Inspection Report

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

Kingsland House

Kingsland Close, Off Middle Road, Shoreham By Sea, BN43 6LT

Tel: 01273440019

Date of Inspection: 19 March 2014

Date of Publication: April 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard

Details about this location

Registered Provider	Barchester Healthcare Homes Limited
Registered Manager	Mr Christopher Patrick Colville
Overview of the service	Kingsland House is a purpose built nursing home situated in a seaside location between Worthing and Brighton. They provide care and accommodation for up to 71 older adults with frailty, physical disability, dementia and related mental health conditions. The home includes 'Memory Lane', a unit to accommodate people with dementia and 'Bluebell' for people with less complex needs. The service offers nursing care, end of life care, respite care and short breaks.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening 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'.

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Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 19 March 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

What people told us and what we found

During our inspection we spoke with seven people who used the service and two of their relatives. We also spoke with the registered manager, four nurses, five care workers, an activities co-ordinator and a visiting health care professional. We looked at care documentation, staff files, records of audits and minutes of meetings.

People who used the service told us that they liked living at the home, they were happy with the care they received and the service met their needs. They told us that staff were "Very kind and caring" and there was usually someone around to provide help and support. However they also told us "We do have to wait sometimes, when they are busy but I don't mind too much." One relative we spoke with told us "It's a bit quieter here at weekends and there are not so many staff around."

We saw that individual care plans provided guidance for care workers, to ensure that the assessed current and on-going support needs of people using the service could be met consistently and safely.

People were protected against the risks associated with medication because the provider had appropriate arrangements in place to manage medicines.

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

Staff told us that they had received regular training and supervision. They said they felt valued and were supported to carry out their roles and meet the needs of people who used the service.

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.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People who use the service were given appropriate information and support regarding their care or treatment. Some people who used the service were unable to fully communicate with us, due to their mental health needs. However we saw people being prompted and supported sensitively, safely and appropriately by care workers. As far as practicable, with regard to their condition, and in accordance with their individual care plans, people were enabled and supported to make choices about their daily lives.

The manager told us that an individual's care and support needs were thoroughly assessed prior to their admission to the home and continued to be monitored subsequently during regular care plan reviews. Such reviews would also include personal and environmental risk assessments regarding their welfare and safety.

During our inspection we saw examples of comprehensive person centred support plans, including pre-admission assessments (now only carried by registered nurses), which had been developed for each person using the service. The plans documented people's wishes and preferences in relation to how their care was provided, how they liked to spend their time and how they preferred to be supported. This meant that individual needs could be met in a structured and consistent manner.

We observed and overheard staff to talk to people respectfully and use their chosen form of address. We observed that people were provided with choices such as whether they wished to join in with an activity or not and whether they would prefer to access alternative areas of the home. People told us their choices were respected.

People expressed their views and, as far as practicable, were involved in making decisions about their care and treatment. We saw evidence of people who used the service being offered activities appropriate for their needs and ability and reflecting their individual interest and preference.

We spoke with the activities co-ordinator, who enthusiastically told us about the activities programme they had implemented and various projects within the home that they were involved in. We saw that a programme of weekly activities was clearly displayed on notice boards throughout the service, which meant that people could join in as much or as little as they wanted to. We also saw that one to one activities took place for people who preferred them. The activities took into account the needs of the people who lived in the home. People we spoke with told us that they enjoyed the activities provided. However we also spoke with some people who said that they preferred to be left alone.

People who use the service were given appropriate information and support regarding their care or treatment. The senior nurse confirmed that, as far as practicable, independence and individuality continued to be promoted in the home. They told us that care plans, including risk assessments, were developed and regularly reviewed in consultation with the individual or, where appropriate, a relative or representative. This was supported by care plans that we were shown. The manager also confirmed that relatives were routinely given the opportunity to take part in reviews. This demonstrated that, as far as practicable, people were involved in their own care and treatment.

Relatives we spoke with told us that they felt involved in many of the care decisions and they were informed about any changes. One relative told us "Most of the staff here know me very well by now and will always let me know if there are any problems. They are very kind and thoughtful and also very patient with the people here ".

As part of a new initiative to reinforce staff awareness and ensure that people using the service have their privacy, dignity and choices respected, the manager has identified a specialist dementia care programme. They told us that all staff, beginning with those working on Memory Lane will be attending the training, entitled "So kind" an acronym for Short, Organised, Knowledge Into Nurturing Dementia care. "To galvanise people not only to be aware but to put knowledge into action" which amongst many other aspects covers respect, privacy, dignity and choices giving practical advice, guidance and support to help staff with significant challenges that they may face

During our visit we saw that people were being spoken with and supported in a sensitive, respectful and professional manner. Before entering rooms we saw that care workers always knocked on the door and in accordance with their individual care plan, they were called by their preferred term of address. This demonstrated that people's privacy, dignity and independence 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.

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

Reasons for our judgement

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

The manager told us that Kingsland House provided care for people "of mixed dependency levels, from 'first stage' dementia to end of life care."

During our visit we observed staff interacting with people in a sensitive and supportive way. We saw that people who used the service responded positively to staff and generally appeared relaxed and settled. One person told us "The staff are all very helpful and there is always someone around." This demonstrated that people had experienced care, treatment and support that met their needs.

The manager told us that the service had a protocol in place ensuring that certain parts of care-planning and information gathering be completed within 24 hours of admission. Other areas of care planning were to be completed within seven days of admission.

They confirmed that within 24 hours the Medicine Administration Record MAR sheet will be implemented and a photograph of the individual obtained. The pre admission/ admission assessment will be reviewed and signed. Risk assessment for falls will be undertaken, targeting intervention for falls if a moderate or high risk has been identified. Moving and handling assessment, safe use of bed rails if appropriate, skin integrity inspection record, wound care if appropriate, choking risk assessment, nutritional assessment and any other identified risk.

The manager also described the other areas to be completed within 7 days. These included care plans re all of above and progress and evaluation, daily activity record, temperature, pulse and respiration (TPR) and blood pressure (BP) record, activity information, a review of healthcare details and registration with a local GP. This timescale will also include all specific care plans, as appropriate, including pain management, any breathing issues, mental state and cognition. Each person will be allocated a named nurse and a keyworker.

The manager confirmed that individual care plans were completed by the person with support from their named nurse. They also told us they had written to all families regarding their involvement in care planning. This was supported by care plans that we saw and through discussions with relatives during our inspection.

The provider may wish to note that Mental Capacity Act (MCA) assessments had not been completed. This was acknowledged by the manager who confirmed that it was "an issue regarding trained staff" However they told us that the MCA and Deprivation of Liberty safeguards (DOLs) was part of mandatory training and would be provided.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We looked at five care plans, including risk assessments that related to specific and identified risks to people's safety. The service used a 'new person checklist' to prompt staff and to record the date that each assessment and part of the care plan had been completed. We saw from this that the service's policy and protocol had been met within the 24hr and 7 day timescale.

We saw that where necessary there was specific guidance for staff. An example of this related to a person with behavioural needs. It was recorded that they regularly called for help. The service had sought the advice of a Community Psychiatric Nurse (CPN) and drawn up a behavioural chart to keep a record of this behaviour. It sated that all staff had been informed. The individual had also been assessed as being at risk of falls and this had been monitored through the use of a "falls diary". We saw documentary evidence of regular health checks, including weight, BP and TPR. There were also instructions regarding pain management. We saw evidence of regular contact with other health professionals, including a CPN, GP, a memory assessment nurse, and record of a referral to a falls co – coordinator. This demonstrated that the person centred care plans reflected the changing needs of people who used the service.

During our inspection we spoke with a visiting health care professional regarding the incidence of pressure sores. They explained the correlation between vascular dementia and vascular disease of limbs, which effects the circulation and can lead to the breakdown of the skin. However they told us that pressure area care within Kingsland house was "well managed".

The care workers also confirmed that they had received appropriate training and support to ensure that they had the relevant knowledge and skills and were confident and competent to meet people's identified support needs. This was supported by training records that we were shown.

The manager told us of recent initiatives to improve communication including 24 hour management reports completed daily by both units and filed in the manager's office. During our inspection we also observed the daily 'stand up meeting' involving the manager and RGNs, which takes place at 12 noon and is used to discuss any patients whose condition is giving cause for concern as well as any recent developments or emerging issues. The minutes of these meetings are kept on the back of the management report from the previous day and signed off by the manager or deputy manager.

We were told by a nurse that all people using the service were registered with local GPs and had access to psychiatrists and other health care professionals, including district nurses and chiropodists, as required. It was noted, in care plans that were examined, that all appointments with, or visits by, health care professionals were recorded. This meant

that people received any necessary medical treatment, care or advice promptly.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Medicines were safely administered. We observed the morning medication round. The service had a policy that only trained nursing staff were permitted to administer medicines. The nurse who administered the medicines wore a red tabard to indicate to other people that they should not be disturbed during this procedure. During our observation they were not interrupted. This meant that they could concentrate and remain focussed on the medication administration.

We saw that, where appropriate, people who used the service were assisted to take their medicines sensitively and were not rushed. Consideration was given to maintaining their dignity. Simple explanations appropriate to people's level of understanding were provided. This demonstrated that medicines were administered in a person-centred way.

Appropriate arrangements were in place in relation to the recording of medicine. We looked at the medication administration record (MAR) charts for nine people. The MAR charts all had a photograph of the person attached and had been completed appropriately. There were no gaps or omissions on the MAR to indicate that people had missed doses. All of the MAR charts that we looked at had been completed accurately. We saw that the nurse supported people to take their medication. They remained with person until they were certain that they had taken it. The nurse then recorded what medicines the person had taken before they moved on to the next person. This meant that records were accurate and there was less of a risk that recording errors would be made.

Medicines were kept safely. We saw that medicines were kept in locked trolleys. These were stored in a locked clinical room when not in use. We saw that when medicines were being administered to people arrangements the trolley was locked and at no time were any medicines left unsupervised. We observed that the keys to the medication trolley were held by the nurse on duty at all times.

Some people had been prescribed 'as required' medicine (medicines prescribed to be taken as and when needed). Most of this PRN had been prescribed for pain relief. We observed that the nurse asked each person if they had any pain and assessed the level of pain to determine whether they needed any pain relief. For each 'as required' medicine

there was a chart to record what had been given and the assessed level of pain at the time. However the provider may wish to note that there was not specific individual guidance for each person. The nurse told us that this guidance was available but was not routinely held with the medication file.

The manager told us that all nurses received training and an annual competency assessment regarding the safe handling of medicines. They also confirmed that all medication was regularly monitored by a local pharmacy. We were shown training records and audits to support this. This meant that appropriate arrangements were in place in relation to the recording of medicine and medicines were handled appropriately.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. We saw that staff rotas were in place to clearly show the staff on duty and their allocation within the home. This ensured that shifts were covered reliably and cover for holidays planned in advance. We found that staff sickness was now reported to the management team or nurse in charge in a timely manner to allow time for cover to be arranged.

On the day of our inspection there were 63 people using the service. The manager told us that on 'Bluebell' there were 25 residents and 38 on 'Memory Lane' which was divided into two separate areas, with 25 people on 'St. Mary's' (A) and 13 on 'Adar' (B). The service deployed 13 care workers (up from 12 at the last inspection) and three registered nurses in the morning and 10 care workers (down from 11 at last inspection) and three nurses in the afternoon, seven days a week. It was noted on the staff rota that was made available to us that for two days, Saturday 29 March and Sunday 30 March, there were only two RGNs on duty between 7.45am and 8pm. However the manager confirmed that all gaps in the rota were subsequently covered and reflected in the daily allocations.

According to the rota there were three care workers (down from five at last inspection) on Monday to Thursday night and four care workers on shift from Friday to Sunday night. There were also two registered nurses on duty during the night time, from 7.45pm to 8am. We noted that on several occasions, 24, 2, 28, 29 & 30 March and 5 & 6 April there was only one RGN on the rota. However the manager again reassured us that there were two RGNs on night duty on these dates and any gaps in the rota were covered and reflected in the daily allocations.

We looked at the way staff were allocated to each unit. We found that Bluebell was allocated five care workers and one nurse in the morning until 2pm, three care workers and one nurse in the afternoon, two care workers and one nurse at night. Memory lane was allocated eight care workers and two nurses in the morning, seven care workers and two nurses in the afternoon, three care workers and one nurse at night.

During our inspection some concerns were raised by a relative regarding staffing levels, particularly at weekends. One relative told us "It's a bit quieter here at weekends and there are not so many staff around." We discussed with the manager the procedure taken when

more staff were needed to meet people's needs. They confirmed that staffing levels were closely monitored to ensure that they reflect people's changing care needs. They also told us that a comprehensive assessment of staffing levels, based directly on dependency levels, was being introduced across the organisation. We saw examples of the assessments which included an information gathering survey, completed by staff to determine individual dependency levels. This meant the provider carried out a needs analysis and risk assessment as the basis for deciding appropriate staffing levels.

The provider may wish to note that there were some inconsistencies in the level of staffing throughout the service. We established this through discussions with people who use the service, their relatives and care staff and from duty rotas that we saw,

A person who used the service told us "We do have to wait sometimes, when they are busy but I don't mind too much." Another person told us "Sometimes they take a long time to answer the call bell and tell me they were the only staff on duty." One relative we spoke with told us "It's a bit quieter here at weekends and there are not so many staff around."

A care worker who we spoke with told us Staff shortages effect people as some (residents) require the support of two members of staff for hoisting or moving and handling. We can get support from the nurse if an incident occurs. I've spoken to the manager and deputy manager but they say staffing levels are appropriate. Some night shifts there's only one carer which means that some people may have to go to bed earlier than they would wish."

The manager told us that the service also had access to bank staff, including nurses who used to work for the service and who could be called in case of emergencies. This meant the provider ensured there were sufficient numbers of staff to meet the needs of people who used the service at all times.

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

Staff received appropriate professional development. We spoke with five care workers, four nurses, the activities co-ordinator and the registered manager. The care workers and nurses told us that their induction process had been comprehensive. Their induction included shadowing more experienced staff for a period of two weeks and the completion of an induction workbook during a three months period of probation. We were told that probation was extended by a further three months when staff needed more support.

We saw a copy of the supervision matrix which indicated that all staff received regular supervision. The manager told us that a programme of individual annual appraisals for all staff was scheduled and we saw that this had started. Appraisals addressed individual professional development and included individual training needs, demands of the role, career aspirations and levels of satisfaction. This meant that the provider ensured that persons employed received appropriate professional development, supervision and appraisal appropriate to the work they performed.

The staff we spoke with told us that they had been encouraged and supported to further their knowledge with additional training and studies to gain qualifications relevant to their roles. One care worker we spoke with told us they had completed all core mandatory training such as moving and handling, infection control and health and safety. They had also received more specific training to meet the needs of people who used the service. They said that the dementia training helped them to understand people's needs and considered the overall training to be "really good".

Another care worker told us they were due to start NVQ level 2. They had completed all core and mandatory training including fire, infection control health and safety and moving and handling. They had also received dementia awareness training and the previous day had covered pain recognition for people with dementia.

We saw contracted hours, duties and location of work had been changed to accommodate staff's special needs and requirements. Staff we spoke with were aware of the whistle blowing policy and confirmed that they were able to raise their concerns and felt confident that they would be listened to and acted upon.

The manager confirmed that all new staff received comprehensive induction and foundation training programme in conjunction with Skills for Care (Common Induction Standard). They also told us that core skills training was provided, including first aid, moving and handling and fire safety.

We were shown a copy of the current training matrix and certificates which indicated that all staff had received appropriate training in all mandatory and core subjects. This demonstrated that care workers received appropriate professional development.

Two care workers told us that they felt valued and supported by the manager and deputy manager, who they described as "approachable" and "supportive". They confirmed that relevant training and formal supervision was provided on a regular and ongoing basis.

The care workers also told us that morale amongst the staff was "better than it used to be" and that communication within the home was generally effective, although "it could be better." Another care worker told us that staff meetings were infrequent.

As well as handovers at the start of each shift and daily 'stand-up' meetings, with the manager, we were told that staff meetings covered any issued raised or best practices shared. We were shown copies of the minutes for recent meetings, including a Registered Nurses (RN) meeting held on 7 February. This meant that there was a clear commitment by the management to promote effective communication, transparency and inclusivity.

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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