

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

Cuerden Developments Limited - Alexandra Court

Alexandra Court, Howard Street, Pemberton,
Wigan, WN5 8BH

Tel: 01942215555

Date of Inspection: 21 July 2014

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2014

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	✓	Met this standard
Cooperating with other providers	✓	Met this standard
Supporting workers	✓	Met this standard
Assessing and monitoring the quality of service provision	✓	Met this standard
Complaints	✗	Action needed

Details about this location

Registered Provider	Cuerden Developments Limited
Registered Manager	Mrs Judith Lesley Melling
Overview of the service	<p>Alexandra Court is a 40 bed intermediate care centre that provides a time limited period of assessment and rehabilitation for people who may have had a hospital admission but are not ready to be discharged home safely or to be supported at home.</p> <p>It is a purpose built two storey building with bedrooms on both floors. There is a car park at the front of the home.</p> <p>As an integral part of the purpose and function of Alexander Court staff members employed by the NHS or social services such as physiotherapists, occupational therapists, social workers and a GP are either based there or work there on a regular basis.</p> <p>It is located in Pemberton, near Wigan and is close to shops and public transport links.</p>
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

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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 21 July 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 and talked with staff.

What people told us and what we found

During this inspection the Inspector gathered evidence to help answer our five key questions; Is the service caring? Is the service responsive? Is the service safe? Is the service effective? Is the service well led?

During the inspection we looked at care and welfare, cooperating with other providers, supporting workers, quality assurance and complaints.

This is a summary of what we found, using evidence obtained via observations, speaking with staff, speaking with people who used the service and their families and looking at records:

Is the service caring?

During the visit we saw staff offering care with patience and courtesy. Staff made efforts to ensure people's dignity and privacy were preserved at all times.

The service provided people with information about the service and a questionnaire on admission to ensure their expectations were understood and needs met as far as possible.

We spoke with four people who used the service and six visitors. One person who used the service said, "Staff have been great – can't do enough for you". Another told us, "Staff are pleasant and polite. I have been here before but it is better this time". A third person said, "I like it here, I've only been in a short while, but staff are all nice and helpful".

A visitor remarked, "We have no complaints whatsoever. We are made welcome and staff have made drinks for us". Another visitor commented, "You are made very welcome, you can make a drink, which we appreciate as we come a long way".

Is the service responsive?

Assessments were carried out prior to people being admitted, to ensure they were in the correct place to meet their needs. We were told that personal goals were agreed between people who used the service and therapy staff and all staff would then work towards these with the person.

Care plans were contributed to by the person and their family, the care staff and therapy staff. This helped ensure all were aware of the progress being made and plans being followed.

People's support needs and abilities were reassessed on a daily basis and risk assessments were reviewed on an on-going basis to ensure individuals' progress was on track.

Complaints and concerns were generally responded to appropriately. However, we found an example of a complaint that had not been addressed in a timely or appropriate manner and the omission had not been picked up in the audit process. We asked the manager to deal with this as soon as possible.

The service worked closely with other agencies, such as the Stroke Association, Think Ahead, Carer Support and Age UK to ensure people obtained all the assistance and support they needed to help them make a good recovery. Appropriate referrals were made to other services, such as falls service, when required.

Is the service safe?

We saw evidence that care staff were recruited safely and the induction procedure was thorough. Staff told us they were well supported by management.

There were sufficient numbers of staff on duty at the service to ensure people's needs were met safely. The service was looking at dependency levels of people who used the service, so that people with higher dependency levels could be accommodated on one floor. This would help inform staffing levels and expertise for each level.

Staff training was up to date and on-going and staff with whom we spoke had a good knowledge of care planning, care delivery and risk assessing. Staff with whom we spoke understood how to recognise deteriorating health and well-being and were aware of how to address this.

Areas of high risk, such as falls, were constantly monitored and methods implemented to try to minimise the risk.

Health and safety checks were carried out regularly and the building and equipment were well maintained.

Accidents and incidents were appropriately recorded and audited. Any patterns were analysed and problems addressed in a timely way.

Is the service effective?

The service had a mixture of care and therapy staff in order to try to meet both the social and health needs of people who used the service. There was also a GP who attended the service five days per week to contribute to the multi-disciplinary provision within the home. Staff with whom we spoke demonstrated a good understanding of their roles and

responsibilities and all felt they worked well with other disciplines as a team. One staff member told us, "Everyone plays their part, there is good communication, good rapport and team work"

Care plans we looked at included factual and up to date information about people's health and support needs.

Recent questionnaires filled in by people who used the service indicated a high level of satisfaction. Comments included, "Lovely place, nice people", "Meals were not terrible, but not wonderful, and, "Staff were brilliant, kind, understanding and patient".

Is the service well-led?

The home had a manager in place at the home, who was appropriately registered with the Care Quality Commission.

A significant number of audits were undertaken, some internal and some external. The results of these were analysed and any shortfalls addressed to help ensure consistent standards of care within the service.

Questionnaires were completed with people who used the service, to gain their opinions and suggestions and gauge their level of satisfaction. Results were analysed and used to inform continual improvement to the service.

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

What we have told the provider to do

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

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

More information about the provider

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

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

Our judgements for each standard inspected

Care and welfare of people who use services

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The workers at the home were a mixture of NHS and Adult Social Care staff due to the nature of the Intermediate Care Service. People who had suffered a loss of abilities were offered therapy and rehabilitation in order to help them return home safely.

We looked around the home and saw staff attending to people's needs in a competent and respectful manner. Staff took time to ensure they responded appropriately to people's needs and were patient and unhurried when assisting them. People's privacy and dignity was respected by means such as staff knocking on people's doors before entering and obtaining consent before administering care.

The upper floor housed a number of people who had suffered strokes and the manager told us the plan was to accommodate all those with more complex needs on this floor, with those who had less difficulties being accommodated on the ground floor. The manager felt this would enable staff to better respond to the particular level of need on each floor.

People were assessed following a medical referral and admitted according to whether the service could accommodate them and felt their needs could be met. On admission, people were given information on what to expect from the service and requested to complete a questionnaire to ensure they were fully involved and information about them was up to date and relevant. The manager told us an initial assessment would be carried out within 24 hours of a person entering the service.

We looked at a sample of care records for four people and a number of monitoring charts where monitoring of issues such as nutrition, fluid intake and weight were recorded. The care records were comprehensive and contained information on people's condition on admission, including photographs of any wounds, health information, medication records, multi-disciplinary team daily records, risk assessments and accident reports. Any incidents or accidents were also recorded in the accident log.

Monitoring charts were separate from the care records and had been completed appropriately. In one person's file it was apparent that they had been experiencing problems with nutrition and fluid intake and this was being closely monitored by staff. However, although it was clear, from the daily records, that staff were monitoring food and fluid intake and pushing fluids as per medical advice, there was no separate monitoring chart for this particular person. We spoke with the manager about this and she admitted this was an oversight. The provider may wish to note that separate charts should be completed in all cases where there is a concern, as per the home's usual practice.

We looked at the home's policies and saw they were regularly reviewed and changes noted. All policies and guidance documents were up to date at the time of the inspection. Policies included Patients' Well Being, Consent, Pressure Sore Management, including National Institute for Health and Care Excellence (NICE) guidance, Wound Care Plans, Safeguarding, including guidance and contact details.

We spoke with six staff members, some of whom were carers, others nurses and therapy staff. All were aware of the home's policies and guidance and had a good understanding of how to follow and complete care plans. We saw a number of posters around the home, about the Mental Capacity Act 2005 (MCA), outlining the principles which staff should adhere to regarding people's abilities to make informed decisions.

Staff told us personal goals were agreed between people who used the service and therapy staff and all staff would then work towards these with the person. We asked staff how they identified deteriorating health and what steps they would take to address this. All gave examples of how they would recognise this, such as being aware of the person's base line and past medical history and noting changes. Examples of addressing deterioration included ruling out issues such as Urinary Tract Infections (UTI), close monitoring and considering referral to other services. A staff member told us workers were expected to read all care files and the manager or nurse would take the time to explain any issues or conditions not understood.

We spoke with four people who used the service and six visitors. One person who used the service said, "Staff have been great – can't do enough for you". Another told us, "Staff are pleasant and polite. I have been here before but it is better this time". A third person said, "I like it here, I've only been in a short while, but staff are all nice and helpful". Another person said, "The food is alright, quite nice".

A visitor remarked, "We have no complaints whatsoever. We are made welcome and staff have made drinks for us". Another visitor commented, "You are made very welcome, you can make a drink, which we appreciate as we come a long way".

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

We looked at how the service worked with other agencies and how recording of this interaction was undertaken. We saw there was a great deal of partnership working, both internally and externally, due to the nature of the service.

We saw multi-disciplinary staff working well together and we spoke with six members of staff, all of whom felt communication was good. One member of therapy staff told us, "Care staff are brilliant, we have a good relationship and they feedback to us and handover well. Communication is good". Another staff member told us, "Everyone plays their part, there is good communication, good rapport and team work". Other staff with whom we spoke agreed that handovers were clear and they felt senior members of staff and the manager of the service were approachable and would provide help and guidance where needed.

Only medical referrals to the service were accepted and referrals were received from the local hospital and from medical services in the community. We were told that there had been difficulties with communication within referrals received from the hospital, but this was being worked on as the manager attended a number of joint meetings with the hospital to discuss these matters.

We saw evidence of referrals to other services, such as the falls service, and these were recorded within the care files. Any hospital admissions or out-patient appointments were appropriately recorded and followed up.

We spoke with the GP with Special Interest (GPSI) who attended the service five days per week. He told us communication and recording was good. He said staff followed advice and instructions well and referrals were made appropriately via a communication book.

We saw evidence that Carer Support and Age UK attended the service on a regular basis and offered assistance and advice to people within the service and took referrals where needed. There were posters advertising their service in the entrance to the home.

Similarly the Stroke Association and Think Ahead, a community stroke group, offered support and assistance to people undergoing treatment at the service. Posters and leaflets were displayed on the first floor of the building, where people who had experienced strokes were accommodated.

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with six members of staff, all of whom told us they felt the service was a good and supportive work environment. We were told staff meetings were infrequent, due to the shift patterns and different disciplines of staff, but that they provided a good opportunity to raise issues. We looked at minutes of the most recent meeting which included a thank you to staff, discussions around training, environment and recording.

We asked care staff about the induction process and were told this was comprehensive and included mandatory training, such as fire safety, food hygiene, safeguarding and moving and handling. We were told an induction pack was given to care staff, which they had thirteen weeks to complete. This contained questions to answer and was checked regularly by the staff member's supervisor.

The service had an Induction Policy and Staff Supervision Policy, which were regularly reviewed and up to date. There was also an Employee Responsibility Policy which included a code of conduct, adherence to policies and dress code.

We looked at three staff files and found they included application forms, proof of identification, interview notes, references and signed contracts of employment. There were also Criminal Record Bureau (CRB) or Disclosure and Barring Service (DBS) checks which were carried out to ensure people were not unsuitable to work with vulnerable people. We also saw evidence of training undertaken by employees.

Many staff had undertaken recent appraisals and reported these were helpful and useful. We were told extra training and personal development was encouraged by the service.

All staff with whom we spoke told us communication was good and handovers helpful. One person said, "Good team work, we are a happy team, always laughing. Some experienced staff mentor new staff". Another staff member told us, "It is a happy place to work". A third staff member told us, "Staff morale is very good and staffing levels are usually adequate, agency staff are used if needed". They went on to say that all staff were required to write in care files. They said staff were encouraged to have an opinion and things had been changed in response to staff suggestions, making staff feel valued.

Assessing and monitoring the quality of service provision

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The service had a manager in place who was appropriately registered with the Care Quality Commission.

We looked at the results of the most recent quarterly survey, completed by people who used the service. They showed a high level of satisfaction with the service and comments included, "Surprised to find our pets could visit – we had missed them", "Lovely place, nice people", "Meals were not terrible, but not wonderful, and, "Staff were brilliant, kind, understanding and patient".

We saw a number of audits, including several accident and incident audits for the past few months. We saw the results of these had been analysed and follow up actions undertaken, such as risk assessment reviews.

Falls audits consistently demonstrated a high number of falls within the service and staff explained that this was often due to people having experienced a recent reduction in mobility and being anxious to regain this. In some cases cognition was impaired and people would not remember that they could no longer walk around safely.

Efforts had been made to address this problem by various methods, including a falls prevention exercise group being held weekly on each unit. Each person was given a chair based exercise programme to take home with them on discharge. Some people had posters in their rooms reminding them to press their call buzzer for staff to assist them if they wished to go somewhere. Therapy staff told us people were reassessed on a daily basis, risk assessments updated and measures, such as equipment and assistive technology, used if appropriate to help minimise the risks.

We spoke with the GP who attended the service five days per week. He felt the number of falls reflected the nature of the service and agreed the service monitored and assessed the falls on an on-going basis and addressed the risk in an appropriate way. He felt thorough assessments were undertaken after any accident or incident to try to minimise risks.

Other audits completed by the service included fortnightly water temperatures, monthly medication audits and weekly checks on the maintenance log. These audits also included the identification of concerns and actions to be completed.

We saw care plans and risk assessments were reviewed weekly or responsively when changes occurred and re-admissions were audited monthly. Quarterly audits were carried out by both the Contract Monitoring Department and the Clinical Commissioning Group (CCG), the results analysed and actions identified.

People should have their complaints listened to and acted on properly

Our judgement

The provider was not meeting this standard.

There was an effective complaints system available, however complaints people made were not always responded in a timely and appropriate way.

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

The service had an up to date complaints policy in place. This set out timescales in which a response should be received by the complainant and contact numbers for other routes the person could use to make a complaint.

The Care Quality Commission had received a number of complaints and we looked at the general issues set out in these during the inspection. We were told verbal complaints had not been responded to, however, we saw examples where a timely response had been made. In one care file we saw a verbal complaint made by a family member had been addressed by the manager, who had acknowledged the person's concerns and given an explanation for the service's actions over the telephone.

We looked at the complaints log, which included details of complaints received, investigations undertaken and responses given. We saw that one quite serious complaint had not been followed up appropriately as, although an investigation had clearly been instigated and it was recorded that a written response had been sent out, this could not be found. There was nothing recorded about what the response was and, when we questioned the manager, she felt this may have been an oversight.

The complaints log had been audited, but had not flagged up this omission. This may have been missed in the audit as the complaint was received at the end of a month and the next audit may have begun from the following month and not followed up the response time of this complaint.

We asked the manager to send out a written response as quickly as possible and to ensure that the complaint was thoroughly investigated and concluded. We also asked that audits of the complaints log be made more robust to minimise the risk of issues being missed in the future.

Most complaints had been responded to appropriately and we saw evidence that discussions had taken place around avoiding repeat occurrences. However, because the overlooked complaint included a number of issues and was of a serious nature, we felt the

lack of written response within 28 days, in accordance with the company's policy, was not acceptable and the service needed to take immediate action to address this.

If complaints are not responded to and addressed appropriately the consequence could be that people do not feel protected and their rights to fair treatment could be compromised.

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	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints
Diagnostic and screening procedures	How the regulation was not being met: The provider did not take appropriate steps to coordinate a response to a complaint where that complaint related to the care or treatment provided to a service user.
Treatment of disease, disorder or injury	

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

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

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