Care Quality Commission

Inspection Report

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

Priscilla Wakefield House

Rangemoor Road, London, N15 4NA

Date of Inspections: 08 April 2013
04 April 2013

Date of Publication: May 2013

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

Standard		Outcome
Respecting and involving people who use services	✓	Met this standard
Care and welfare of people who use services	✓	Met this standard
Safeguarding people who use services from abuse	✓	Met this standard
Staffing	✗	Action needed
Assessing and monitoring the quality of service provision	✗	Action needed
Complaints	✓	Met this standard
Records	✗	Action needed

Details about this location

Registered Provider	Magicare Limited
Registered Manager	Mr. Barry Healy
Overview of the service	Priscilla Wakefield House is a care home in Tottenham which is registered to provide care and accommodation for 112 people. At the time of this inspection there were five units in the home. Copperfield for people who required nursing care, Nickleby for people who required residential care. Dorrit for older people who required dementia nursing care and Haversham and Pickwick for younger adults who may have dementia, brain injury or physical disability and required nursing care.
Type of services	Care home service with nursing Rehabilitation services
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

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Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 April 2013 and 8 April 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information we asked the provider to send to us. We talked with other authorities.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We visited Priscilla Wakefield House over two days and met with people during the day and night shifts. We spent time on all the units. There were about 100 people living in the home at the time of our inspection. We spoke with twelve people who used the service, three relatives or friends of people who used the service, and sixteen members of staff. Some people were not able to tell us what they thought of the home and we used a number of methods to help us to understand their experiences including structured observation.

People were generally positive about the care which they received. One person told us "They look after us well" and another person told us, about the care staff, "They communicate with us". We observed some positive interaction between care workers and people who used the service. We looked at sixteen personal files on different units and there was evidence that care plans were written with the involvement of people who used the service.

Family members and friends we spoke with were positive about the experiences of the people they visit at the home. One family member told us "they involve me in everything".

Some staff told us there were not always enough staff particularly during the night. We looked at the staff rotas which indicated that there was not always sufficient cover for unplanned staff absences.

We found that some of the records were not stored securely.

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 05 June 2013, 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

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

People who used the service and their relatives told us they were provided with information to make choices relating to their care and treatment. People told us that care workers and nurses were respectful towards them. One person who used the service told us "nurses respect and listen to me". One relative told us "they involve me in everything". People told us they were given choices about when to get up and when to go to bed. We saw that people could choose whether to have meals in their rooms or in the communal dining area, where they had the capacity to make that decision. We spent time on all the units and spoke to people on all the units and where people were not able to communicate easily, we undertook structured observation. We observed some positive interaction between members of nursing and care staff and people who used the services.

We saw that mental capacity assessments had been completed in the files that we looked at. These established in which specific areas people lacked capacity in accordance with the Mental Capacity Act (2005). This documented where people had the capacity to make a choice and when they did not.

We saw that people were able to choose whether to have their doors open or closed during the night. We observed that when personal care was given, this was done discretely to ensure the dignity of people who used the service. We saw care workers who were providing care explained to people who used the service what they were doing which afforded them respect.

We spoke with care workers and nurses who were able to explain to us how they ensured that they respected the dignity and privacy of people who used the service. They told us that they asked people to whom they were delivering care about their preferences about where they would have their meals and whether they would prefer to have their doors open or closed during the day and night.

We saw, during a meal, that someone with a cognitive impairment who did not have English as a first language struggled to be understood. Staff could understand some basic words in his native language and we were told in situations where a person in the service

does not speak English family members were able to interpret. The provider may find it useful to note that people who may have difficulty in communicating in English may not be able to receive the care they require and the use of pictorial signs or symbols could facilitate this where there is a language barrier.

The information available in the foyer about the home was out of date and there was no written information about the home provided to people on admission. We were told by the manager that the provider was planning to update information given to people and their relatives on admission to the home. The provider may find it useful to note that the lack of clear and understandable information for people who join the service may mean some people do not have clear expectations of their rights and opportunities within the home.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Most of the people we spoke with told us they were happy with the care that they received at Priscilla Wakefield House. One person said "they look after us well". One care manager who had placed someone at the home told us that they were happy with the placement and the person's family had been happy with the placement.

We saw that relevant and necessary information about medical and social care needs were gathered before people were admitted to Priscilla Wakefield House. People were assessed by a member of staff before being admitted to the home which ensured that their needs could be met.

As well as talking with people who used the service, we carried out structured observations on the units where people were less able to give direct feedback. We observed some good interaction between people who used the service and care workers.

We saw that Dorrit, the dementia nursing unit, had been decorated to provide a stimulating environment for people with dementia, including bright colour schemes and rummage boxes. Another unit, Haversham, which has people with dementia and nursing care needs, had poor signage and no signs indicating names on bedrooms or any identifiable features. The provider might find it useful to note that on a unit which caters to people with dementia, the lack of clear signage may result in increased risk of people who used the services being disorientated in their home environment.

We looked at sixteen files across all the units. We saw that risk assessments were completed in terms of specific areas such as moving and handling, bed rails assessments and pressure care management. The issues raised in the risk assessments reflected the care plans and the care which we observed being delivered and was also referred to in the daily logs we read.

Care plans were reviewed regularly and specified the individual needs of people who used the services. The care plan and the regular reviews took account of people's individual preferences and established a picture of the people who used the service. We saw that some people had additional 'short term care plans' where a particular issue needed to be addressed in terms of health needs.

We saw that some activities were coordinated with the local primary school which encouraged participation in the local community. We were told that one person attends a local mosque and that a local church holds regular services in the home for people to attend.

We were told that there were regular meetings with residents and relatives planned and that the next one was happening in the month we visited. The last meeting had been six months previously.

Prior to the inspection we received information raising concerns about the amount of activities offered during the day. We met with the activity coordinators who were able to describe the work they did to ensure that meaningful activity was offered during the day. We saw a timetable of activities and activities offered, which were varied and had been documented thoroughly. During our observation we saw one arts and crafts activity taking place on a unit and it was well-attended. We saw that people attending the session enjoyed it. One person who used the service told us they had enough activities offered during the day. One staff member told us they thought that the activities offered were sufficient. Another person who used the service told us they would like the opportunity to do exercise activities. We were told by the activity coordinator that chair-based exercises are offered.

On three units we observed that rooms which had toiletries, including razors, were left unlocked. The provider might find it useful to note that this may present a risk to people who may have a cognitive impairment.

One person was subject to an urgent authorisation under the Deprivation of Liberties Safeguards. We saw that the request for a standard authorisation had been made to the relevant local authority indicating the provider was aware of the necessarily legal framework.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We spoke to members of care and nursing staff who were able to tell us what they would do if they suspected abuse of someone who used the services or if they were concerned about a colleague mistreating a resident. All the staff we spoke to had completed training in safeguarding. We looked at records on all of the units and found that unexplained injuries were recorded and investigated.

We had received notifications of some recent safeguarding issues raised which we saw had been appropriately managed and the home manager was aware of the local safeguarding arrangements which were in place.

We checked the system that the provider used to ensure that people's finances were managed and we saw that the records relating to people's finances were correct and managed sufficiently to protect people who used services from the risk of financial abuse.

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.

The provider had not ensured that there were always enough qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.

The provider was not meeting regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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 received information prior to our inspection regarding concerns raised about the level of staffing, particularly at night. We arrived on both days of the inspection early in the morning before the day shift started to check the numbers of night staff as well as day staff. On the days we visited, we found that the staffing levels were reflected on the rotas provided to us. We checked the rotas from the previous month which showed that there had been days and nights where the staffing levels both of nursing and care staff had been lower than the level which the service had indicated was necessary. The provider indicated that it needed three nurses and nine care assistants during the night. For the period of two weeks prior to the inspection, between 24/3/2013 and 7/04/2013 there were seven nights where there were only two nurses in the home. Over the same period, there were eight nights where there were fewer than nine care assistants and on one night, 29/3/2013 there were only six care assistants on the rota. The manager told us that when there was a shortage of nurses at night, the nurses during the day would help with medication and the manager would cover some shifts which were short when possible.

We spoke to staff who worked during the day and at night. Five members of staff we spoke with told us they did not feel the staffing level was sufficient, particularly during the night. One nurse told us, "we could do with more staff during the night". Another nurse told us "sometimes there aren't enough nurses [at night]. Sometimes carers call off sick and there are no replacements". A care worker told us "the only problem here is the staff shortage". Another care worker told us "The day staffing is fine. [The manager] comes in if there are any problems".

Staff also told us there was not a robust system to cover unexpected absences of staff members. When a shift needs to be covered the manager told us they would try to find staff who were not working to cover the shift but they did not use agency staff frequently as they did not know groups of residents well. They told us that there is no bank system in place apart from asking staff who were not on duty if they will cover shifts that become

available at short notice. This meant that sometimes shifts were left unfilled if no member of staff was available at short notice to cover the absences. The manager told us they covered shifts themselves and when there was a shortage of nurses for the night shift, nurses who were on shift in the day would ensure that they helped administer medication which was due at night to ease the workload of the nurses at night.

We saw that the provider had completed a 'staffing tool' which was in the file of each resident.There was no clear needs analysis of the basis for deciding sufficient staffing levels across the home and on each unit.

One nurse told us that the manager sometimes covers for staff shortages. Some staff told us the manager is very supportive to them and takes a 'hands on' approach to staffing levels.

We found that it was not possible for the service to ensure that there were always sufficient numbers of suitably trained and experiences persons on duty and this had a moderate impact on people who used the services.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider had not provided a sufficient system to allow the registered person to collate information or analyse incidents that resulted in, or had the potential to result in, harm to a service in order to, where necessary, make changes to the treatment or care provided.

The provider did not meet regulation 10 (2) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. The manager carried out 'spot checks' during day and during nights which monitored the service regularly. The provider employed an external consultant to visit and compile a report monthly which was used to indicate areas which the service could improve. We saw the most recent reports produced which highlighted some areas for improvement which the provider targeted. The most recent audit we saw which had been completed in the month prior to our visit raised issued around decor and the environment around the home. It also raised some issues relating to staff interaction with residents. These allowed the provider to address particular issues and we saw that there had been an emphasis on improving the environment and decoration on one unit in response to this feedback.

We were told by the manager there would be regular meetings between residents/families and staff. The most recent meeting had been six months previously. We saw posters advertising this meeting to residents and family, friends and advocates. We saw that staff meetings occurred regularly which would allow staff to feed back issues of concern. We saw the minutes from team manager meetings and we were told by staff that they had regular meetings within the units they worked on. We were told that a drop-in evening had been held for family members so that people were offered different times to come and meet the management. People who used the service told us they felt they were able to raise concerns with staff members.

We found that there was an inconsistency to the ways that incident reports were collated. Incident reports were not collated by the manager according to the internal policy which we were told was in place. This could lead to a gap in the learning from incidents when they occur. Some incident reports were placed in the files of people involved and some were

collected by unit managers. The incident book in the manager's office was not up to date. We found an incident report on one person's file that had not been entered in the incident book in the manager's office.

Complaints

✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was a complaints policy in place which was appropriate.

Reasons for our judgement

We had concerns raised with us directly about way complaints were managed by the provider. We saw that there was a complaints policy in place and information about this policy was on the wall on one of the units. The complaints policy which was present in the main lobby area did not contain up to date information. Care staff and nursing staff told us they knew how to make complaints and were aware of the whistleblowing policy. Most people who used the service and family or friends that we spoke to told us they were aware of how to make complaints if they wanted to. We saw one complaint had been logged in the complaints file over the previous year and had been followed up appropriately however from the information we had received prior to the inspection, we understood that at least one other complaint had been made that had not been recorded.

The provider may find it useful to note that the lack of clear documentation of complaints made may lead to the complaints policy not being enacted to the level of expectation of the people who used the services and their family members or advocates.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

The registered person had not ensured that confidential records were kept securely. The provider was failing to comply with regulation 20 (2) (a).

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at sixteen records for people and we looked at records held on every floor. These records included care plans, risk assessments, daily log recording and accident/incident reports. We found that the care plans and risk assessments were up to date and contained information relevant to the people concerned which would provide person-centred care.

In two files we found that risks which were identified in the daily logs or in care plans were not evidenced with management plans in risk assessments. The information about the risk was evidenced in the daily logs but the lack of appropriate information on risk assessment documentation may lead to care being given which may not be appropriate. There was no evidence that this had impacted directly on the level of care given for the people concerned. The provider may find it useful to note that the lack of comprehensive risk assessments may lead to people being provided with care which does not meet their needs in terms of the presenting risks.

We saw looked at some records related to the management of pressure sores and found that in two of the files the recording was not consistent. We did not find that this had had a direct impact of the level of care which was delivered.

The provider may find it useful to note that the lack of attention to the pressure care management policy in place may lead to the potential risk of harm from some people who used the service.

Records were not kept securely. When we visited the home we found that the records including personally identifiable information about current and former residents as well as members of staff were being stored in a room which was being converted into an office for staff and had no lock on the door. It was accessible to anyone in the service or to people visiting the service who were supervised.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** The provider was not meeting regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. They had not ensured that there were, at all times, sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** Under regulation 10 (2) (c) (i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010) we did not see evidence of robust collation and analysis of incidents that resulted in, or had the potential to result in, harm to a service user.
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Under regulation 20 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 records with personally identifiable confidential information were not being kept securely.

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 05 June 2013.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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