Inspection Report

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

Ash Grange Nursing Home

80 Valley Road, Bloxwich, Walsall, WS3 3ER Tel: 01922408484

Date of Inspection: 30 June 2014 Date of Publication: July 2014

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	HC-One Limited
Registered Manager	Mr Shawez Khwaja
Overview of the service	The service is registered to provide accommodation and nursing care for up to 42 older people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 June 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff, reviewed information sent to us by other authorities and talked with other authorities.

What people told us and what we found

One inspector carried out this inspection. Below is a summary of what we found. The summary is based on our observations during the inspection, speaking with people using the service, their relatives, the staff supporting them and from looking at records.

If you want to see the evidence supporting our summary please read our full report.

Is the service safe?

People told us they felt safe. Safeguarding procedures were robust and staff understood how to safeguard people they supported.

People told us that they felt their rights and privacy were respected. One person said, "I love living here. We're treated as individuals and they know what we like."

Systems were in place to make sure that managers and staff learned from events such as accidents and incidents, complaints, concerns, whistleblowing and investigations.

Staff knew about risk management plans and discussed situations in which they had followed them. People were not put at unnecessary risk but also had access to choice and remained in control of decisions about their care and lives.

The registered manager set the staff rotas and they took people's care needs into account when making decisions about the numbers, qualifications, skills and experience required. This helped to ensure that people's needs were always met.

Policies and procedures were in place to make sure that unsafe practice was identified and people were protected.

Staff records demonstrated that mandatory training was up to date and that staff were trained sufficiently to meet the needs of people who lived there. Staff were trained in caring

for people with dementia and challenging behaviour. The home did not have any people living with a Deprivation of Liberty Safeguards authorisation in place but staff had been trained in the correct procedures to follow if this situation changed.

Is the service effective?

People's health and care needs were assessed with them, and they were involved in writing their care plans. Where people did not have the capacity to consent to care, there were procedures in place to ensure that decisions were made in the best interest of the person.

Specialist dietary needs had been identified where required. People said that their care plans were up to date and reflected their current needs. Staff told us that care plans were personalised which helped them to understand how to provide care in a way that respected the person's personality, likes and dislikes.

Is the service caring?

We spoke with people who lived in the home and spent time observing them being cared for by staff. We asked them for their opinions about the staff that supported them. Feedback from people was positive, for example, "I like everything here. The staff are so lovely, I enjoy sitting chatting to them." And, "The staff are brilliant, I'm well looked after."

When speaking with staff it was clear that they genuinely cared for the people they supported. People using the service, their relatives and other professionals involved with the service were able to be involved in regular meetings with staff. Where shortfalls or concerns were raised these were taken on board and dealt with.

People's preferences, interests, aspirations and diverse needs had been recorded and care and support had been provided in accordance with people's wishes.

Is the service responsive?

People knew how to make a complaint if they were unhappy. One person said that they had never made a complaint but knew how to do so. We found that previous complaints had been dealt with appropriately by the provider and resolved in the best interest of people who lived there.

The service worked well with other agencies and services to make sure people received care in a well-structured way.

Is the service well-led?

The service had a quality assurance system, and records showed that identified problems and opportunities to change things for the better were addressed promptly. As a result the quality of the service was continuously improving.

Staff told us they were clear about their roles and responsibilities. Staff had a good understanding of the ethos of the home. This helped to ensure that people received a good quality service at all times.

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

More information about the provider

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

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We looked at care plans, risk assessments and people's daily care observations and spoke to staff and the manager. We found evidence that people's consent was always sought in the delivery of care and treatment and that this was regularly reviewed. Each care plan included documented evidence that people had been involved in their care plan. This included a 'daily statement of wellbeing' which staff used to record any changes in a person's health or behaviour as well as any comments or special requests from the person. This helped them to keep track of people's preferences and to deliver care in a way that was important to people's sense of independence.

Care plans included comprehensive and up to date records of visits and advice from a multi-disciplinary medical team and there was evidence that people consented to treatment given. Where the person had not been able to give consent, it was clear who their legally responsible representative was. We spent time observing people in the communal areas of the home during lunchtime and found that people were cared for in accordance with their wishes and their care plan.

We spoke to a person who lived there who told us that communication from staff and managers was clear and easy to understand and that they were always told immediately of any changes in their care or treatment. They also said that they felt involved in the home and that care and treatment needs had been discussed with them by staff who were good communicators and who explained things well. They said, "If I have a problem, they [staff] call my GP straightaway. I've never had to wait for anything like that." Another person said, "We're doing alright here. If you find any problems, come back and tell me! You won't find anything wrong, this is a lovely place to live and I live just how I want."

We spoke to staff who all demonstrated an acute awareness of the importance of consent and respect. We found evidence of this by spending time observing staff working with people who lived there. Staff used touch to let people know when they were being spoken

to and gave them time and space for one-to-one attention, such as sitting with them during lunch and spending time talking to a person who wanted to reminisce.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. Some people were not able to give their consent to care or treatment due to their mental capacity. We reviewed the care plans of people and found evidence in all cases that the reason for lack of consent from them had been identified and a responsible family member or responsible person from the local authority. Where people were not able to make decisions about their care, the manager, nurses and carers used a 'best interest' procedure that helped them to understand the needs of the person. The procedure included a mental capacity assessment which helped to decide who would act in the person's best interest. Records of meetings and decisions that had occurred had been maintained to help staff to provide the appropriate level of care to each person.

We spoke to nurses, carers and the manager about obtaining consent for care and treatment. A member of staff told us, "Nothing is done without the person's consent. We explain to them what their medicine is for and why it's a good idea to take it. If they refuse to take it, we work with them to find out what the problem is."

At the time of our visit, the home did not have any people living there with a Deprivation of Liberty Safeguards order in place. We spoke with staff about this and they told us that they had been trained to look after people if such a need occurred and that they felt supported to provide the specialist care needed. We also found evidence of this by reviewing staff training records.

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We reviewed care plans and found evidence that care and treatment was planned and delivered appropriately. Care plans were person-centred and focused on the needs of the person. They were reviewed at regular intervals and the manager maintained records of changes in behaviour patterns or needs which helped staff to provide effective care. We found that each person had a 'personal information action plan' that allowed staff to plan and deliver care flexibly and in the best interests of each person whilst respecting the person's wishes.

Care plans included a 'daily statement of wellbeing', which helped staff to monitor how people felt about living at the service and the care that they received. Care plans also included risk assessments to help people to take part in activities safely. Records of each person's requests regarding the decoration of their bedroom and their daily routines were maintained by staff to help them to provide care in a way that was important to each person. We spoke with staff about this who said, "Everything we do here is for the residents. All of our work is in their best interest and we're well trained to do that."

We looked at daily log records as well as personal care reviews and found that assessment of people's needs was on-going and that care was provided flexibly and in the best interests of the person. We found that regular quality assurance checks by the registered manager helped to maintain this standard and that corrective action took place where any inconsistencies were found.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We reviewed risk assessments and found them to be thorough, up to date and fit for purpose. Risk assessments had been carried out in a way that allowed people to live in a way that was important to them and still be cared for to a high standard. For example, people who wished to remain sitting in lounge chairs for mealtimes had been accommodated safely with the installation of foot plates to each chair. We found from our observations that people were supported to spend time in the communal areas and in their private rooms safely because staff were able to provide one-to-one support.

We also found evidence that care and treatment was delivered safely by reviewing multi-disciplinary care and treatment records. There was a consistent approach to involving appropriate medical professionals in people's care. There was evidence that the registered manager was responsive in changing care or treatment delivery, when needed, to ensure a person's welfare. We found that where the welfare of a person might be at risk because of a change in behaviour or medical condition, the registered manager was responsive with involving appropriate professionals. We spoke with people who lived there about this. A person said, "I've got no problems with living here. If I want so see a doctor, the staff get me an appointment. They're great at taking care of us."

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. We reviewed personalised care plans and medical records and spoke to people who lived there. We found a strong awareness of people's individual needs and found no evidence of unlawful discrimination. A person who lived there said, "If I have any problems, staff are always there. I get a great nights sleep every night and I feel safe here." We spoke to staff and found that care was delivered depending on the wishes and personality of each person which enabled a culture of equality to exist.

There were arrangements in place to deal with foreseeable emergencies. We spoke to the registered manager and staff about emergency provision and were told that they were confident in dealing with fires and evacuations. Staff told us that they were happy with the content and frequency of fire and evacuation training.

People's welfare was supported by staff with the provision of recreational activities that were important to people. We spoke with a member of staff responsible for activities. They told us that people were asked for their views on activities and these were planned with nurses and staff so that people could take part safely. The home had its own mini bus which staff were trained to use safely. Past activities had included table football, story telling, pamper days, fish and chips days for the World Cup and coffee mornings. A person who lived there said, "I've enjoyed making new friends here. I've met some lovely people and we make time to socialise each day." We observed staff helping to support people with this, such as by helping someone to celebrate their birthday with their friends and relatives.

We looked at the care plans of people with complex needs and found evidence in all cases that comprehensive risk assessments had been put in place to allow people to live there safely whilst maintaining their sense of independence. For example, some people had complex nutritional needs but wanted to be able to eat at mealtimes with other people. The home's chefs had received specialist training in meeting people's nutritional needs and were able to prepare fresh, nutritious food that was tailored to the needs of each person.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People's food and drink met their religious or cultural needs. We spent time looking at care plans and found that the comprehensive assessment completed with people when they came to live in the home, as well as personal histories, were used to provide food and drink appropriate to them. We spoke with staff who told us that the catering team was responsive and was able to provide specialist food on request and on short notice. We spoke with a chef who told us that they had received specialised training that helped them to modify food and drink to meet people's preferences whilst meeting their nutritional needs. They said that they were able to provide Halal and Kosher food whenever this was requested and that they were also trained to provide liquidised food when needed.

People were supported to be able to eat and drink sufficient amounts to meet their needs. We spoke with the registered manager who told us that each person received a nutrition assessment before they came to the home so that their dietary needs could be planned for. We found that care plans contained comprehensive nutritional needs information and by speaking with staff we found evidence that people's needs were understood and catered for.

People were supported to influence the menu on a daily basis so that they could eat their preferred foods. Catering staff arranged the menus as requested by people and they were supported to ensure that the food met individual nutritional requirements by consulting dietary reference sheets supplied by staff. We found that training had been planned for catering staff to be able to provide textured food for people on the recommendation of nutritionists.

People were provided with a choice of suitable and nutritious food and drink. We found evidence of this by reviewing daily menus which were freely displayed in dining areas. These menus highlighted a range of food and drink options available throughout the day. Special dietary requirements were clearly noted on the menus for staff to easily consult. We asked people who lived at the home how they felt about the food. In all cases we found a positive attitude. One person told us, "The food here is lovely. I especially enjoy the Sunday roast and fish and chips. Mealtimes are really something I enjoy here." We also spoke with some relatives of people. They were positive about the provision of food and drink and said that they thought it was high quality and that people enjoyed it.

We observed people during their lunchtime meal. We found that people were supported to

eat with dignity and that they were able to make special requests whenever they wanted. People who needed assistance to eat were given this and it was provided by staff who were friendly and who gave people time to enjoy their meal without rushing them. We reviewed the results of an independent survey of people who lived in the home as well as their friends and relatives. All 21 of the respondents indicated that food and drink provision was either good or excellent.

We found that prior to our inspection some concerns had been raised by the home's clinical commissioning group regarding the use and administration of sub-cutaneous fluids for people who needed extra hydration. As part of our inspection we looked at the action plan put in place by the provider to ensure that the use of such techniques was correctly documented and only put in place in the best interests of the person. We found that the provider had improved how the use of such fluids was documented and evaluated and that nurses were able to help people to use them safely.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. We spent time in the home observing staff and people in communal areas and found that staffing was sufficient to be able to deliver care effectively. We spoke to a person who lived there who said they were very happy with the nurses and carers. Another person said, "I feel very happy with the manager. He's always around. I've never had a problem here but I know I could speak to him about anything that was bothering me." A relative said, "Staff are lovely. They've really helped [my relative], its nice to be able to leave after a visit and feel they're in good hands."

We looked at the staff rota with the registered manager and found that staff were deployed based on the needs of people who lived there. We found evidence that staffing levels were flexible and responsive to the needs of people, including people who had complex needs. We spoke to staff who said that they often worked under pressure and that they would like more staff to be on shift at the same time. We did not find evidence that this impacted the level of care that people received and the manager had implemented a new staff policy to reduce a pattern of weekend sickness.

We spoke to staff about working at the service and they told us that they were very happy and felt supported to be able to provide effective care. They also said that the manager was friendly, supportive and approachable and that they felt confident that any issues would be resolved. We were told that regular staff meetings helped people to discuss people's care and to share learning from their experiences in the home. They said that concerns raised in staff meetings were followed up by the manager.

We looked at the staff training matrix as well as training records and found that training was appropriate to the service and that staff had to demonstrate competence before they were able to practice. We spoke with staff about the training that they had received. One staff member said, "The online training is great because it fits around my work here. It's helpful and I feel that I'm up to date with what I need to know. I can also ask the manager for any extra training I need and they'll help me get it." We found that importance was placed on the ability of staff to treat people with dignity and respect. This was demonstrated by the provider's support of staff to gain the Dignity Champion title after undergoing special training. We saw that this helped staff to understand the diversity of people and their needs.

We spent time observing and speaking with a member of staff who had recently completed specialised instruction which enabled them to train other staff in the safe use of manual handling equipment. We saw that they were able to provide a high standard of safe care to people who needed help to move around the home. They told us that the training had helped provide a higher standard of care to people who needed help with mobility and that by training their colleagues, they had improved the level of care that was given around the home. They said that they had noticed improvements in the way staff helped people to move after receiving the training.

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

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We found evidence of this by looking at the records of regular meetings between people who lived there, their relatives, staff and managers. There was a strong focus from staff on supporting people to express their views and finding innovative ways of meeting special requests. Relatives were able to join meetings if they wanted to and provide their own feedback and support to people who lived there and staff. We spoke with a member of staff who was responsible for organising activities for people. They said that activities had been implemented based on the feedback from people in meetings, in which they were supported to offer frank views on the care they received.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We spoke to the registered manager about the scope of care provision and found that they were acutely aware of the needs of people and of their ability to provide it. Each person had an admissions assessment in place which had been used by the appropriate staff to decide if the home was equipped to provide care for them. We spoke with staff who told us that they were well prepared to look after each person and that the depth of the material provided for them in care plan supported this. Where a change in need or medical condition could have put a person at risk there was a robust plan in place to involve the appropriate professionals as well as relatives and the person where appropriate. We looked at multi-disciplinary medical records and found that changes to care or treatment were clearly and appropriately documented. The appropriate professionals had been involved in instances where care or treatment had changed and we found evidence that people were involved in this process.

There was evidence that learning from incidents and investigations took place and appropriate changes were implemented. We reviewed the incident log and found that incidents were responded to quickly and appropriately. We also found evidence of this by reviewing daily record sheets and handover paperwork from night shift to morning staff. We found that a robust accident analysis and tracking procedure was in place that enabled the registered manager to investigate incidents and provide support to people and staff where appropriate. This also enabled the registered manager to implement any changes

that might help prevent future incidents. We spoke to staff who told us that they were aware of the procedure to follow if there was an incident when the registered manager was not on site and that they felt the investigation procedure helped to support and protect them.

The provider took account of complaints and comments to improve the service. The complaints policy was freely available to people who lived there, their family and visitors. We looked at the complaints log and found a positive relationship between the registered manager and the provider that helped resolve complaints quickly. We found that learning from complaints took place where appropriate and that people who made complaints were protected from discrimination. The people we spoke with had not had the need to make a complaint but they said that their relationship with staff and managers was good and they knew who to speak to if they had a problem.

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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