the lead for cleanliness and infection control for the whole home.

We spoke with two cleaning staff who told us tasks were shared to ensure communal areas and people's bedrooms were cleaned in line with the provider's policy. The cleaning supervisor told us they completed visual checks of cleaning standards at the end of the day. The cleaning supervisor told us they had not maintained written records of cleaning audits since August 2013. This meant it would be difficult to analyse cleaning issues or plan actions to improve or maintain standards of cleaning in the home. The cleaning supervisor demonstrated a good understanding of infection control risks. For example, how to prevent cross contamination from one area to another.

We observed the laundry room was clean and organised and laundry was separated into colour coded bags. The laundry staff said colour coding ensured infected laundry was kept separate and the correct temperature and treatments were used to prevent the spread of infections. The laundry staff were able to demonstrate a good understanding of the specialist washing machines and cleaning cycles. This meant there were effective processes and equipment in the laundry to prevent the spread of infection.

We inspected the kitchen and found most areas to be clean and tidy. We saw the base unit of one cooker was stained and had visible debris on it. We observed records of daily cleaning tasks were maintained for items in everyday use such as sinks and crockery. We saw records which showed other cleaning tasks had been completed on a monthly basis. For example, store cupboards. We looked at records which showed the temperatures of fridges and freezers had been checked twice a day. One kitchen staff told us this ensured food was stored at the correct temperature which prevented health risks to people.

We inspected all areas of the home and found cleanliness and infection control risks had not been maintained. We saw seven people's bedroom's which included en-suite toilet and sink areas. We looked at three communal bathrooms, two kitchenette areas used by people and staff. We observed all the en-suite toilets had stained toilet bowls and dirty toilet brushes. All communal and personal bathroom areas had pull lights which were discoloured and dirty. This meant because of the poor hygiene there were risks of infections and cross contamination infection.

We observed cleaning tasks had not been completed thoroughly. For example, behind one communal bath we saw the floor was discoloured and had visible debris on it. We saw dirty tissues on the floor behind the bath and under chairs in people's bedrooms. Soap dishes in the communal bathrooms were observed to have scum on them. This meant the appropriate standards of cleanliness and hygiene had not been maintained.

We observed areas of the home and furnishings needed repairing or replacing as they presented infection control risks. For example, we saw there were large drains in people's personal toilets and in the communal bathrooms. All these drains had visible scum and debris attached. Carpets in the halls by bedrooms were stained in areas. The radiator covers in kitchenette areas, people's bedrooms and the communal bathrooms were rusted in areas. Rust cannot be effectively cleaned and decontaminated. We observed all waste bins in bedrooms, bathrooms and the kitchens had stains on the lids and were not foot operated. People with memory loss may not have appreciated items were unclean and avoided touching them. This meant people were at risk of cross contamination and infection.

We spoke with the senior staff who had recently been given responsibility for leading on infection control in the home. This person demonstrated a good understanding of risks related to infection control for example the use of personal protective equipment and hand washing techniques. This staff told us they had just started an infection control audit and did not know when the last audit had been completed. This meant the provider had inappropriate systems in place throughout the home to assess the risk of and to prevent, detect and control the spread of infections.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke to four staff and the manager. We looked at records to see how staff were supported to provide in their roles.

All the staff we spoke with said senior staff and the manager were approachable and would listen to any concerns. Staff told us they had received regular supervision which they found a helpful to their roles. Staff said if they had any concerns they would immediately talk with senior staff. All the staff we spoke with told us they liked working at the home and staff supported each other when on duty.

Staff told us they attended staff meetings and felt able to contribute to discussions. We looked at the records for the last staff meeting and saw a mixture of care and ancillary staff had attended. These records showed different people had contributed to the agenda and subsequent discussions. This meant the provider had appropriate systems in place to support staff with their roles and responsibilities.

We spoke to staff about the training they received. Staff told us additional training had been arranged to improve standards of care. For example, an external dementia care specialist had been booked to provide training sessions. All staff told us there were opportunities to obtain further qualifications relevant to their roles. This included National Vocational Qualifications (NVQ). This meant staff were enabled to obtain further qualifications to deliver safe and appropriate care to people.

We looked at the supervision records of five staff and saw these had taken place in line with the provider's policy. We looked at the providers mandatory training records. We saw training was not in date for approximately 50% of staff for different subjects. These included safeguarding people from abuse, understanding the Mental Capacity Act and fire safety. We looked at records of annual appraisals for staff and saw 40% were not in date. The manager told us they were aware of these issues and had made action plans to ensure all staff were appropriately trained and supervised.

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

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke to five people and the manager and looked at records to see how the quality of the service was assessed and monitored.

The five people we spoke with all told us they would speak to staff if they had any concerns about the service. The manager showed us a summary of findings from the most recent survey of people's views dated February 2013. This showed a 50% response rate. We saw the survey had been adapted with pictures and included questions on a range of subjects. For example, how independence was supported, and views on nutrition and staff communication. This meant the provider had taken appropriate steps to obtain people's views of their experience of care.

We saw positive feedback related to meals and a catering service no longer used by the home. All the people we spoke with during our visit told us they were offered meals choices but did not particularly enjoy the food. People said none of the food was 'home made', sometimes looked unappetising and was not always tasty. People said they would prefer to eat fresh food cooked from scratch in the homes kitchen. The manager confirmed the provider used external food supplier and all meals purchased were frozen. The manager told they would ensure this was further explored with people.

We saw the provider had written details about accidents and incidents and had evaluated these for potential service improvements. We saw records of complaints and actions subsequently taken. We saw information regarding how to make complaints was available a notice board in the home. We saw the providers complaints policy stated a clear process to follow including timescales to reply. This meant the provider had systems in place to monitor for risks and service improvements.

The provider had other systems in place to assess and monitor the quality of the home. We saw minutes of separate staff and managers' meetings. Staff told us they understood the importance of making comments on behalf of people who lived in the house. We observed the team meeting records showed health and safety was discussed. This meant systems were in place to manage risks to people's safety and welfare. We saw minutes of

general house meetings involved people, relatives and staff. The manager told us these forums gave people, relatives and staff additional opportunities to express their views and experiences.

We saw the quality assurance tool used by the provider which involved an internal audit of the majority of the Care Quality Commissions essential standards. This was spread over the year and the audit tool was used by senior managers. Information from these monthly audits was fed into an annual audit report. This identified service improvements to be actioned the following year. We noted the last annual audit recognised staff development standards had not been met. This was in line with what the manager had told us and the action plans they had subsequently put in place. This demonstrated the provider's internal audit system was effective at identifying deficits which impacted on the quality of the service.

We saw other records which showed there were systems in place which assessed and monitored the quality of the service. For example we saw the gas, electrics and water systems had all been serviced in line with the provider's policy. The manager told us any maintenance issues noticed by people or staff were reported to the maintenance person employed by the home. We saw issues and outcomes were documented and dealt with promptly. This meant there were systems in place to protect people from the risks of unsafe care.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not protected from the risks of infection due to poor standards of cleanliness and risks of cross contamination, particularly in bedrooms, en-suite toilets, communal bathrooms and kitchenette areas. Some furnishings presented infection risks. These included rusted radiator covers and unhygienic light pulls, and toilet bowls. Infection control monitoring and auditing was not completed throughout the home. This is a breach of Regulation 12 (1) (a), (2) (a) and (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

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

The provider's report should be sent to us by 12 February 2014.

CQC should be informed when compliance actions are complete.

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

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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