Inspection Report

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

OSJCT Bartlett House

Old Common Way, Ludgershall, Andover, SP11 9SA

Tel: 01264790766

Date of Inspection: 03 January 2013

Date of Publication: January 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Safety, availability and suitability of equipment	✗ Action needed
Staffing	✗ Action needed
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Orders of St John Care Trust
Overview of the service	OSJCT Bartlett House is registered to care for 49 older people who have residential care needs, these may include dementia needs.
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'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether OSJCT Bartlett House had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Cleanliness and infection control
- Safety, availability and suitability of equipment
- Staffing
- Assessing and monitoring the quality of service provision
- Records

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 3 January 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 and talked with staff.

What people told us and what we found

People told us they liked living in the home and staff met their needs. One person said "everyone's been looking after me so well". Another person described the staff as being "so kind" when they had fallen over. A person told us about the "kindness and patience" of staff.

The provider had much improved its systems to ensure all of people's care needs were met. They had ensured risk to people from cross-infection was reduced. There were clear records maintained, including care records and records relating to heath and safety. The provider's quality audit system identified matters which needed to be addressed and action plans were put in place when deficits were identified.

People told us they did not feel the home's staffing levels supported them at all times. One person said "staffing levels aren't good". Staff told us staffing levels could be low, particularly at weekends. Records we reviewed indicated staffing levels at weekends could be an issue.

The home had the equipment and furniture available which people needed. Some equipment, including cleaning and linen trolleys needed attention to ensure they could be cleaned effectively.

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 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

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 which met their needs and protected their rights.

Reasons for our judgement

At our last inspection, we found people did not consistently experience care and support which met their needs. Care was not always planned and delivered in a way which ensured people's safety and welfare and did not reflect relevant research and guidance. Following the inspection, the provider sent us an action plan which detailed how they would become compliant with this outcome area.

We met with people living in the home. All of the people we met with told us the home met their care needs. Comments included "everyone's been looking after me so well" and "they do come and help me". One person described how they had fallen and said care workers had come and assisted them to get up. They told us care workers had been "so kind" when this happened. Another person told us they had been unwell recently and staff had been "so wonderful" to them.

Many of the people living in the home had additional dementia care needs. We observed one person who appeared confused and anxious. Care workers were supportive to this person, taking time to explain what was happening and making sure the person understood what they said. We saw care workers were also happy to return to the person and repeat their advice when the person had forgotten what they had been told. Care workers did this in a kindly and supportive manner.

We talked with different care workers about people living in the home. They all showed a detailed knowledge of the people they were caring for and how to meet their individual needs. For example a person told us they fell at times. Care workers knew about the person's risk of falling, how they reduced this risk and how often the person had fallen since they had lived in the home. A care worker showed an appreciation of how any fall must be upsetting for the person.

We looked at people's records. Care plans were individualised and reflected what we had been told. For example, we met with a person whose mobility care plan stated they had been advised to use a walking aid to mobilise. Their mobility assessment and care plan showed care workers had assessed the person was safer and more confident when

mobilising if they did not use the aid. This was because, due to their dementia, the person found it difficult to understand how to use the aid.

The provider might like to note one person had two care plans which gave slightly different directions about documenting observations of a person's dementia related behaviours. We talked with a senior care worker who told us which of the care plans they were currently using. As the home was using agency care workers, two differing sets of instructions could be confusing to certain staff.

We met with a person who informed us they wished to go home. The person's records showed they had dementia needs and documented how the home were meeting these needs. This person's records was person centered and there was no use of judgmental wording to describe their dementia care needs. Staff we spoke with told us about the person's mental capacity and how they made best interest choices on behalf of the person. The provider might like to note the person did not have an assessment of their mental capacity on file.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

At out last inspection we found the provider had not ensured people were cared for in a hygienic environment and risk of infection was not prevented. Following the inspection, the provider sent us an action plan which detailed how they would become compliant with this outcome area.

The home had an outbreak of an infectious disease when we inspected it. We observed care workers correctly followed standard guidelines in relation to management of the outbreak. As much as possible people were asked to remain in their rooms to reduce risk of spread of the infection. People we spoke with, including some people who had memory loss, were aware of the importance of doing this. They told us staff had kept them regularly informed about the situation in the home. There were no odours present in the home, despite the outbreak. This indicated the effectiveness of the home's hygiene systems.

We saw care workers correctly handled items which could present a risk of cross infection. They always used disposable gloves and aprons when providing care and handing waste. Used items or contaminated items were correctly disposed of. Care workers made appropriate decisions when dealing with potentially infected items. For example, we saw a care worker found a linen bag for potentially infected items was full. The care worker promptly took it to the laundry to ensure there was no risk of spillage from the used linen bag.

Staff we spoke with told us they had been trained in infection control and showed an awareness of how to prevent risk of spread of infection. There were clear records relating to the outbreak to ensure relevant professionals could assess the extent of the outbreak and how it had been managed.

We met with one of the members of staff who lead on infection control. They showed a detailed understanding of how environmental factors could affect risk. For example they were aware of the risk presented by the deteriorated radiator covers in several communal toilets, which could no longer be wiped down and could be used by some people as grab rails. The manager told us there were plans to replace these covers. We also discussed the sluice rooms where we saw sanitary items such as commode inserts were either stacked on top of each other on a draining board or placed on the floor. There were no racks in the sluice rooms to enable such items to be placed separately above the floor to dry. The manager told us this had been identified and the provider had plans to refurbish

the home's sluice rooms, including the provision of more washer disinfectors and drying racks.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were protected by the types of equipment provided. People were not protected as some of the equipment was not suitably maintained or available in sufficient quantities.

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 observed the provider had invested in a range of new equipment and furniture since our last inspection. This included new easy chairs in sitting rooms. We met with several people who had been provided with new beds, to replace older divan beds. These new beds were domestic in style but could be raised or lowered to meet people's individual disability needs. One person said to us "it's so nice" about their new bed.

The home had a range of mobility aids for people who had a disability. These induced different hoists and slings. Records showed the hoists had been serviced regularly. Care workers we spoke with knew about how to use the hoists and the different sizes of slings needed, depending on people's weight and build.

We went into the laundry and saw the trolleys for the linen bags were rusty in places and showed debris round their wheels. The trolleys for people's laundered clothes had deteriorated plastic covering, showing areas of bare metal underneath. This meant both of these types of trolleys could not be effectively wiped down. The containers for people's clean clothes were also old and stained. Some trolleys were mobile in their fixings, so were not secure when pushed. This could present an additional heath and safety risk.

We looked at cleaners' trolleys. The cleaners' trolleys showed deposits of in-grained scale in groves, including handles of buckets. The wheels of the cleaners' trolleys showed deposits of in-grained debris. A red mop bucket showed deposits in groves and on some flat surfaces. A carpet shampooer also showed white scaling in groves and flat surfaces.

We asked different domestic workers about the equipment. They told us some items had not been replaced for an extended period of time. For example one domestic worker thought the trolleys for people's laundered clothing were over five years old. A domestic worker told us they had brought the issue up with management. We looked at the home's quality audit, but these items of equipment had not been identified as areas for attention. The manager contacted us following the inspection and informed us all such deteriorated items of equipment would be replaced.

A person we met with told us they wanted assistance. We rang their bell for them. A care

worker did not attend for over four and a half minutes. We rang another person's bell and they were attended to in under a minute. On this occasion we observed the care worker had a pager on them. We discussed our observations with staff. Staff told us there were currently only two pagers for all of the care workers on duty, so they did not always know when a person had rung for assistance. We discussed this with the manager who reported they would look into the situation and ensure more pagers were made available to enable staff to respond promptly when people rang their bell.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough skilled and experienced staff to meet people's needs on some shifts.

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 spoke with people about staffing levels. People made positive comments about the support they received from staff. One person told us "they're so good" about the staff and another person described the "kindness and patience" of staff. However some people qualified this by telling us they felt the home was short of staff. One person told us "they're very, very busy" and another "staffing levels aren't good".

We talked with staff about staffing levels. Several members of staff told us they were particularly busy when we visited, as during the infections disease outbreak people were encouraged to remain in their rooms. This meant, for example, that mealtimes took much longer. We observed this to be the case; the last meal was not served until 1:45pm and we heard several people saying they were hungry. We asked staff if people's comments related only to the current situation when the dependency of people was higher than usual. Some staff said they were concerned about staffing levels generally and they felt they could not perform their role as they wished to at all times. Staff told us staffing levels were particularly difficult at weekends, as there was no laundry worker. This meant care workers performed laundry then, as well as their caring roles. One member of staff told us they could not understand why staffing levels went down at weekends, as people needed the same care as during the week.

We observed staff performing their roles. We saw staff at all levels were keen to ensure people had their needs met. Staff worked as a team, for example we saw the maintenance worker mopping the dining room floor. They told us this was because the domestic worker was busy elsewhere in the building.

We observed some areas which needed cleaning, which we showed to the manager. For example there was a dust trap between the entrance area and dining room which showed deposits of dust and debris along its length. We showed the manager the undersides of three of the dining tables which had dried-on debris stuck to them. We talked with staff about cleaning. They told us the home was a larger home and they felt attending to people in their rooms was a key area. Due to this there was not always sufficient time to attend to all other areas. This was particularly at weekends, when staffing levels were

lower.

We looked at staffing rosters. We looked at the rosters for November 2012 and the beginning of December 2012, before the infectious disease outbreak. We saw there were three weekend shifts during this period where the home did not achieve its own agreed staffing levels. The rosters also did not show additional staff had been placed on duty to perform the laundry, so even where staffing levels were at the level set by the provider, care workers would be performing additional domestic roles.

We discussed the situation with the manager and area manager. They told us they called in agency staff when the home was not meeting its agreed staffing levels. They told us they had a funded post to perform the laundry at weekend but they had not yet been able to successfully recruit to this role. They did not have an action plan about how laundry and other roles were performed at weekends when a specific member of staff was not performing the laundry. We asked how the provider monitored if the home was meeting its agreed staffing levels on a day to day basis, and analysed if staffing levels, such as domestic roles, were sufficient. The area manager described the provider's systems for addressing temporary deficits in staffing levels, for example when staff went off sick. There were systems in place within the Order of St John Care Trust across their homes in the area to review staffing cover arrangements to move staff between homes to cover absences and bring in agency staff when necessary. At Bartlett House these had not been followed to ensure staffing was maintained to cover deficits from the agreed staffing establishment. Although unexpected absences were not frequent, combined with the vacant laundry worker/domestic post at weekends this had led to a situation where staffing was not sufficient to maintain the cleanliness of the home. This was evident from our observations and comments from people and staff about the impact of staffing shortages at weekends.

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 in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

At our last inspection, we found the provider had systems to regularly assess and monitor the quality of service which people received, but it was not effective in practice, as it did not enable the provider to assess, identify and manage all of the risks to people's health, safety and welfare. Following the inspection, the provider sent us an action plan which detailed how they would become compliant in this outcome area.

We talked with people about what they thought of the service. One person said "it's so lovely" about the home and another described it as "smashing here". People told us they felt they could talk to staff and they would be listened to. We observed a member of staff giving out drinks listening to what a person had to say. They made sure a specific issue was passed on to a senior care worker.

Staff told us they felt able to bring matters up with more senior staff. We observed a junior care worker asking for a senior care worker's advice and support. The senior care worker listed to what the junior care worker said and took action to make sure the matter was addressed.

The home held meetings with people and their relatives, as well as meetings for staff. Minutes from the meetings showed people could bring up matters they wanted to put forward. For example, the minutes of a recent night staff meeting showed management had clarified responsibilities for cleaning of the dining room floor with staff. We saw in the minutes of a recent staff meeting a request had been made for a new stainless steel tea pot, as the current one was stained and old.

The provider had an established system for assessing the quality of service provided to people. Their most recent audit took place in November 2012. The audit showed areas were identified for action, including timescales. For example the audit had identified leaves were building up by the entrance area and this could increase the risk of people slipping. The audit showed the maintenance worker had been asked to clear the area. When we toured the building, we observed many of the doors and skirting boards were chipped and scratched. This had been identified in the home's quality audit. The manager told us the provider's central maintenance department had a plan to address all such areas in the new financial year.

The manager performed regular audits of areas which might affect people living in the home. This included an audit of falls, which considered a range of factors when people fell. The audit had identified more people fell at night. The manager had developed an action plan to reduce falls at this time. The audit showed their intervention had worked and reduced the number of falls.

The manager also reviewed complaints and concerns, including matters raised verbally, to identify any trends.

The provider had systems to ensure regular maintenance of the building. We looked at the fire log book and this showed the home was following the provider's fire policies and procedures.

We asked about cleaning schedules and saw each domestic worker completed a record when they cleaned an area. The provider might like to note, there were no records of spot checks on the quality of cleaning, to identify areas, such as those detailed in outcome areas above.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

At our last inspection, we found people were not protected from the risks of unsafe or inappropriate care, as the home was not maintaining appropriate and accurate records about them. Following the inspection, the provider sent us an action plan which detailed how they would become compliant in this outcome area.

When we visited, as many of the people had been affected by an infectious disease outbreak and did not feel well, they needed their fluid intake monitoring. We looked at records of people's fluid intake. We saw all records had been regularly completed, to show how much fluid they had been able to drink in a 24 hour period. We saw staff completed the record at the time they assisted people to drink.

We met with a person who had recently been admitted. They had an admission assessment record. This reflected what both the person and care workers told us. The provider might like to note, the person told us about their past life and interests, however the provider's "life history" document had not been completed one month after the person's admission.

We saw all bathrooms had a record where staff documented the water temperature when they gave a person a bath. This had been fully completed when each person was given a bath. The record provided a full history of bath water temperatures during the past year.

The manager maintained a matrix of staff training. This meant they could see at a glance which members of staff had attended which training and when they were due for refresher training.

We asked where day to day maintenance was recorded. We were told there was a maintenance record which was kept in the office where staff wrote down areas which needed attention. We were also told staff would tell the maintenance worker verbally of matters needing attending to. We observed two smaller areas of maintenance needing attention when we toured the building, which we showed the manager. The provider might like to note that neither of these matters were documented in the maintenance book. Additionally some staff were documenting areas relating to maintenance in one of the other three communication books which were also kept in the office. This meant there was not a full record of areas which needed the maintenance worker's attention.

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 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: People were not protected as some of the sanitary and cleaning equipment was not suitably maintained and other equipment was not available in sufficient quantities.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not enough skilled and experienced staff to consistently meet people's needs, including at weekends.

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 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.

This section is primarily information for the provider

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@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk