Inspection Report

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

Partridge Care Centre

Partridge Road, Harlow, CM18 6TD

Tel: 01279452990

Date of Inspection: 16 May 2013

Date of Publication: July 2013

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	✖	Enforcement action taken
Supporting workers	✓	Met this standard
Assessing and monitoring the quality of service provision	✖	Action needed
Records	✖	Action needed

Details about this location

Registered Provider	Rushcliffe Care Limited
Overview of the service	Partridge Care Centre has four units providing residential and nursing care. At the time of our inspection the home was registered to accommodate 79 people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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 16 May 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We talked with other authorities.

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

What people told us and what we found

We previously inspected Partridge Care Centre on 07 January 2013 and found the provider had failed to plan and deliver care in such a way as to meet people's individual needs and ensure their safety and welfare. We judged this had a moderate impact on people living there and we required the provider to make improvements. The provider wrote to us setting out their action plan which stated that they would be compliant by 31 March 2013 or sooner.

When we inspected the home again on 16 May 2013 we found the provider was still not compliant. This was because there was a delay in supporting people living in the Mallard units with their personal care requirements. This adversely affected other aspects of care such as providing people with breakfast or medication. We saw that people were not protected against the risks of receiving care and support that was unsafe because care plans for pressure ulcers were not in place.

The provider supported staff to deliver care by means of a training and supervision programme.

The provider did not have an effective system to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. This was because audits had failed to identify that there were shortfalls in the standards of care delivered on the Mallard units.

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 24 July 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Partridge Care Centre to protect the health, safety and welfare of people using this service.

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 ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

When we previously inspected Partridge Care Centre on 07 January 2013 we found that the provider was not compliant with this standard. This was because the provider had failed to plan and deliver care in such a way as to meet people's individual needs and ensure their safety and welfare. In particular, we noted that people who had been recently admitted to the home were not adequately assessed. Up to date information about risks that might affect their health and wellbeing was not present in their care plans. This meant that people did not experience care and treatment that met their needs. We had also noted that people who lost weight were not monitored effectively, either because their records were not properly completed or because no action had been taken to address the weight loss.

We judged this had a moderate impact on people living there and we required the provider to make improvements. The provider wrote to us setting out their action plan which stated that they would be compliant by 31 March 2013 or sooner.

We inspected the home again on 16 May 2013 and carried out observations in the Mallard and the Kingfisher Units and interviewed people and staff. We found a disparity in the standards of care and treatment between both units. For instance, on the Kingfisher 2 unit we saw that the people who live there had awoken and had been supported with their personal needs, such as washing, dressing and having breakfast by mid-morning. We also observed that there was frequent and friendly interaction between staff and people.

In contrast, on both the Mallard 1 and Mallard 2 units, some people were still being supported with their morning personal care throughout the latter part of the morning up to

midday. On the Mallard 2 unit we saw that one person was still being supported in this way at 12.10pm. Furthermore, some people did not receive their breakfast until after 11am. We saw one person for example, sitting unattended, with a cooked breakfast in front of them and not eating it. After around 25 minutes a staff member came and helped the person to eat by which time the food was cold.

We saw that the delay in people being supported with their morning routines and with their breakfast had an impact on the administration of medication. We noted that the morning medication round was still being carried out at 11.15am despite having started at 8.30am.

We also saw that there was no meaningful activity provision and no interaction with the people living on either the Mallard 1 unit or the Mallard 2 unit. A staff member said, "We can't spend time with the residents. There's no activities; no communication." This meant that people living with dementia were not supported to be engaged with life enriching experiences.

We found that people who were at risk of developing pressure ulcers or from poor nutritional intake were not receiving care that ensured their safety and welfare. For example, we saw that one person who was at risk of developing a pressure sore was sitting on a chair without a pressure relieving cushion. The person had also not experienced a positional change for over five hours.

Another person who was being cared for in bed and who already had a developed pressure ulcer had been living at the home for over six days without having their care planned to manage the pressure ulcer. This meant that care and treatment was not planned in a way that ensured people's safety and welfare.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported by the provider by means of a training and supervision programme.

Reasons for our judgement

During our inspection we spoke with nine staff members across both the Kingfisher and Mallard units. Staff members told us that there had been some recent changes in the staffing arrangements introduced by the new management team and that there had been a firmer approach about working practices. This had been brought about by the need to take robust action to deal with shortfalls in the planning and delivery of care identified in our previous inspection of January 2013. In general, most of the staff we spoke with welcomed the firmer, but supportive approach of the new management team because they were clear about their working practices.

Staff received appropriate professional development. Staff members said they felt supported in their role through training that the provider offered and that the training opportunities had increased significantly since the provider had employed a new senior manager. For example, one staff member told us, "We get three paid training days for mandatory training. That includes training in dealing with challenging behaviour, health and safety, infection control, safeguarding and moving and handling." They also told us that the management team had introduced penalties on staff who failed to turn up for training that had been booked. However, rather than this being punitive, they felt it was a supportive measure because it meant that people would be cared for by staff that would be up to date with their knowledge and skills.

We looked at the posted schedules of training that the provider required all staff to undertake. We saw that the nursing staff, the care staff, the care team leaders and the ancillary staff all had specific training for their particular role. The provider has also supplied us with a breakdown of information about training received by staff between August 2012 and May 2013 and this confirmed that such training has taken place.

We also found that the provider had begun an effective supervision regime. We looked at information the provider sent us about supervision sessions that have taken place between September 2012 and May 2013. We saw that a significant number of staff from all role types such as care, nursing and ancillary staff had received formal one-to-one supervision and formal appraisal. An even greater number of staff had also had their practice observed by supervisors.

Staff told us that supervisions were effective. For example, one member of the nursing team told us that they had recently received a supervision session where they had raised the issue of a lack of continuing professional training for the nursing staff. As a result, they told us that the provider had scheduled such professional training in catheterisation and venepuncture for all of the nurses. We saw the schedule of planned training which confirmed that this was to be delivered before July 2013.

The provider also offered opportunities for professional development that were relevant to their responsibility to provide key training to their staff. Three staff members told us that they had been offered trainer training so that they could deliver key subjects such as moving and handling and infection control to their staff colleagues at the home. This was also confirmed in the schedule of planned training that we looked at.

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 an effective system to regularly assess and monitor the quality of service that people receive.

The provider did not have 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.

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

Reasons for our judgement

The provider wrote to us and set out a plan of action to deal with shortfalls we had identified in the care and welfare of people at our previous inspection in January 2013. One of these actions was to carry out a review of care plans to ensure they were meeting people's needs. This was to have been completed by 31 March 2013.

When we inspected the home on 16 May 2013 we looked at people's care plans and saw that they been audited by a member of the home's management team. The audit indicated where there were shortfalls and directed the staff responsible for the person to take action to rectify these.

We saw that action was taken to address these shortfalls in a timely way. For example, an audit dated 08 May 2013 required mental capacity assessments for aspects of personal care to be carried out for decisions made by the person. This action was completed by the staff member responsible on 13 May 2013, within the timescales set by the manager.

We noted that the care plan audits had been effective in rectifying some shortfalls. However, it had not been effective in every case. For example, the provider's action plan arising from our previous inspection stated that care plans for newly admitted people would be completed within 72 hours. This was to have been effective immediately. During our inspection on 16 May 2013 we saw that a person with pressure ulcers who had been at the home for six days did not have a care plan to manage the pressure ulcers. Staff said they had been too busy to complete such a plan. In this instance the provider had failed to meet the 72 hours criterion stipulated in their action plan. The home's senior manager told us that all care plans of new people were reviewed after one week by the manager or deputy so that shortfalls were identified and addressed. This meant that this particular person was not protected against the risks of unsafe care and treatment for a further

period of four days because the 72 hour criterion was not monitored.

Since our last inspection in January 2013 we had received concerning information about staffing levels. We were told this had led to low staff morale, staff being overstretched and no time to provide proper care. When we inspected on 16 May 2013 we found that a new shift system had been implemented where all staff were rotated to cover night duty and the introduction of 12-hour shifts. A member of the provider's senior management team told us that the three shift system with predominantly 12-hour days had been introduced because staff said they preferred to have more days off. For each of the four units there was one care team leader and three care staff members during the morning of our inspection. Each of the three units designated as nursing units also had a nurse on duty. Staff said this was the typical number for the day shifts. We also noted that two additional staff were employed to provide one-to-one support for two people.

Three staff members in the Kingfisher 2 unit told us they preferred to work night duty occasionally because it helped them to understand people's needs better at different times of the day. They also said they felt their morale was good and that staff numbers were about right. Throughout the morning we saw that staff in the Kingfisher 2 unit engaged with the people living there frequently and in a friendly and unhurried way.

This was in contrast to both of the Mallard units where the staff we spoke with said they were very busy because there was not enough staff. They said they were always tired and this affected the people they were looking after. A visitor to the Mallard 2 unit who spent a lot of time at the home with their relative every day complimented staff on their attitudes towards people and their care skills. However, they said, "There's always a shortage of staff. You can tell that the staff get very tired as they come to the end of their shifts." During the course of the morning we saw that staff on both the Mallard 1 and Mallard 2 units moved from room to room supporting people with their personal care requirements, continuing beyond midday. This adversely affected their capacity to engage with people and to complete the medication round.

We asked the home's senior manager for information about how staffing requirements were calculated in relation to people's dependencies. They explained that they used dependency and assessment of individual needs to determine staffing requirements. They also said this had resulted in them being able to secure funding for the one-to-one support for two of the people.

The numbers of people living on the Kingfisher 2 unit and both of the Mallard units were similar, between 17 and 19 people each. However, we saw there was a considerable difference in the level of people's dependency across the units owing to their personal care requirements, their nursing needs and needs due to living with dementia. Despite this, the staffing levels of one nurse, one care team leader and three care staff were identical on each unit.

The manager told us that work had been on-going over recent weeks to provide clear direction and leadership to staff on the units so that they were working more effectively. However, we found there was a significant disparity between the Kingfisher 2 unit and the Mallard units in both the morale of the staff and their capacity to be effective. The manager explained that they had been addressing issues of direction and leadership on the units. However, it was evident from our observations that the issues of morale and the staff capacity to be effective had not been rectified at the time of our inspection.

Since our last inspection in January 2013 we had also received concerning information that people were at risk through failures to manage or report falls properly and that people were left for long periods without care. Following our visit on 16 May 2013, we asked the manager for some additional information. We asked for a copy of the two most recent incident reports for each of the four units that show how falls and other incidents were recorded and followed-up. Only one of these records was sent to us by way of an example. We also asked for information about specific audits for falls, pressure care and nutrition. The manager told us that these incidents were already being monitored and followed up with any necessary action. They said that a new weekly risk monitoring report had been introduced to collate information from each of the units to help the home's management to have oversight of such incidents and take any follow-up action. However, this monitoring report had not been implemented until the week following our visit.

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

Reasons for our judgement

During our previous inspection in January 2013 we found there were shortfalls in the way people's records were maintained and that this had an impact on their care and welfare. Furthermore, prior to our inspection on 16 May 2013 we received concerning information that appropriate records had not been made about people who had fallen. Therefore, when re inspected the location on 16 May 2013 we looked at the systems in place for maintaining people's records. We specifically looked at the records of seven people.

We saw that every person living at the home had a daily record which the provider referred to as an 'individual needs' chart. This was a record of a series of different pieces of information about the person ranging from their food and fluid intake to the activity they participated in. We saw that people were observed every 30 minutes as a rule but that people who were more dependent were observed more frequently. Staff we spoke with told us that they understood the importance of records about these observations of people. One staff member told us that they felt there was too much paperwork but that it was necessary because it helped to show if there were changes in people's conditions that required action. They said, "They are necessary. I was not in yesterday so I can have a read and a catch up about what happened as well."

We saw that there was a difference in practice between the Kingfisher units and the Mallard units. For example, on the Kingfisher 2 unit we saw that staff completed people's daily records as they completed a task or activity and that they took the opportunity of interacting with people as they did this. We saw staff members making records about what people had eaten for breakfast. They were sitting with people in the lounge area as they were writing in the records and they chatted with people as they did so.

In contrast, we saw that staff working on the Mallard 1 unit did not complete the records about people in a timely way. We checked the 'individual needs' records of people on the Mallard 1 unit at 12pm and saw that there had been no entries recorded at that time for the foregoing morning period. We noted that staff carried around pieces of paper and paper towels in their pockets upon which they scribbled information about people so that they

could complete the records later. One staff member said, "We don't have time for paperwork. We are constantly trying to catch up."

We found that information in people's records was not accurate or was missing. For example, the records of one person living in the Mallard 2 unit who was subject of a pressure care management plan contained no entries for the day of our visit since an entry shown as "…before 7am". This person was described in a conflicting way as 'at ease', 'comfortable', 'quiet' and 'noisy' all at the same time. This meant that staff reviewing the records at a subsequent time would not be able to determine whether there had been any changes in the person's condition that affected their plan of care.

We saw that care plans were intended to be reviewed monthly. However, we found evidence that where people's needs had changed these were not recorded accurately and bore conflicting information. For example, in the care plan of one person we saw a risk assessment about their mobility that showed that on 18 March 2013 they were "…mobile with a frame". However, we also noted that this person was now using a wheelchair and had been assessed as requiring one-to-one support. This meant that the mobility risk assessment was not accurate and was therefore not fit for the purpose it was intended.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 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 protect people who may be at risk against the risks of inappropriate or unsafe care and treatment by means of the effective operation of systems to regularly assess and monitor the quality of the services provided or to identify, assess and manage the risks relating to health, welfare and safety of people using the service. Regulation 10(1)(a) & 10(1)(b)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider did not ensure that people were protected against the risks of unsafe care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record about them which included documents in relation to care and treatment provided. Regulation 20(1)(a)

This section is primarily information for the provider

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 24 July 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

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 23 August 2013 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The provider did not take proper steps to ensure that people were protected against the risks of receiving unsafe or inappropriate care or treatment because they did not plan and deliver care in such a way as to meet people's individual needs or ensure their safety and welfare. Regulation 9(1)(b)

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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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