Inspection Report

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

The Hydro Domiciliary Care Agency

Unit 5, Hydro Gardens, Chesterfield Road,
Matlock, DE4 3DQ

Tel: 01629580919

Date of Inspection: 08 May 2014

Date of Publication: June 2014

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Management of medicines	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Progressive Care Limited
Registered Manager	Ms Carol Ann Rowlands
Overview of the service	The Hydro Domiciliary Care Agency provides care and support to people in their own homes. The service is operated from the site of Lilybank Hamlet care home in Matlock.
Type of service	Domiciliary care service
Regulated activity	Personal care

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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

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

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 May 2014, observed how people were being cared for and talked with people who use the service. We talked with staff and reviewed information given to us by the provider.

What people told us and what we found

The Hydro Domiciliary Care Agency currently provides support for up to six people in flats owned by the provider and rented through a separate tenancy agreement. Four people were receiving care at the time of our inspection. A separately registered older person's home and two community houses for people with learning disabilities are located on the same site.

A manager was appointed in September 2013 for The Hydro and the community houses, and had applied for registration with the CQC. The care home is managed by another manager registered with the CQC.

As part of our inspection we spoke with three people receiving care, managers and staff working at the service. We also examined records and observed people receiving care.

Below is a summary of what we found.

Is the service safe?

People we spoke with receiving support told us they were happy with their care. One person said, "It's the best place I've been to." Systems were in place to monitor the safety and quality of care provided by the service. A plan was in place to help ensure people could continue to receive care if an emergency occurred. People's needs were assessed but care planning did not always ensure their welfare and safety. Changes and updates were not always made to care plans and important information about reducing risks and specific care needs were not always included. People who had behaviours described as "challenging" did not have adequately detailed plans to ensure their care was safe and appropriate. Insufficient guidance was available for staff to help people who may need to be physically restrained. This meant there was a risk to people's safety and welfare. Adequate numbers of suitable staff were provided in the daytime and evening but there were not enough staff to provide safe support for people at night, including if there was an emergency. Restrictions placed on some people at the service to keep them safe could

mean they were at risk of having their liberty deprived. Appropriate procedures had not been followed to ensure people's rights were not breached.

Is the service effective?

We found although consent was sometimes obtained for people's care, appropriate arrangements had not always been made if people could not consent for themselves due to their learning disability. We found people's needs were assessed and care files included some information about risks that could affect them. The care planning process had not always been used to effectively describe people's needs and the support they needed. This meant people's welfare and safety was not always protected.

Is the service caring?

People told us they liked the staff and were happy with their care. One person told us, "The people are all nice and I like my flat too." We saw staff providing people's care and that they were respectful and responsive to their needs. People's preferences and lifestyle choices were included in their care records.

Is the service responsive?

People receiving care told us they were confident any concerns or complaints about the service would be properly responded to. Systems were in place for obtaining people's views about the service including regular meetings for people receiving care, team meetings for staff and surveys for people connected with the service. Records showed the manager made changes in response to any concerns. Care plans were not always updated to reflect changes in people's care needs.

Is the service well-led?

A system of checks was in place regarding managing medicines, staff training and health and safety at the service. Professional advice was obtained to help plan people's care and this was usually followed.

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 28 June 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning. We will check to make sure that action is taken to meet the essential standards.

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

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

The provider had taken some steps to ensure that people's consent was obtained for their care. Where people did not have the capacity to consent, however, arrangements were not fully in line with legal requirements.

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

At our inspections on 14 April 2013 and 22 October 2013 we found that the provider's procedures for obtaining consent for peoples' care were not fully in line with legal requirements. At this inspection, we checked to see whether the necessary improvements had been made. We found that some improvements had been made.

At the time of our inspection, a new manager had recently been appointed to work at The Hydro. The manager told us that due to their learning disability, some people would not be able to consent to the care received from staff at The Hydro. They also told us that although some progress had been made, they were still in the process of obtaining people's consent for important decisions about their care. We found the manager was aware of what arrangements should be made for obtaining consent if a person lacked the mental capacity to make their own decisions. They also told us that they were aware of the Mental Capacity Act 2005 (MCA) which is a law that provides a system of assessment and decision making to protect people who do not have capacity to give consent themselves, whether this is temporary or permanent.

We examined two people's care files and saw evidence that the MCA had been used to assess people's capacity to make decisions about specific aspects of their care including having medication administered and managing their finances. We saw that consent had not been obtained for other important decisions. People's personal money, for example was kept on their behalf by the provider with no record of whether consent had been obtained or why this decision had been taken. We also saw that sometimes relatives had signed to consent to people's care, but there was no record of any process or assessment that had been used to determine whether or not the person could consent for themselves. This meant that where someone lacked capacity, arrangements for seeking consent were

not in line with legal requirements and there was no evidence that decisions made on their behalf were in people's best interests. It is important that a detailed record is made of any decisions made on the person's behalf including the specific reasons for making the decision, options considered and how the person had been involved.

We found that where people did not have capacity to make decisions about their care, records did not clearly state whether there was anyone appointed to do this for them, for example a welfare attorney. This meant the correct person may not be contacted if a decision relating to the person's care needed to be made.

The records we saw contained conflicting information about whether the person could consent to their care. One person's "Essential Information" sheet included that they were able to consent to all aspects of their care. Assessments we saw that had been completed on other dates, however, concluded the person was not able to provide consent for important aspects of their care. We saw another person's care records had similar documents that were contradicted by others. The manager told us this was because old documents had not been removed from peoples' care files. It is important that records clearly show that valid consent has been obtained for peoples' care.

Although the manager had begun to use the required procedures to obtain consent for people's care, we found arrangements were not fully in line with requirements at the time of our inspection.

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.

Care was not planned and delivered in a way that fully ensured people's safety and welfare.

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 three people who told us that they liked the staff that provided their support. One person said, "I like them. I go out a lot." Another person said their care was, "Pretty good." We saw staff delivering peoples' care were patient and sensitive to the person's needs.

We examined two people's records and saw assessments were completed about their care. Care plans we saw described the person's preferences and summarised their needs. Care plans did not, however, contained sufficient detail about how people were supported in practice. We saw general comments including, "Staff help me to budget", or, "Prompts needed to take medication" with no details about the care the person actually received. Staff we spoke with described strategies that were used to help people with money and medicines that were not included in care plans. This meant people's individual needs may not be fully met, particularly when they received care from less familiar staff.

We saw that steps were not always taken to ensure care planning included consistent and accurate information about people's needs. One person's file we saw had three different care needs summaries and two different weekly activity plans with no indication of which one was accurate. We saw that some information was included in care files about the person's disability and also that assessments had been completed about some risks that could affect them. Some important information was not included in people's care plans, however, including specific diagnosed conditions that affected how the person felt and how they needed to be supported. This included autism and other conditions. Because adequate guidance was not included in care plans, staff did not have sufficient information to ensure people's needs were fully met.

Care files we saw did not always contain up of date information about peoples' needs. We observed one person used a communication method using images to create a schedule of their activities. Staff told us this was important for the person to plan what they were doing each day and prevent them from becoming anxious. Staff told us about other support that the person needed, for example with eating and vomiting. We checked the person's care

plans and saw found no guidance was provided for staff about these aspects of their care. Communication care plans we saw were brief and did not contain specific information about how people expressed themselves or made choices. Both care files we saw included that the person used a form of sign language, intended to be used together with speech, called 'Makaton'. We found no record of what signs people used and staff told us they were not trained to communicate using this language. Because staff were not provided with information that fully described how people should be cared for, this meant people were at risk of receiving inappropriate care.

The manager told us some people had behaviours described as "challenging". They also told us staff were trained to recognise signs of anxiety or aggression and take appropriate action, including physically holding or restraining the person if necessary. We found the provider was not always following published professional guidance regarding this kind of support. Detailed plans, for example, were not in place about how people should be helped with behaviours that challenged. We saw that behaviour support plans in peoples' records were generalised and brief. Plans we saw stated, for example, that staff should, "re-direct" people if they became agitated but did not describe how this should be done. Where specific risks had been identified, for example pulling of staff members' hair, guidance stated staff should, "remain vigilant" without describing how to avoid situations and what to do if an assault occurred. Important information was not always included in plans about preventing the person becoming upset or angry and, if they needed to be held or restrained, exactly what methods should or should not be used. We saw that charts were used to record incidents involving challenging behaviours. We examined the charts of two people and saw that consistent responses had not always been used when incidents occurred. One bedroom we saw had been fitted with wall padding to protect the person from injury if they had an aggressive outburst. Guidance was not available about when and how this room would be used to keep the person safe and records did not clearly state it must not be used as a sanction or a kind of seclusion. The lack of planning about these support needs meant that people were not protected from the risk of receiving inappropriate or unsafe care.

We found some people could be deprived of their liberty at The Hydro. The manager told us some people were not able to leave their home without staff support. Staff we spoke with told us people would need to be prevented from leaving their home, in many circumstances, to keep them safe. We found some people received support from one or two staff members at all times. Where these kinds of restrictions are required, care providers are required to seek authorisation from the Court of Protection about exactly what can and cannot be done to keep the person safe. This is to ensure that only the least restrictive options are used, and that these are properly monitored, to keep the person safe and well. We spoke with the manager about this who told us they would contact social services and also ensure legal advice was taken to ensure people's right to their personal freedom was not breached.

We found the provider had taken steps to ensure people could continue to receive care in case an emergency occurred. We saw a plan was in place describing what action should be taken, for example if there was a fire or the electricity or gas supply was lost. If enough staff were made available, these plans were adequate to provide people's care in an emergency and protect them from harm.

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

The manager told us that all people receiving care required staff support to ensure they received their medicines and records we saw confirmed this. We saw there were suitable systems in place for ordering and managing stocks of medicines. Staff described safe, appropriate procedures for checking stock levels and ordering medicines. Prescriptions were checked, for example, before an order was made and medications received into the home were checked and recorded accurately. This ensured people received the right medicines and records of available medicines were accurate.

We saw records confirming medications that were no longer required had been returned to the pharmacy. This system ensured all medicines could be accounted for.

We saw medicines were safely stored in a central locked cupboard. Weekly amounts for people to use were then transferred to lockable cabinets in peoples' bedrooms. We saw information was also recorded about people's known allergies. This information was also included in care plans to ensure people were not prescribed or given unsuitable medicines. This helped to ensure people were protected against the risks associated with medicines.

We saw people's Medication Administration Records (MARs) were mostly fully completed to record the medicines people were given. Staff had signed to confirm each dose had been taken or used a code to describe why it had not, for example if a tablet had been declined. We saw one MAR with a gap in staff signatures where the person had not received their medication because they had been away from the service. We discussed this with the manager who said that they would ensure that following our inspection that MARs would be fully completed, including when medication had not been administered. Where variable dosages of drugs were prescribed the actual dosage given to the person had been recorded. MARs we examined included information about medicines prescribed for use 'as required' (known as PRN). We saw a protocol was in place for each PRN medication prescribed. This contained guidance for staff about the specific circumstances when the medicine should be used and instructions regarding the dosage and frequency. We saw that staff were not always recording how effective these medicines had been. It is important that full and accurate records are made to ensure people receive PRN

medicines only when required and at the correct dose. This would fully ensure people's medicines were administered safely and as prescribed.

We found that no medication was being given to people without their knowledge, known as 'covert' administration, at the time of our inspection. The manager was aware of procedures to follow should medication need to be given to people covertly. This helped to ensure medicines were prescribed and used safely.

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 provided 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

We spoke with three people receiving care about the staff employed by The Hydro and also to care staff and managers.

People we spoke with said they liked the staff and that they helped them. One person said, "They are ok. I like most of them and they have training."

We examined two peoples' care records. One person had two staff with them throughout the day and evening and another had one staff member with them constantly until night-time. We checked staff working rosters and saw that adequate arrangements were made to ensure suitable numbers of experienced staff were available during these times.

We found, however, that adequate numbers of staff were not available during the night to ensure people were safe. Records we saw showed only one staff member was provided at night to provide four peoples' support. Staff we spoke with told us people using the service had needs described as "challenging" and also that they would be unable to evacuate the building safely without staff support in an emergency. We spoke with the manager who told us a staff member from the older persons' care home on the same site could be called upon if necessary. This would, however, leave the other care home with insufficient staff to ensure the welfare and safety of people there. This meant sufficient staff were not available to meet peoples' needs and ensure they were safe at night.

We spoke with the manager after our inspection who told us a meeting was planned with the provider to discuss the safety of people at the service and levels of staffing provided by The Hydro.

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 a system in place to regularly assess and monitor the quality of service that people received.

Reasons for our judgement

We spoke with the manager, five staff and three people receiving care about how service provision was monitored at The Hydro.

People we spoke with told us staff asked them for their views about their care, including in formal meetings. They also confirmed that they knew how to raise concerns about their care or make a complaint. One person receiving care pointed to the manager and told us, "I tell [the manager] if anything's bothering me. It's usually sorted out alright." We saw the views of people receiving care and also other people connected with the service were obtained each year using questionnaires. Records we saw showed the manager responded appropriately to the comments people made, for example making arrangements if someone wanted to do a specific activity.

We saw the manager completed checks to monitor different aspects of the service including how medicines were managed, changes to peoples' care needs, complaints and concerns and staff training needs. We saw that accidents and incidents were recorded although systems for ensuring information was analysed and any risks managed were not fully effective. This was because this information was summarised and recorded at the provider's head office but the results were not reported back to the manager to help them continue to improve the service. It is important that effective systems are in place for learning from incidents / investigations and appropriate changes implemented.

We saw from people's care records that professional advice was sought regarding their care. Although this advice had mostly been followed we saw records that showed an important recommendation from a psychologist about one person's need to be provided with a bath rather than a shower had not been followed. Other professional advice, for example from a speech and language therapist, had been followed by care staff. This showed the provider mostly took account of professional advice to ensure people received appropriate, safe 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
Personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The provider had not always made fully appropriate arrangements to obtain the consent of people, or those appointed to consent on their behalf. (Regulation 18 (1) (a)) Where people lacked capacity, the provider was not always using the Mental Capacity Act 2005 to undertake an assessment or making a proper record any best interest decisions made on a person's behalf. (Regulation 18 (1) (b))
Regulated activity	Regulation
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider was not taking proper steps to fully ensure people's care was planned in a way that met their individual needs and ensured their welfare and safety. (Regulation 9 (b)(i)(ii))

This section is primarily information for the provider

Regulated activity	Regulation
Personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not taken appropriate steps to ensure sufficient numbers of suitable staff were available to safeguard people's welfare and safety. (Regulation 22)

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 28 June 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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