

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

Lavender House

69 Welton Road, Brough, Hull, HU15 1NU

Tel: 01482666013

Date of Inspection: 22 January 2013

Date of Publication: February 2013

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
Management of medicines	✗	Action needed
Requirements relating to workers	✓	Met this standard
Complaints	✓	Met this standard

Details about this location

Registered Provider	Quality Care UK Limited
Registered Manager	Ms. Sarah Warrington
Overview of the service	Lavender House is situated in the centre of Brough and provides accommodation for up to 32 older people, some of whom may have a memory impairment. Most bedrooms are single en-suite. There are two lounges, one with dining space, and four bathroom facilities. A passenger lift gives access to the upper floor and there are bedrooms up or down another set of stairs. The front of the house has gardens and car parking. An extension is in progress.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	5
More information about the provider	5
Our judgements for each standard inspected:	
Consent to care and treatment	6
Care and welfare of people who use services	7
Meeting nutritional needs	9
Management of medicines	11
Requirements relating to workers	13
Complaints	14
Information primarily for the provider:	
Action we have told the provider to take	16
About CQC Inspections	17
How we define our judgements	18
Glossary of terms we use in this report	20
Contact us	22

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 22 January 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

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 spoke with six people that used the service, as well as the manager and a district nurse to obtain views about the care provided in the home. We also observed people being supported and cared for by using a 'short observational framework for inspection' (SOFI) and we looked at documents and records. We saw the lunch time meal being served, we carried out an audit of the medication systems in use and we observed a staff member administering medication to people.

We found that people were satisfied with the support and care they received, enjoyed the meal provision, interacted well with each other and staff and were treated with respect. People said, "The staff are lovely, they always help us when we need it and they do work so hard" and "I have lived here for quite a while now and I like it very much, I have some friends and the staff are very helpful." They said, "We are well looked after" and "I am given as much help as I need." A district nurse told us that the service took their advice and cared well for people.

We found, through use of the SOFI, that staff were caring and considerate. We found that there were some concerns regarding the handling and storage of medication, and we concluded that medication was not being administered safely and records did not account for when they had been administered or refused.

We found that staff had been safely recruited and that there was an appropriate system in place to address and resolve complaints.

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

What we have told the provider to do

We have asked the provider to send us a report by 28 February 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

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

We spoke with people that used the service and with the manager about consent to care and treatment. We also observed interactions between people and staff and we looked at documentation to evidence consent had been given.

People told us they cooperated when staff offered them support because they realised the staff were doing a good job. People said they did not always manage to care for themselves. One person said, "When we ask for help the staff are lovely, very kind." We observed and heard people asking for assistance and staff offering it and we saw that people consented to support by cooperating. We saw one person who had been ill and had vomited being assisted to the bathroom to change their clothes, and several other people assisted to maintain their personal comfort. We saw many people assisted with their mobility in and out of chairs and wheelchairs. Each time the staff explained to people how they wanted to support them and each time the people gave consent to their help.

We saw in case files that people and their relatives had been involved in providing information about themselves, so that staff had an assessment of peoples' needs which was translated into a care plan. The staff then had instructions on how best to assist and care for people so their needs were met. We saw that care plans had been signed by people where possible and by their relatives where not. The staff therefore had written consent from people to support them with their care needs.

At the last inspection in March 2012 the provider did not have a written policy on obtaining consent to care and support from people. Since then the provider had compiled a policy on consent and we saw a copy of this during this inspection.

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

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

We spoke with people that used the service, a district nurse and the manager about ensuring peoples' care and welfare. We also observed interactions between people and between people and staff. We used a 'short observational framework for inspection' (SOFI) tool to record these interactions. We also looked at three care plans to see how peoples' needs were recorded and how they were recorded as being met.

People we spoke with, apart from one, told us they were satisfied with the care and support they received. People said, "The staff are lovely, they always help us when we need it and they do work so hard", "I don't need help to go anywhere and I can stay here for lunch, as I don't have to move from here" and "I have lived here for quite a while now and I like it very much, I have some friends and the staff are very helpful."

One person said, "I am not impressed with residential care and if I had my chance again I would not come into the home." They explained why they felt like this and it was not because of any mistreatment or dissatisfaction with the help they received, but to do with their dislike of 'group living' and the situations this entailed.

Other people said, "We are well looked after and we can decide what we want to do and when", "I like to go to my room for an afternoon sleep and the staff help me to go up to my room each day," "I have not been well lately, had some pain and so the manager has called for the doctor to visit me" and "I am given as much help as I need."

We saw that people were assisted with their mobility, with going to the bathroom and with their meals. We saw and heard staff taking time to explain what they wanted people to do when assisting them and we saw that staff were respectful, patient and polite. We saw that staff practices with mobility were mostly safe in that people were guided in and out of their chairs or wheelchairs and people were accompanied when using walking frames. However, we saw that on two occasions foot rests were not used on wheelchairs when transporting people and on one occasion a staff member started to assist a person out of a wheelchair and did not engage the brakes until we reminded them. The provider may find it useful to note that two staff had not used mobility equipment safely so people were at risk of a fall and injury while having their needs met.

When we used the SOFI tool we saw that the four people we monitored were briefly engaged in contact with staff and visitors, but more so with other people that used the service. Whenever staff did engage with people it was either in a positive or neutral way. We also saw and heard other people that used the service engaging in positive or neutral engagement with staff, though these people were not part of the SOFI exercise. We observed no negative engagements. Later in the day we saw that the same four people received other positive contact with staff and concluded from the SOFI exercise and from other observations that people received 'a share' of attention from staff throughout the day according to the needs they had.

We saw people engaging with each other and sharing companionship. We saw people smiling and being interested in each other. We also saw many visitors coming and going in the home, as well as two district nurses. We spoke with one district nurse and they told us they were not a regular visitor to the home, but colleagues were. They told us that the manager and staff took the district nurses advice and in their opinion provided good care.

We saw in case files that they contained photographs, assessments of need, personal details, profiles and histories, care plans, risk assessments, monitoring charts, diary notes, key worker notes, records of visitors and healthcare visitors, reviews of care with the placing local authority and records of monthly reviews of care held by the service.

Peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Care and treatment was planned and delivered in a way that was intended to ensure peoples' safety and welfare.

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

We spoke with people that used the service and with the manager about meeting nutritional needs and we looked at the food that was provided at breakfast and lunch time.

People told us they had a choice of food at breakfast and each lunch time, that they thought the food was good and that they had plenty of it. People said, "The food is very good and if we don't like it we can have something different", "I can choose what I want from the menu on offer," "There is always plenty," "My friend and I would like more availability of pasta and curry, but we can get this if we want it from the local supermarket and sometimes we do" and "I like the food very much, I always eat everything."

When we asked the manager about ensuring everyone's food preferences were met because two had said they wanted more pasta and curry, the manager told us that pasta and curry had been tried on the menu, but no one else had liked it. They said that the service sometimes provided the two people with individual meals of this kind, but that the people also made trips to the supermarket to buy these meals themselves. The provider may find it useful to note that not everyone had their menu preferences respected.

We saw that people were offered cereals, toast, tea and coffee for breakfast and soup, fish pie, fruit and ice-cream for lunch. We saw staff providing hot and cold drinks at breakfast, mid morning, lunch time, and mid afternoon. We saw that people had water and juice on their side tables throughout the day. We heard staff offering extra hot drinks at meal times and we saw people being given them. We saw some people eating heartily and others picking at their meal. We saw the cook taking time to ask people during the morning what they wanted from the menu and we also saw and heard her ask one person after lunch if they had not liked the fish pie because they had not eaten any of it. The cook offered them alternative foods but the person said they did not feel well and so declined everything. This told us the staff had communicated to the cook where they thought a person had not eaten well. We heard people being encouraged to eat their food and we saw that no one required physical assistance with eating.

We saw that case files contained information about peoples' food likes, preferences and allergies, as well as a nutritional screening tool. We saw risk assessments on nutritional needs and on preventing too much weight loss or gain and we saw that 'speech and language therapy' (SALT) referrals had been made where people had problems with weight or swallowing.

We saw details of the menu on display for people to view and we were informed the cook compiled menus seasonally. We were not informed about anyone in the home having particular cultural or religious needs in respect of food, but we were told that some people had diabetes and required specific diets and medication for this condition.

People were provided with a choice of suitable and nutritious food and drink. People were supported to be able to eat and drink sufficient amounts to meet their needs.

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines.

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

Reasons for our judgement

We spoke with people that used the service and with the manager about the administration and handling of medication. We also looked at the medication systems in use and the medication administration record (MAR) sheets, and we observed one of the senior staff handing out medication to some people that used the service.

People told us they received their medication from the staff and preferred this as they thought they were too forgetful to take it themselves. People said, "I have my medicines when I am supposed to" and "I would not want to be responsible for any medication."

The manager told us that a reputable pharmacy had carried out an audit assessment of the medication systems and practices in the service on 17 January 2013, but the report had not yet been received. The manager understood there would be some minor issues to attend to and that a new medication storage fridge was needed as the one in use had broken. The manager informed us that eye drops that had been in use had been put into a container in the service's kitchen fridge as a temporary measure until the new medication fridge arrived.

The manager gave us the contact details of the person that had completed the audit and we spoke with them the day after our inspection. They confirmed they had identified the broken fridge, had commented on the disorganised state of the medication store and had been concerned about the service holding a 'just in case' box with medication that had not been prescribed to a person or receipted into the building. They told us they had planned to seek advice on this issue and to inform the manager and ourselves of the safest position for the handling of the 'just in case' box.

We had identified our own concerns about the organisation of the medication room, the storage of medicines and the unsafe practices being used. We could not be sure that people had received their medication each day according to the prescribed instructions as there were many areas of medication handling that could not be properly audited and not all of the medication could be accounted for.

We saw that the medication room was over-crowded with storage equipment, medication stores and medication delivery bags. We saw that the medication storage was insufficient to handle everyone's medication and so there were twelve plastic tubs (without lids) sitting on top of a cabinet, on a small shelf fixed to the wall and on top of the medication trolley. These tubs were overflowing with medication items: creams, tablets in their dispensed boxes, syringes and dressings. Some tablets were loose in the box though in their foil packaging. In three plastic boxes we saw that there were six loose tablets which were out of their foil packaging as well that could not be immediately identified. We also saw some loose tablets that we recognised as paracetamol and co-codamol. The manager was unsure why these tablets were loose in the plastic tubs.

We looked in the medication trolley and saw that it was full with monitored dosage system (MDS) 'Manrex' cards. When we looked at the cards we saw they contained some medicines that had not been administered. The medication administration record (MAR) sheets did not tell us why they had not been given to people. For one person the MAR sheet stated medication had not been given on Tuesday 08/01/13 because they were at the hospital, though the tablets were still present in the card against the date of Wednesday 09/01/13. An error had been made by the staff administering medication on the 09/01/13, which then resulted in the card and MAR sheet showing the error to have been for the 08/01/13. Staff were not vigilant in their checking of medication when administering it.

These were just two of the concerns we identified with medication handling. Others included staff giving out three peoples' medication at once, the receipting and storage of medication held in 'just in case' boxes, the controlled drugs cabinet having a broken lock and a remedial padlock in use, medication rounds taking hours to complete and medication being easily accessible because of the way they were stored in the medication room alongside other medical items and equipment. There was insufficient room in the medication cupboard to enable staff to administer drugs efficiently and safely.

Medicines were not handled appropriately. Medicines were not kept safely. Medicines were not safely administered.

Requirements relating to workers

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We spoke with the manager about recruitment of staff and we looked at some of the staff recruitment files to see evidence that recruitment had been carried out safely.

The manager told us they followed a recruitment procedure. They said that most staff were employed by the service, but two were employed by other registered services and worked as 'bank' or additional staff at Lavender House. We saw that staff recruitment files contained evidence that staff had been safely recruited and selected. Staff files contained a job application form, a health declaration form, a previous criminal convictions declaration form, a job description, information to verify identity, references and an Independent Safeguarding Authority (ISA) and Criminal Records Bureau (CRB) document showing staff had been security checked.

The provider may find it useful to note that although there was a job application form in use it did not request job candidates to declare any gaps in their employment history or the reasons for these gaps.

We also looked at some staff training and supervision records and saw that staff received opportunities for updating their training and they had regular supervision from the manager. We saw some training certificates that evidenced staff had completed training on the Mental Capacity Act 2005, health and safety, dignity in care, use of hoisting equipment and moving and handling. The manager informed us that training had been planned for February and March 2013 in safeguarding adults, nutrition, person-centred care planning and infection control. Some staff had also been booked on a training course regarding the Mental Capacity Act during this period.

Appropriate checks were undertaken before staff began work. There were effective recruitment and selection processes in place.

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

We spoke with people that used the service and with the manager about making and handling complaints and we looked at the complaint procedure and records to assess how well complaints were addressed and resolved.

People we spoke with told us they had not needed to make any complaints and that if they had any they would talk to the manager about them. People told us they thought the manager was very kind, understanding and able to resolve any problems they could encounter. One person said, "I've never had to complain here and if I did have a problem I think I would keep it to myself, because the staff are very hard working and don't deserve to be criticised." When asked in more detail about this, the person said, "Well yes if I really had a proper complaint I would tell the manager." Other people said, "I would speak with the manager if there were any concerns", "I made a complaint a year or more back because someone took my coat to wear and when the staff offered to wash it before returning it to me I complained that it needed dry-cleaning or it would be ruined" and "I have no complaint to make, I am well looked after here."

The manager showed us the complaint procedure that was listed in the 'statement of purpose' and 'service user guide' for Lavender House. We saw that the procedure was simple and the provider may find it useful to note that it did not contain information about informing a person's placing local authority about any complaints made if they wished, or that complaints could be progressed to the Local Government Ombudsman. The manager also showed us a second complaint procedure that had been held in the staff policies and procedures file. We saw that this was more detailed and contained information about East Riding of Yorkshire Council to whom people could complain. The provider may find it useful to note that it showed an old contact number and address for the Care Quality Commission and the Commission has not had responsibility to investigate complaints for five years or more. None of this was clear in the procedure.

The manager showed us the complaint record and it contained details of one complaint that had been received during the previous twelve months. It recorded details of the complainant and the complaint, the way in which the complaint was investigated, what the outcome was and whether or not the complainant was satisfied with the outcome. This had been progressed to the Local Government Ombudsman as the complainant had not been satisfied with the way their complaint had been handled. However, the Ombudsman

had found that the service had investigated the complaint properly and therefore the conclusion remained valid. The manager informed us there had been no other complaints received since the last inspections in December 2011 and March 2012.

People had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint. Peoples' complaints were fully investigated and resolved, where possible, to their satisfaction.

This section is primarily information for the provider

✘ Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines
	How the regulation was not being met: The provider was not protecting service users against the risk associated with unsafe use and management of medicines by means of making the appropriate arrangements for the handling, safe keeping, recording and safe administration of medicines used for the purposes of the regulated activity, as detailed in regulation 13.

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

The provider's report should be sent to us by 28 February 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

Phone: 03000 616161

Email: enquiries@ccq.org.uk

Write to us
at: Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Website: www.cqc.org.uk

Copyright Copyright © (2011) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.
