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

**Kemple View**

Longsight Road, Langho, Blackburn, BB6 8AD
Tel: 01254243000

Date of Inspection: 21 November 2012
Date of Publication: December 2012

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

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<th>Standard</th>
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<tr>
<td>Respecting and involving people who use services</td>
<td>Action needed</td>
</tr>
<tr>
<td>Consent to care and treatment</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Care and welfare of people who use services</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Safeguarding people who use services from abuse</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Management of medicines</td>
<td>Met this standard</td>
</tr>
<tr>
<td>Safety and suitability of premises</td>
<td>Met this standard</td>
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Details about this location

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<tr>
<th>Registered Provider</th>
<th>Partnerships in Care Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Manager</td>
<td>Miss Margaret Mary Gallagher</td>
</tr>
<tr>
<td>Overview of the service</td>
<td>Kemple View is situated in Langho, near Blackburn, Lancashire. They provide care for up to 90 male patients providing a low secure environment. The hospital comprises of five wards accommodating 79 low secure beds with an additional 11 bedded ward providing a locked rehabilitation and recovery service.</td>
</tr>
<tr>
<td>Type of service</td>
<td>Hospital services for people with mental health needs, learning disabilities and problems with substance misuse</td>
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| Regulated activities      | Assessment or medical treatment for persons detained under the Mental Health Act 1983  
Diagnostic and screening procedures  
Treatment of disease, disorder or injury |
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'.

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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 21 November 2012, observed how people were being cared for and talked with people who use the service. We talked with staff.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

What people told us and what we found

We found suitable arrangements had been made to obtain and act in accordance with the consent of patients in relation to the care and treatment provided for them. Advocates were readily available at the hospital for patients to access. One person told us that they knew about the care and support that had been planned and told us he was consulted with about this.

Most people we spoke to said they were satisfied with the care they received. One person told us, "I have discussed long term plans for my future that I am working toward". Another person said, "I have no complaints at all, you couldn't get better staff and a better place to live in they will do anything for you ".

Suitable arrangements had been made to ensure patients are safeguarded against risks of abuse.

Suitable arrangements had not been made to ensure the privacy and dignity of patients was maintained.

Regular checks and audits had been made by managers, ward staff and the visiting clinical pharmacist to make sure medicines had been prescribed, administered and recorded safely.

We found that the hospital had undergone a refurbishment of some of the wards and improvements had been made to the design and layout of the refurbished wards. Fire risk assessments we looked at for two of the six wards did not include updated information to inform us if the identified risks had been completed or reviewed.
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 25 December 2012, 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  
Action needed

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 not meeting this standard.

Suitable arrangements had not been made to ensure patients privacy and dignity was maintained. This was because the provider has not ensured that all staff uphold, recognise and maintain the privacy and dignity of all people that receive care, nursing and or treatment.

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 visited two wards during our inspection and the Mental Health Act commissioner visited a separate ward.

Some patients told the commissioner that staff treated them with dignity and that their privacy was respected. The commissioner observed that staff knocked on patients’ doors whilst showing them around the ward and waited before entering. Patients told the commissioner that staff go out of their way to help patients, "they've got a lot of time for you", "they are strict but fair", and "some go out of their way to help me. Staff treat patients with dignity and respect their privacy. Patients spoken to by the commissioner all confirmed that they were regularly read their rights under section 132 of The Mental Health Act 1983 and that they understood them, and this was confirmed by their document checks.

The hospital have involved and consulted with patients about many aspects of their care at the hospital. Some of the ways that patients have been involved have included regular patient satisfaction surveys, service user council meetings which provide opportunities for patients to attend the meetings and discuss issues that are important to them on each ward. Community meeting are held weekly on each ward where patients are able to inform the staff of any issues on their ward as well as patients receiving information from ward staff. This means that patients are able to influence how the service is run.

One patient told us that," I am involved in care planning to a certain degree and I feel very much that my views are listened to by the care team" another patient told us that they understood their rights and "they are read to me monthly, and I have had both tribunals and hospital managers' meetings. I use the advocacy service which is always very good".

On one of the wards we visited accompanied by the charge nurse we observed a patient
who was partially exposed in his bedroom with his door wide open. This patient was on 1-1 observations with an allocated staff member outside his room; this was confirmed by the charge nurse. This meant that the patient's privacy and dignity had not been maintained or considered whilst he was on 1-1 observations. The patient could have been observed from outside his room with the door closed to maintain his privacy and dignity because observational glass panels were fitted in all the bedroom doors.

We discussed these observations with the registered manager who confirmed that the issue we raised around the patients privacy and dignity issues would be addressed and reviewed immediately.
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. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Our previous inspection of Kemple View on 2 August 2011 found that suitable arrangements had not been made for some patients that lacked capacity to consent to their care and treatment. The provider wrote to us and told us that they would audit their records in relation to consent and capacity issues and additional supervision would be provided to Responsible Clinicians (RC).

One person told us that they knew about the care and support that had been planned for him and said he was consulted with about this. He said, "If any changes were needed the staff would explain the reasons for this", he told us that he was given the opportunity to share his views about any changes to his treatment.

The hospital was in the process of transferring from paper records onto an electronic patient records system. We examined four patient records on the two wards we visited; these confirmed that suitable arrangements were in place for obtaining consent from patients as well as considering any capacity issues. The records we looked at confirmed that patients legal rights in relation to their detention had been explained regularly and they had been advised regarding access to an independent mental health advocate (IMHA). Advocates were available within the hospital and information was displayed on the units we visited. The registered manager confirmed that some of the units had direct access to advocacy via a phone installed for patients to access.

We were told by staff that consent issues were regularly considered in ward rounds. They advised that if patient disagreed with a particular aspect of care or treatment they tried to identify with them why this was. This meant that patients at the hospital were provided with opportunities to discuss their care and treatment.

We saw that in some cases Second Opinion Appointed Doctors (SOAD) were used where people lacked the capacity to consent to care or treatment to help determine what treatment plan should be implemented in the best interests of the patient. Staff we spoke with confirmed that this was done to protect people’s rights.
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

We visited two wards at the hospital accompanied by a Mental Health Act Commissioner, who visited a separate ward.

Most people we spoke to said they were satisfied with the care they received. One person told us, "I have discussed long term plans for my future that I am working toward". Another person said, "I have no complaints at all, you couldn't get better staff and a better place to live in they will do anything for you".

All of the patients we spoke with told us that they always had time with their Responsible Clinician (RC) and several patients told us that staff go out of their way to help them as well as respecting their privacy and dignity.

We found that the 'recovery STAR tool' was used to support all patients in their recovery pathway in relation to their clinical care and treatment.

The hospital had introduced, 'my shared pathway'; this helped patients become more involved in their care programme approach (CPA) meetings. These meetings provided a framework by which people's individual care was delivered.

Kemple View had consulted with patients about their CPA meetings and some patients had suggested their level of involvement in the meetings had not always met their expectations. As a result of the consultation audits/checks had been implemented and analysed against 20 user-defined standards. The results confirmed that most of the patients had been involved in discussions regarding their needs and preferences.

One person told us that they liked the ward they were on and they had access to their Responsible Clinician (RC). They told us, "I see the Doctor in a ward round and I can request to see him if I need and the ward staff will arrange it". We found that information was displayed on one unit we visited that inform patients of the times and frequency of their ward rounds. This meant that patients had access to their RC and were informed of their meeting.

We looked at four electronic patient records; these provided detailed records of care plans, ward rounds, psychology and physical health checks as well as daily updates of patients care. There were details of health related appointments, leave arrangements, risk
assessments and information relating to statutory rights under the Mental Health Act.

People using the service told us that there were lots of activities available. This was confirmed by information displayed in the wards we visited. A daily occupational therapy (OT) activity board was available for individuals as well as group activities.

One ward we visited provided a rehabilitation programme for some patients. We saw patients on this ward were encouraged to plan their own day as well as being supported to cook their own meals and address daily cleaning of their environment. During the weekend patients had been involved in planning specific themed nights and were also involved in preparing and cooking their meal supported by staff.

The hospital provided 'real work' and activities for patients to access. These included sessions on painting and decorating, gardening and car washing. The occupational therapy unit introduced a social events committee. This meant that patients' opinions and suggestions were incorporated into social and recreational activities provided at the hospital.
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

Our previous inspection of Kemple View on 2 August 2011 found that suitable arrangements had not been made to provide all staff with safeguarding training and de-escalation techniques to help them safeguard and manage patient behaviours. The provider wrote to us and told us that they would provide updated training to all staff in these areas.

We reviewed training records and monthly training reports. These confirmed that most of the staff had completed mandatory safeguarding training as well as de-escalation training. The safeguarding lead confirmed that monthly update training at the hospital had been delivered to new and existing staff.

Statutory notifications of safeguarding incidents had been submitted to CQC as required. We reviewed three records of safeguarding incidents, these had been recorded and appropriate partner agencies notified as well as the local safeguarding teams. The records we looked at confirmed that strategy meetings were held after every incident reported, in relation to safeguarding. This meant that suitable arrangements were in place to respond appropriately to any allegations of abuse.

The hospital had an identified safeguarding lead and policies and procedures were in place.

We found that information had been developed for patients that needed visual prompts. This informed patients of what they should expect from the hospital if they felt they were being harmed. The provider may find it useful to note that some patients on one ward had told the Mental Health Act Commissioner that they did not feel safe on the ward they visited. This was discussed with the management team during the inspection who agreed they would speak with the patients on this ward to discuss and review the patient's concerns.
Management of medicines  
Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

Our previous inspection of Kemple View on 2 August 2011 found that appropriate arrangements had not been made to manage medications. The provider wrote to us and told us that they would implement weekly checks and audits and review their processes, as well as updating staff that administered medication.

Regular checks and audits had been made by managers, ward staff and the visiting clinical pharmacist to make sure medicines were prescribed, administered and recorded safely.

We visited two wards and looked at how medicines were managed. We found improved arrangements for their prescribing and recording had been implemented. Record keeping was mostly accurate and complete and we found the arrangements for ordering and obtaining medicines had improved so that sufficient quantities of medicines were available for patients.

The provider may find it useful to note that on the two wards we visited they had different approaches when advising the pharmacy of any changes. We found improvements in the stock control of medicines but not all medicines could be easily accounted for because it was unclear when the stock had been started. This meant when mistakes occurred it would be difficult to carry out detailed audits of medicines stocks to check whether they had been administered correctly.

We discussed how patients were supported to self medicate and how prior to doing so they had completed a self medication competency booklet, this helped to highlight patients understanding of their medications and if further advice and support where required. Staff encouraged patients to administer their medicines themselves and this was carried out in a safe and appropriate way. This meant that patients were supported to maintain their independence when administrating their own medication.
Safety and suitability of premises  
Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

Our previous inspection of Kemple View on 2 August 2011 found that on one ward (Wainwright now named Deneholme) people were not always cared for in safe and suitable premises. The provider wrote to us and told us that they would address issues by replacing a shower hose and producing risk assessments in the interim period before refurbishing and re developing the ward.

We saw evidence that the ward (now Deneholme) had been closed temporarily following a total refurbishment. A refurbished shower room had been installed on the ground floor as well as refurbishment of a wet room.

Throughout the hospital some wards had been refurbished and plans were in place to complete the refurbishment of two other wards with a capital bid in place to commence work in 2013.

Records we looked at confirmed that patients living at the hospital had been consulted with during the closure of the wards for refurbishment. Patients had also been involved in choosing the colour schemes and choice of décor on the wards.

The provider may find it useful to note that we looked at two of the six wards fire risk assessments (Oakwood and Elmhurst). These told us that actions were required to reduce any identified risks. They provided a name of who was to action the identified risk and by when. We were not provided with information that told us if the assessed risk had been completed or reviewed.
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.

<table>
<thead>
<tr>
<th>Regulated activities</th>
<th>Regulation</th>
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<tbody>
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<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
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<tr>
<td>Diagnostic and screening procedures</td>
<td>Respecting and involving people who use services</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>How the regulation was not being met:</td>
</tr>
<tr>
<td></td>
<td>Suitable arrangements had not been made to ensure patients privacy and dignity was maintained. This was because the provider has not ensured that all staff uphold, recognise and maintain the privacy and dignity of all people that receive care, nursing and or treatment. (Regulation 17 (1) (a)).</td>
</tr>
</tbody>
</table>

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 25 December 2012.

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.
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:

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<th>Essential standard</th>
<th>Regulation</th>
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<td>Meeting Nutritional Needs - Outcome 5</td>
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<td>Cooperating with other providers - Outcome 6</td>
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<td>Safeguarding people who use services from abuse - Outcome 7</td>
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<td>Cleanliness and infection control - Outcome 8</td>
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<td>Records - Outcome 21</td>
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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:
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Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Website: www.cqc.org.uk

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