Inspection Report

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

Canal Vue

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Date of Inspections: 22 September 2014
16 September 2014

Date of Publication: January 2015

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

Care and welfare of people who use services	✖ Action needed
Requirements relating to workers	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Eastgate Care Ltd
Overview of the service	Canal Vue provides personal and nursing care for up to 70 older people. Nursing care is provided by nurses at the home. Some people living in the home have dementia. It is a new purpose built establishment over three floors.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury

Contents

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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 16 September 2014 and 22 September 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. We reviewed information sent to us by commissioners of services, talked with commissioners of services and talked with other authorities.

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

This was the service's first inspection since the provider's registration in March 2014. We visited the service on 16 September and 22 September 2014 in response to concerns raised about staffing levels and the lack of leadership within the home as the registered manager and another staff member with specialist knowledge about dementia care had left the service in July 2014. We were concerned about the impact this had on the care provided. As part of our joint working with the local authority and the Clinical Commissioning Group (CCG), we were able to follow up on the concerns raised about people's safety. The local authority and CCG fund people's care needs and when people were identified as having continuing health needs the CCG helped to fund this.

There were 38 people using the service, two people were in hospital on the days of the inspection. We spoke with four people who used the service, seven staff and five relatives or friends and three visiting professionals. We spoke to the provider, a senior manager from the organisation, and registered manager from another home owned by the provider. They were all supporting the manager. There was no registered manager in post at the time of the inspection. A registered manager is a person who has responsibility with the Care Quality Commission (CQC) to manage the service and has legal responsibility for meeting the requirements of the law: as does the provider. However a new manager was appointed into a management position. They told us they had no previous experience of managing a care service and received support through other managers.

During our inspection we wanted to understand people's experience of the service they were using. We did this by spending time sitting and talking with people. 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. SOFI

allowed us to observe the care experiences of people who had communication difficulties. SOFI was used in the communal setting of the dining rooms. We observed the way staff responded to people. We read three care records about people's care and spoke with staff about people's needs.

The evidence we collected helped us to answer five key questions;

Below is a summary of what we found.

Is the service safe?

People we spoke with told us that they felt safe living at the home. We saw that staff were able to meet people's basic needs but there were times when they were not available to provide extra support to people. Agency staff when available were appointed to provide cover at the home.

Staff told us that they often worked without sufficient staff to maintain cover for the three floors. They told us that they found it difficult to perform their roles safely. This meant people could be placed at risk from receiving care that was not always safe because of inadequate staffing numbers, supervision and support.

Staff recruitment was underway to address staff shortages. However, we found unsafe recruitment practices had taken place historically because relevant safety checks were not always undertaken before staff were employed. The provider told us that adjustments were made to ensure safer practices were followed.

Is the service effective?

We saw that people with capacity to make decisions chose whether they took part in activities. We found from reviewing some people's care records, their rights were protected because meetings had been held to determine that actions taken were in people's best interests. Deprivation of Liberty Safeguard (DoLS) applications had been made to ensure people's rights were appropriately protected. This is where a person is restricted of their freedom and considerations are made in the person's best interest.

We saw that people received a diet that was varied, nutritional and prepared so that they could eat it safely. We saw improvements could be made to the management of meal times. This could include having more staff available to help serve and assist people at meal times.

Staff received training to enable them to provide care in an effective way and communicated with other professionals including community nurses, chiropodists and doctors when people were unwell. Care records and assessments were in place and were kept under review. Regular staff understood people's support needs and people were asked for their consent to care.

Is the service caring?

People told us that they received care provided by staff that were kind to them and knew their individual needs well.

Is the service responsive?

People and their family representatives were provided with an opportunity to attend and share their views at regular meetings where they were able to comment on the care received. They told us they were listened to and actions were taken to address their comments. Concerns and complaints were taken seriously and investigated.

Is the service well led?

People were positive about their life at the home. They told us the staff were helpful and the nurses were approachable.

A registered manager was not in post. However, a manager was in post and they were supported by the management team. This was because the manager did not have the knowledge and relevant experience for managing a care home with nursing. The provider told us that managers were supported for up to three weeks and further time was given to support this new manager.

Staff did not always feel supported by the management team and did not always feel confident to report their concerns directly to them. We found that the management team needed more time to improve and build relationships with the staff team.

Quality assurance systems meant that people's views and those acting on their behalf were obtained and acted on. Although, checks were made by the provider for the quality of the service, people were not always protected from some of the risks associated with regular staff shortages. This could have an adverse impact on the care people received.

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 23 January 2015, 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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People did not always experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a minor 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 looked at the care records for three people. Needs assessments included people's health and social needs, preferences and preferred routines. We found risk assessments were in place. We saw that the records were up to date and that risks were identified and recorded. In one care record, we found that action plans about the person's falls was linked to their behaviours that challenged. Staff told us about the actions they took in relation to the management of identified behaviours that challenged. Some of this detail was not recorded in the care record. This meant there was the potential for each staff member to respond differently to the person's behaviour. This inconsistency could lead to the person's behaviour not improving. We spoke with the manager about this who showed us that new detailed charts were to be implemented for the monitoring of behaviours and for falls.

In one care record we saw an assessment for the administration of hidden or 'covert' medicines in place. This meant if the person refused to take their medication they could have their medicines disguised and given for example in food. The assessment recognised the person as needing a Deprivation of Liberty Safeguard (DoLS). This method was used to administer their medicines and was considered to be in the person's best interest. The covert medicines received a full assessment under DoLS. There was evidence of regular consultations between the local authority, family members, doctor and staff as part of the decision making process. This meant the provider had taken the necessary measures to ensure the correct procedure had been followed. The relevant notification was sent to CQC as part of our regulatory responsibilities for monitoring people's freedom under DoLS. In all three records that we saw we found that mental capacity assessments were in place. This meant that assessments had been undertaken that allowed staff to act in people's 'best interests'.

An external health care professional told us that staff acted on their advice, and that

people's care and health needs were addressed. They told us that staff at the home provided care to people during the end stages of their life. They confirmed that the care needs of the person they were involved with had been met. We saw that training in this area was being updated. We saw that visits by other health care professionals such as the person's doctor, optician and chiropodist were made available to people who used services when required.

We asked people about their meal time experiences. Three people we spoke with told us that they enjoyed their meal. We used SOFI to observe the meal times and found that people's experience of a meal time could vary. It depended on the amount of staff available to meet their individual needs. On the ground floor people spent over fifteen minutes sitting and waiting in the dining area before the meal was served to them. There were eighteen people to be served. Staff were seen to ask each person what they wanted to have as their main course. For people with communication difficulties staff pointed to other people's plated choices to help them to decide. Two care staff served the meals. This meant people had to wait for their meals to be served.

On the ground floor we observed four people who required assistance to eat their meals. They received help from both staff members. However, during the meal time we observed staff to leave the dining area at the same time to help other people in bedrooms. This meant that there were times during the meal time when people were left without help or supervision. One person who needed assistance at meal times told us, "Staff do their best to help me."

On the upper floor during the first inspection visit we observed people who were unsettled and with too few staff to monitor them. When they were seated if staff did not remain with them or assist them they left the room. This meant that people's dining experience was not always catered for as they did not always receive help when they needed it. At the second inspection visit we found the dining experience of people had been improved. We observed staff to be well organised and there were more staff available. The meals were served on time and met with people's expectations. During the meal time a member of staff remained in the dining area and was available to attend to people's needs.

We observed that when the meal time finished people who needed assistance had to wait longer to be moved. We found that during the meal time visitors came to see their relatives at the home. One person told us, "It is like Piccadilly circus here." This indicated how busy it was during meal times.

People using the service were provided with a range of activities to pursue. A staff member was appointed to provide activities that would interest people during the days. They told us that their time of 40 hours a week was divided between the floors. We observed that many people on the upper floor were in need of individual activities. This was because they did not remain in any one place for any length of time. We saw records were kept of the activities provided. People were provided with board games on the upper floor although this was disturbed by the frequent movement of other people in the room.

During this inspection an external entertainer visited. Afterwards people told us they enjoyed this. One person told us that regular entertainers visited and provided activities for them to enjoy. A small number of people from the upper floor were brought to the ground floor to listen to the entertainer. We saw that the entertainer did not visit the remaining people on the upper floor. This could mean that not all people who used the service had the opportunity to be involved in all activities.

The provider confirmed that nurses and senior care staff were trained to deal with first aid situations and all staff had received fire safety training. The provider confirmed that they were available to staff 24 hours each day and because of this there were arrangements in place to deal with foreseeable emergencies.

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People who used the service were not able to comment about staff recruitment because they were not consulted about staff recruitment issues However, people did tell us that the staff were, "All very good to them."

We looked at three staff records and found appropriate checks were undertaken. However, in August 2014 we received information of concern from the local authority. This was because recruitment checks were not always safe. The local authority had found that references were not always been taken up before staff were employed at the home. Staff told us that if their personal staff records were not completed with references for example, senior managers had asked them to follow this up themselves. This did not demonstrate good practice. It did not meet the provider's own policy of having safety measures in place to protect people who used the service.

The provider confirmed that people at the home were no longer placed at risk and that all safety checks on staff were up to date.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not always enough qualified, skilled and experienced staff to meet people's needs.

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

In May, August and September 2014 we received information of concern that suggested that the provider was not able to retain staff in sufficient numbers to meet the needs of people who used the service. We were told there were regular staff shortages and a recent staffing rota for 15-28 September 2014 identified this. On five occasions the shifts were covered by less than four care workers. This was particularly noticeable at night. We saw agency nurses were requested when needed. The use of agency staff did not always mean that sufficient staff were available on each shift and the shift would have to manage with fewer staff than desired.The provider told us this was because the agency were not always able to cover all the gaps on the rota and when due to the shortness of time, cover by the agency could not be found.

The provider told us that they did not use a dependency tool to assess the number of staff required. They were not able to evidence how they worked out the number of staff required. This meant people's safety needs could not be guaranteed at all times. We spoke with the managers about this. They told us that they were actively recruiting staff to cover shortages. They told us they used agency to cover but that this was not always possible due to short notice and lack of agency staff availability.

We observed staff to attend to people in a polite manner. Staff gave people the individual attention and time that they needed when they attended to them. A cook and a new assistant were available in the kitchen but did not serve the meals. This meant that during meal times people could be kept waiting for their meals to be served and given to them. We found that when sufficient staff were provided as seen on 22 September 2014 where there were eight staff on duty, people received their care in an organised and timely manner. Staff we spoke with told us that when cover for the shifts was not found it was particularly difficult to provide the levels of supervision that people needed.

In a recent incident a relative told us that they found their parent sleeping in another person's bedroom lying on the bare mattress. They told us that staff had been apologetic however and had stated they had not had enough time to help their relative as they had

not been co-operating that day and didn't sleep well during the night. On another evening they discovered that foot care had not been given for a while and their relative communicated with them to say that their foot was hurting because their nails were long and uncomfortable. A senior member of staff was asked to arrange for an urgent chiropodist visit. The chiropodist visited on 13 November 2014. This relative summarised the care as being short of trained staff. This meant that there were times when due to insufficient numbers of skilled staff the care provided did not meet people's needs.

During the inspection we observed staff who were asked to supervise people whilst in the lounge areas. When people needed two staff to help them, staff could not always be present in the lounge areas. This was because the care they needed took time and a task could take over half an hour or more. We observed people to walk between the rooms including other people's bedrooms at the times that staff were not available to supervise. We observed one person who collected items that did not belong to them. We asked staff about this and a staff member told us "We do our best to keep an eye on everyone but it can be difficult when there are too few of us." Another staff member told us "We have a lot of people whose movement on the upper floor is unrestricted, sometimes people get annoyed with each other and friction can develop."

The provider told us people's safety needs were being improved through the monitoring of incidents and accidents and the active recruitment of permanent staff at the service. This would mean that there were more staff available to supervise people.

Assessing and monitoring the quality of service provision ✖ Action needed

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 not meeting this standard.

The provider's system to assess and monitor the quality of service that people received was not always effective.

We have judged that this has a minor 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 saw that people who used the service and their representatives were asked for their views about their care and treatment as part of the survey conducted at the home in May 2014. An action plan was completed following the comments made. This included finding ways to improve the laundry facility so that people's belongings were returned to them. We asked a relative about this. They told us that there had been some improvements as people's name labels were added to items of clothing. As part of the feedback from people some people had asked for activities that were more structured. During our inspection we saw that structured activities were now provided for people either in small groups or with the person on their own.

We saw a copy of the staff meeting dated 29 September 2014. Four staff attended. This did not reflect the contribution of all staff members. This meant an opportunity for staff to provide feedback on care had been missed. The provider was not able to provide an explanation for this but suggested that they may have been night staff. We asked the provider if the minutes had been circulated in the staff room or as part of a follow up within the supervision records for staff. The provider explained that they could not find them in there. However, staff told us they were provided with meetings with their line manager on an individual basis to discuss any issues that concerned them. A few staff told us they did not find the management to be approachable and supportive.

A complaints procedure was available for people to use. We saw complaints were investigated and recorded with actions taken where necessary.

The registered manager was no longer employed by the provider. The provider told us that the manager who was appointed required additional support. The manager appointed to the home told us that they were undertaking a qualification in management for care. We saw that they received regular support from other managers in the organisation.

We saw that a health and safety audit tool was undertaken by the manager of the service

in August 2014 and areas covering fire safety, first aid, personal protection evacuation plans and maintenance were fully completed. We saw that accident reporting was included and was audited monthly. It reported on patterns and trends. The provider told us a further assessment took place and this could result in the use of sensory alarm monitors and a referral to falls clinic for further assessment and support.

We found there were gaps in the delivery of care. This was because people were not always supervised and their welfare and safety needs were not guaranteed and they were at risk of experiencing injuries. There were regular shortages of staff at the service and although agency staff were supplied, staff were still leaving the provider's employment. This meant the monitoring and quality of the service was not always able to meet people's needs.

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 activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: (1) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of— (b) the planning and delivery of care and, where appropriate, treatment in such a way as to— (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user, Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 22 of the Health and Social Care Act 2008

This section is primarily information for the provider

	(Regulated Activities) Regulations 2010
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** (1) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to— (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this Part of these Regulations. Regulation 10 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 23 January 2015.

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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