Inspection Report

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

Choice Healthcare - Barnsley

G5 Willow Suite, Oaks Business Park, Oaks Lane,
Barnsley, S71 1HT

Date of Inspections: 11 February 2014
05 February 2014

Date of Publication: March 2014

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

Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Supporting workers	✗ Action needed
Assessing and monitoring the quality of service provision	✗ Action needed
Records	✗ Action needed

Details about this location

Registered Provider	Choice Healthcare (Trust) Ltd
Registered Manager	Miss Loveline Watat
Overview of the service	Choice Healthcare Barnsley is a domiciliary care agency providing care to people in their own homes. The service is provided within the Barnsley area. At the time of our inspection there were approximately 79 people using the service.
Type of service	Domiciliary care service
Regulated activity	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 in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 February 2014 and 11 February 2014, talked with people who use the service and talked with staff. We talked with other authorities.

What people told us and what we found

This inspection visit was undertaken as a result of concerns that had been identified following a scheduled inspection at an associated service.

We visited four people and spoke, via telephone, with seven people who used the service. We spoke with a manager who was overseeing the Barnsley and Doncaster offices, the care co-ordinator, the human resources manager and four care staff.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People's comments about the service included "No qualms with them. I'm glad there are such people about so that I can stay at home" and "I'm happy with them. I would change companies if I wasn't."

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

There were effective recruitment and selection processes in place.

People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Staff did not receive regular supervisions to ensure that they were competent and effective in their roles.

The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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 11 April 2014, 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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People we spoke with who used the service were positive about Choice Healthcare. Their comments included, "No qualms with them. I'm glad there are such people about so that I can stay at home", "I'm happy with them. I would change companies if I wasn't", "It's getting better", "No problems at all, can have a bit of fun with everyone, it's great", "They're very good, no problems" and "I'm quite satisfied up to now. They've been very very good."

When asked about the staff, people told us, "They're like family to me", "Can have a laugh with them, very friendly", "They're polite, can have a laugh and a joke" and "They're very kind to me and I like that."

People told us that care workers always turned up for visits and were usually on time, with the exception of a few occasions which they said was understandable due to travel problems or other unforeseen issues. People said that someone would usually call to inform them if a care worker was running late by a significant amount of time. The care co-ordinator and staff we spoke with also confirmed that people would be informed beforehand about any changes to their visits. This meant that people were kept informed about changes in delivery of their care.

The majority of people said that they tended to see the same group of carer workers and would be introduced beforehand to any new care workers. One person said, "I always know who's coming, a new one is coming tomorrow." Other people said they had a list which told them who was coming the following week. The provider may find it useful to note that one person told us that they never got a list telling them which staff were coming and another person said they received one "occasionally."

Everyone said that they felt the care workers provided support to meet their needs. People said care staff always left after they had completed all tasks as required in the care plan. One person said it would be nicer if staff had time to "care more and chat" as they were straight in and out although they had no complaints about the service.

At the four people's homes we visited, we saw that each person had a file containing information which related to their care and support. Each file contained a current care plan for the person as well as a risk assessment and other information pertinent to their care, such as medication records. People told us that staff completed notes in their file each time they visited. We saw where these contemporaneous entries had been completed and they detailed what support had been provided.

Care plans contained relevant contact details for the person and details about what support they required and at what times. Involvement from others was included, for example community care assessments and/or hospital discharge information if the person had been referred from the local authority or hospital. Risk assessments were in place alongside care plans. There was involvement with family members and other healthcare professionals where applicable which showed a holistic approach to care provision. Staff told us that care plans were reviewed at set periods, or sooner in response to any changes. The provider may find it useful to note that there was some confusion between staff members as to how often care plans and risk assessments were reviewed.

The service had an on call procedure which was covered by senior staff who took turns to cover. This meant that if someone called outside of office hours there would be someone available for guidance and assistance. People we spoke with told us whenever they had needed to contact the office they had always managed to speak to someone.

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

We asked people about any assistance they required with medication from care workers. Comments included, "They write everything down when we take our medication", "I recently had some extra medication to take and they saw to that no problems", "She [care worker] brings me my tablets over, counts them and I do too and agree with the number. Got a sheet of paper they fill in when I've taken them" and "I get them ready myself on my tray and they make sure I have them all." No one we spoke with had any concerns regarding medication.

The service had a medication policy which the manager told us was currently being reviewed. We saw pro forma of a new 'medication record sheet' which we were told would be implemented to improve consistency across the service.

Care files we looked at, where applicable, contained details of the person's medication, a medication permission form in some instances and a medication risk assessment form where this was applicable. The provider may find it useful to note that the risk assessments were not always completed correctly and did not always reflect the person's current circumstances. For example, risk assessments recorded that people did not take medication when in fact they did.

We spoke with four care workers who told us about their role in assisting with medication and completing relevant documentation. We saw a training matrix which showed where people had received medication training and evidence in staff files we viewed to show training had been completed. It was not clear whether, and how often, this training was refreshed. The provider may find it useful to note that no competency assessments or formal observations were undertaken whereby staff would be observed handling medication to ensure they were proficient. Staff told us they would contact the office if they were unsure about anything relating to medication.

We looked at MAR (Medication Administration Record) charts for three people who used the service. These were completed within the person's home and we were told that they were returned each month to the office for filing. At one person's home, we saw the current months chart and saw that information had been recorded and signed where required.

At the office, one person's previous MAR charts we requested could not be located. We were only able to see their records from July 2013, even though the person had still been taking medication since this date. The provider may find it useful to note that we saw several gaps in the chart for this month where nothing had been recorded. No code had been completed to account for the omission, for example if the person had refused their medication. It was not evident that these omissions had been investigated.

There was no formal procedure in place for completed returned MAR charts to be checked and audited. As such, any errors or omissions, unless reported at the time they were identified, could not be investigated. This meant any recurring trends such as repeated omissions or incorrect recordings were not being addressed and actions put in place to rectify these.

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.

There were effective recruitment and selection processes in place.

Reasons for our judgement

The service had a recruitment policy in place and the HR manager we spoke with, via phone, told us that this was currently due to be amended in line with changes the service was planning to implement. She told us that new employees would not start working unsupervised until satisfactory references and DBS checks (Disclosure and Barring Service) had been received for that person. The policy stipulated that two references were required where possible and that various other checks would be undertaken, including DBS check, prior to appointment.

We reviewed nine staff files. We saw evidence of application forms, interview notes, job descriptions, references and evidence of DBS checks. The provider may find it useful to note that two references, as per the recruitment policy that was in place, had not always been obtained for people before they started employment.

We spoke with four support workers about the recruitment procedure they went through. All said that they had to attend an interview, supply references details, undertake a DBS check and a period of induction and shadowing. This confirmed that there were measures in place designed to safeguard against recruiting unsafe or unsuitable individuals.

Staff we spoke with told us that they were aware of their role and responsibilities. They told us that they could contact the office or a senior staff member for support if they were unsure about anything in relation to their role.

Supporting workers ✖ Action needed

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was not meeting this standard.

People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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

Reasons for our judgement

We looked at nine staff files and found that the majority of staff had not received regular supervisions. For example, the first supervision record we saw for someone who had commenced employment in 2011 was dated May 2013. None were seen since this date. Another person had started employment in February 2013 and the first and only supervision seen was dated October 2013. Several files had no details contained of any supervisions taking place.

We spoke with the manager who informed us that staff should receive regular supervisions. The supervision policy stated that all care staff should have at least one formal supervision every three months. Conversations with staff we spoke with confirmed that this was not occurring. One care worker who had been working for the service for approximately a year told us they thought they recalled having a supervision on one previous occasion. This person said that they would speak to a senior if they did have any issues they wanted to raise.

We saw yearly appraisals forms for one staff member only, however the majority of the staff whose files we viewed had not worked for the service for 12 months at the time of our inspection. The service had no system in place to identify when staff members were due to have supervisions and appraisals. This meant the provider was not monitoring the performance of staff to ensure they had sufficient skills and competency to carry out their duties and meet people's needs.

We looked at the staff training records of four staff which were provided to us on our second visit. These covered training in a number of areas including medication awareness, food hygiene, pressure area care, dementia care and health and safety. We saw the service's training matrix and identified that some training was out of date, for example, some staff had not received training in first aid, health and safety and food hygiene since 2010. Not all current staff were listed in the training matrix and in some cases we were not able to determine whether training had been delivered or when it was due for renewal. It was unclear whether the records had not been updated or the training had not occurred.

Staff told us that they were encouraged to undertake NVQ training provided by the company. On the date of our second visit, NVQ assessors were seeing staff in the office to assess their progress. This showed that staff did have opportunities to access additional training relevant to their role and improve their skills where they wished to.

Staff we spoke with told us that they had received an induction prior to starting employment. This was currently completed by a member of care staff who had been trained to deliver the training involved. Staff told us they undertook shadowing periods with other staff as part of this induction as well as attending the office for various training courses. This showed that there was a process in place for new staff members joining the company however this was not always formalised.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

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

The care co-ordinator told us that people who used the service would be visited periodically to check that they were satisfied with the service and to provide any feedback. People we spoke with confirmed that someone had been to see them to discuss how they felt about their support and to see if they wanted to change anything. One person said, "We used to have more visits but I've cut them down as we don't need the night carers anymore." We saw the 'quality questionnaire results' that had been compiled from responses to questionnaires sent out in November 2013 to each person who used the service. Actions had been identified for implementation to address the issues identified, for example ensuring that people received rotas. This showed that people had opportunities to influence their care needs and feedback had been acted upon.

There was no evidence of formal quality monitoring systems in place. The manager and care co-ordinator told us that each month staff should bring completed documentation from people's care plans into the office. This included medication records, daily journals and financial transaction records. The care co-ordinator told us that senior staff looked over these records however there was no process in place to evidence that these were checked nor were records brought in consistently. In one instance there were no financial records for one person who received assistance with shopping and purchases. This meant there was no process in place to monitor the care and support provided to people to ensure it was appropriate and to identify any areas that required improvement.

We saw that the service had a process in place for reporting incidents however these were not being followed up adequately. In one person's care file we saw three separate incidents dating from July 2013. Two of these incidents consisted of safeguarding issues but had not been referred to the local authority as required. The service had also failed to notify us of the matters as is a requirement under the Health and Social Care Act 2008. The 'actions to be taken' completed for each of the three incidents was inappropriate and no feedback had been recorded to show whether the incidents had been resolved. The care co-ordinator told us they recalled some aspects of the incidents but was unable to say

how they had been dealt with. The manager told us she had been unaware of the incidents at all.

Due to the nature of these incidents we spoke with the regional manager and asked them to refer these incidents to the local authority as required. We saw information to evidence that this action was undertaken. The initial failure to report these incidents to the relevant organisations meant there was a risk to people's care and welfare due to inadequate processing and monitoring of incidents.

We saw details of a situation where allegations had been received that some service users were potentially at risk of unsafe care. The care co-ordinator told us this matter was being dealt with by senior management. We were aware that at the time of our inspection no measures had been put in place at to mitigate the risks to people. Therefore, people were still potentially being put at risk by lack of any discernible actions into these allegations. We asked the regional manager to ensure that this matter was also referred to the local authority as required, and again we saw evidence to confirm that this was done.

We viewed nine staff files and saw that only four of these contained evidence of spot checks and/or monitoring visits to observe staff competency. This showed that measures in place for monitoring staff efficiency were not routine.

No one we spoke with who used the service had any complaints. One person told us that they had made some 'minor' complaints previously and that these had been dealt with satisfactorily. As the service was unable to locate its complaints file we were unable to assess whether complaints were dealt with effectively and in line with the service's own procedure.

The service had policies and procedures in place to give guidance and information about how the service was managed. The policies we saw had been reviewed in October 2012 which was not in line with information in the service user guide which stated that polices would be reviewed at least once annually.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

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 included this outcome during our inspection due to a number of concerns we became aware of relating to records.

At our first visit to the service, we established that some important information was not present at the office. The manager said that personnel files were being audited at head office, which led to us returning a second time to be able to view a sample of these files. The care co-ordinator had told us the files were always kept there. The service did not have a current policies and procedures file and the complaints file could not be located, despite senior staff telling us they had recently seen these files in the office.

Whilst looking at care plans we asked to see some specific records for an individual for the preceding months. These could not be located. The care co-ordinator and administration staff showed us how information from care files, such as MAR charts and daily records, was filed. Records were not filed individually for each person and were in no logical order. Information was difficult, or not possible, to locate which meant important records were not always able to be accessed promptly.

We looked at minutes of recent staff meetings and found within these, minutes of a meeting that contained confidential information relating to a staff member. The care co-ordinator confirmed to us that this file was kept in the office and accessible to staff. We requested that they remove the personal information and store it securely. This demonstrated that confidential information was not being stored appropriately by the service.

We viewed a sample of five care files at the office in addition to viewing four people's care plans at their home. Some of the files at the office had dates omitted from the file's checklist so that it was not always possible to see where some people had been referred to the service, had a care plan review or when they commenced using the service. We found that not every file at the office contained a care plan. The administration officer told us that staff were in process of transferring people's care plan to new documentation and

taken them out of the files. We saw the service used a computerised system called people planner which recorded certain information but we found this information was not always reflected in the actual files.

We noted that one person we visited at their home was reliant on medical equipment they used for an ongoing health condition. When we looked at this person's care plan, this information was not recorded on their risk assessment which meant the information did not accurately reflect their situation. We saw risk assessments for two other people which stated that the person did not take medication when in fact their care plans evidenced that they did. This meant there was a risk of people receiving inappropriate or unsafe care as all risks had not been accounted for and documented correctly within their care files.

Staff files were not uniform and we had to obtain information from a number of different sources. For example, one person had no evidence that they had a current DBS check. We had to ascertain this information via the HR manager. Some files had written on them where references had been requested but the information was not signed or dated so we could not see when these requests had been made. This meant that important information was not always stored with the relevant records.

We saw pro formas of induction training records were available for new staff members but confirmed that senior staff were not all aware of the existence of these. Consequently they had not been completed so it was not possible to evidence that staff had completed an induction to a satisfactory level

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
Personal care	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Regulation 23 (1) (a)
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have effective systems in place to identify, assess and manage risks to the health, safety and welfare of people who used the service and others. Regulation 10 (1) (a) (b) (2) (b) (ii)
Regulated activity	Regulation
Personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010**

This section is primarily information for the provider

	Records
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 20 (1) (a) (2) (a)

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 11 April 2014.

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 other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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