Inspection Report

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

Rosedale Manor Care Home

Sherbourne Road, Crewe, CW1 4LB

Tel: 01625417800

Date of Inspection: 17 October 2013

Date of Publication: November 2013

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

Care and welfare of people who use services	✖	Enforcement action taken
Safeguarding people who use services from abuse	✖	Enforcement action taken
Management of medicines	✖	Enforcement action taken
Assessing and monitoring the quality of service provision	✖	Enforcement action taken
Records	✖	Enforcement action taken

Details about this location

Registered Provider	Four Seasons 2000 Limited
Registered Managers	Mr. Cesario Domingo Jr Mrs. Natalie Holdcroft
Overview of the service	Rosedale Manor is a two-storey purpose-built care home set in its own grounds.The home is in a residential area close to Crewe town centre, local shops and other facilities. On the ground floor, Willows unit provides accommodation for ten people with severe and enduring mental health needs and Woodlands unit provides accommodation and nursing care for 24 people with dementia. The first floor of the home provides nursing and personal care for up to 46 older 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 to check whether Rosedale Manor Care Home had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Management of medicines
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 17 October 2013, observed how people were being cared for and talked with staff. We reviewed information given to us by the provider, were accompanied by a pharmacist, reviewed information sent to us by other authorities and talked with other authorities.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We carried out this inspection to follow up concerns from our inspection in June 2013. The provider had given us an action plan of how they were planning to address these concerns. We are not satisfied that any of these issues have been dealt with or resolved.

We spoke to eight people who lived in the home and most of them told us that they were not happy with the standard of care being provided. One person said; "I don't really know how long I have been here now I have lost track of it, every day is the same so it's hard to remember...I don't like TV much and that's all there is really…I have asked but there's no point as no one is interested so I don't bother anymore I just get on with it."

We looked at the procedures in place to safeguard people from harm and abuse and found that they were not always followed and risks were not always identified and managed properly. We looked at the medication administration procedures and found that they were not always safely administered and not at the correct times.

We looked at the quality assurance procedures in the home and found that the audits were not being completed properly and that issues were not being identified or followed through.

We looked at the records in the home and found that they were not to an acceptable standard. They were inconsistent, lacking in the detail recorded and on some occasions

illegible.

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

What we have told the provider to do

We have taken enforcement action against Rosedale Manor Care Home 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.

Care and treatment was not planned and not delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a major 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

We looked at this outcome to follow up on concerns from our previous inspection in June 2013.

We saw that some activities were taking place. During the morning of our inspection we saw that there was a baking activity and there was a film session in the afternoon. However, people who lived in the home told us that they were bored and there was nothing to do. One person said; "I just knit that way I keep myself busy there isn't much to do. It's alright here but I feel sorry for the staff I think they try their best for us they could do with more I think."

We saw that life histories were being completed for people who lived in the home and that these were on display outside people's bedrooms.

During this inspection we noted a number of incidents where we were concerned about the lack of staff support for the person involved. We observed one person seated in the same place (a chair in a corridor) throughout the length of the visit (we came and revisited this section of the care home at different times). This person looked poorly dressed and their personal hygiene was very poor. This person ate their dinner sat in a chair in the corridor and seemed to be disorientated. Although several members of staff walked past them at various points in time, we did not observe any staff member enquire if they were alright or if they needed anything.

We noticed a person located in a chair in a corridor which had some communication/alarm panel above their head. The panel was making audible noises of a type of high frequency

noise/alarm sound. This person was copying the sound and was repeatedly saying "beep beep beep." We stayed in the corridor for some time and watched as staff walked passed them and made no gesture to either silence the noise or ask if they wanted to move. Eventually, a senior member of staff who had walked past previously said to them; "alright X I will sort that out and get it stopped."

Another observation included us hearing a person saying; "Please help, please help, I beg somebody please help me". We were located a few feet away from this person's bedroom and counted staff pass by on 12 occasions in 25 minutes. On each occasion no staff member looked into to see what this person's distress was, or if they needed assistance.

We went into a person's bedroom and the temperature was very hot. This person told us that they felt unwell because it was so hot. The fan in this room had been turned on. We checked the radiator and found that it was on full. At the person's request we turned it off. We reported this to the staff and duty and they said "No wonder X said they were hot."

We observed a situation where a person's dignity was not respected and we had to ask the staff to support this person. We also overheard a staff member speak to a person who lived in the home in a challenging and aggressive manner but they changed their behaviour when they realised that we were watching. We informed the manager.

We looked at the care records of one person who lived in the home and we were very concerned about their safety and wellbeing. They had a number of health issues which had recently resulted in emergency admissions to hospital. We did not feel that the home had taken appropriate steps to safeguard this person and provide safe and effective care for them. We saw that only one incident report had been completed and there were three separate emergency hospital admissions and none of these incidents had been notified to CQC.

We saw on the one completed incident form that the staff had been told to "refer to the e learning" in order to manage this condition for the person. We told the manager that this was inappropriate and unsafe. We were told by the local authority that they had requested emergency training for the staff to support this person. The local authority also told us that they had received a 'care concern' about this person from the home but they had to ask for it to be rewritten as if was illegible. We were concerned that the home had not been proactive in instigating this training to ensure staff had the skills to manage this person's particular condition. We looked at other aspects of this person's care and were concerned that their needs were not being met. We urgently referred this person to safeguarding ourselves and requested that all aspects of their care was reviewed.

We also had concerns over the care plans and recording systems in place in the home. These are covered in the records section of this report.

Safeguarding people who use services from abuse ✖ Enforcement action taken

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a major 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

We looked at this outcome to follow up on concerns from our previous inspection in June 2013.

We looked at the safeguarding policy and saw that it was up to date and contained information about recording and reporting incidents and allegations of abuse to the local authority safeguarding unit and to the Care Quality Commission.

We saw that an incident had occurred in August 2013 where a person who lived in the home had managed to leave the building unsupported and had been found a considerable distance away from the home. This incident had been reported to the Care Quality Commission (CQC) in October 2013. We asked the manager why there was a delay. They informed us that they had not been aware of the incident and when the local authority quality monitoring team had completed their visit and they had discovered the incident and requested that the manager refer this person to safeguarding and notify CQC. We asked the manager how this person had managed to leave the building unsupported and they said; "We presume that visitors let him out because he looks normal." The manager told us that there had not been an investigation into how this incident had occurred. We were particularly concerned about this incident as at our previous inspection in June 2013, someone else had managed to leave the building unsupported and that incident had not been properly dealt with.

We were aware of another incident that had occurred in the home that had not been reported and we had been alerted to this by the local authority. A person who lived in the home had alleged physical abuse by a member of staff. This incident had not been reported to safeguarding or notified to CQC. We asked to see this incident report. We had concerns as the person who the allegation had been about had conducted the investigation. We pointed this out to the manager and they told us that they had also

conducted an investigation and was sure that there was no abuse or concern. We pointed out that this incident should still have been reported. The manager had reported this retrospectively on the advice of the local authority but had not notified CQC.

As outlined in Outcome 4, Care and welfare of people who use services in this report, we described our concerns about a person's welfare and how it was being managed by the home. Our concerns were so significant that we urgently referred this person to the local authority safeguarding unit and requested that all aspects of their care be reviewed immediately.

Management of medicines ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

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

We have judged that this has a major 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

We looked at this outcome to follow up on concerns seen at our precious inspection. The provider had given us an action plan of how they were addressing the issues.

Appropriate arrangements were in place for obtaining medicines. However, we found that two medicines needed by one person living at the home had been out of stock for sixteen days. This meant that the person could suffer discomfort. A new supply of medicines had not been ordered. Two unit managers told us that they had not carried out any medicines audits (checks). This meant that staff might not notice any mistakes in the handling of medicines.
The home had a medicine policy which described how medicines should be handled in order to protect people living in the home from harm. We noticed that extra guidance (a protocol) had been written for some people prescribed a mild pain-killer 'when required'. This meant that staff could administer this medicine to 'best effect'.

However, medicines were not always given to people and recorded appropriately, or administered safely. We found that the administration of a medicine to thin the blood was not recorded properly. We also found that the home's records were not good enough to be able to check if two people had received the right doses of this medicine.

We watched some people being given their medicines. We saw that staff signed each person's chart after they had administered the medicine. However, one person was prescribed a medicine that must be given at particular times for it to work properly. This medicine was administered three hours late. Not administering and recording medicines appropriately puts people at risk of harm.

Medicines were not always kept safely. We noticed twice that a medicine trolley was left open while unattended. This put people at risk of harm if they took medicines from the trolley. The temperature of one medicine refrigerator was not monitored in the correct way.

This meant that staff could not be sure that medicines inside had been stored at the correct temperature as directed by the manufacturer, and were safe to use. Storage at the incorrect temperature could make them unsafe for use.

We visited one person's room and saw that their medicated creams were not locked away. The creams were being applied by untrained staff and records were not being kept. One cream was different to the cream named on the person's medicine chart (although normally used for the same condition). This meant that the person was not being cared for adequately.

We found that controlled drugs were stored in the way required by law. We checked the stocks of some controlled drugs (CDs) and found that the amounts recorded in CD registers were right. However we saw that one entry in the register had not been written correctly. This increases the chance of the mishandling of CDs.

Medicines were disposed of appropriately and a disposal record was kept.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

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.

We have judged that this has a major 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

We looked at this outcome to follow up on concerns from our previous inspection in June 2013.

We looked at the same audit file that we looked at in June 2013. We saw that the audit file was put in place by the provider. This was completed by the registered manager on a monthly basis. The manager told us that this process had started in March this year. We looked at the audits and saw that that there was very little detail recorded. The questions were all answered in a way that implied that no shortfalls or issues had been identified and there was no evidence of any actions to follow through. These audits were still being completed in the same way that we had identified was unacceptable in June 2013.

We looked at a medication audit that had been completed in September 2013. 'Yes' was written in every box implying that the auditor had found no problems but there was no explanation of what evidence had been looked at to come to that conclusion. We pointed this out to the manager and they agreed that there was no clarification of how each 'yes' had been reached.

We looked at a safeguarding audit. We were unsure when this had been completed as it was not dated or signed. The audit was held in the August 2013 section of the file so we presumed that it had been completed in August. We pointed out to the manager that the audit had not been completed properly as we were aware of safeguarding issues that had occurred in August 2013 and had not been dealt with appropriately.

We looked at the accident/incident file and raised concerns that it was incomplete. We found evidence of incidents that had occurred that had not been recorded as an incident. We found evidence of incidents that had occurred and been reported as incidents but had then not been escalated through appropriate channels.

The manager showed us that they had completed some individual care plan audits for people who lived in the home around specific aspects of their care for example, bed rails, medication or pressure relief. We saw that the manager had completed these for three people who lived in the home in one month. They told us that the nursing staff were also completing audit information for care plans. We were concerned as the home has capacity to care for up to 80 people. We asked for the manager to demonstrate to us how they could be sure that every care plan in the home would be audited on a regular basis. They told us that there was not a current system in place to do this but they would look at providing one.

Records

✖ Enforcement action taken

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 major 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

We looked at this outcome to follow up on concerns from our previous inspection in June 2013. We had concerns that some of the records were illegible and the action plan had stated that this was being addressed.

We saw in the home's internal audit records that it had been identified by the regional manager in September 2013 that some of the records made by staff were difficult to read. We had also spoken to the local authority prior to this inspection and they told us that they had concerns with the standards of record keeping within the home. They had recently specifically requested that a record was rewritten as they could not read it.

We looked at the records stored in a person's bedroom. These records were in place for staff to make regular checks on the person's care to ensure that all their needs were being met. We looked at a record from 4 October 2013 and we were unable to read it. We showed it to the manager and they were also unable to read it. This record had been completed by two members of staff. The manager told us that this was in the process of being dealt with. We pointed out to the manager that we had been told these concerns were being addressed in June 2013.

We looked at the daily food and drink intake for one person as we were concerned about this person's hydration. On many occasions it was recorded that this person had declined drinks. On some occasions the record stated that this person had a drink but the amount was rarely recorded. We pointed out that the document needed to be completed appropriately if it was to be of any use in looking at the person's intake of food and drinks.

We looked at the positional changes and daily food and drink intake records for a person recorded on the day of our inspection. We saw that these two records did not correspond. The positional changes record said that the person had sat up for breakfast at 8.40am. The food chart said that the person had breakfast at 9.45am. There were many crossings

out on these records which made them difficult to read. We went back into this person's bedroom at 3.30pm and saw that the food chart said that the person had coffee at 1.00pm. We saw a full cup of cold coffee on this person's bed side table so we did not believe that the record was a true account of what this person had drank.

We saw in the same person's file an audit completed by the manager and they had said that the records were incomplete. We asked to see the record that preceded the current one (which was less than two weeks old). We were told that we could not see it as it could not be located.

We looked at a risk assessment on a person's file regarding a specific health issue and saw that it had not been updated for two months. We were aware that there had been significant incidents relating to this person's health that required changes to their care plan and risk assessment. We also saw that the risk assessment did not include specific relevant issues that were fundamentally necessary as they heightened the risk to that person. We showed this to the manager.

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 30 November 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	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
Diagnostic and screening procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** The registered person was not taking proper steps to ensure that each service user is protected against the risks of receiving care and treatment that is inappropriate of unsafe.

We have served a warning notice to be met by 30 November 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	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
Diagnostic and	**How the regulation was not being met:**

This section is primarily information for the provider

screening procedures Treatment of disease, disorder or injury	The registered person had not made suitable arrangements to ensure that service users are safeguarded against the risk of abuse.
We have served a warning notice to be met by 30 November 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 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines** **How the regulation was not being met:** The registered person is not protecting the service users against the risks associated with the unsafe use and management of medicines.
We have served a warning notice to be met by 30 November 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	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The registered person was not protecting service users against the risks of inappropriate or unsafe care and treatment by means of an effective operation of systems designed to assess and monitor the quality of the service.

This section is primarily information for the provider

injury	
We have served a warning notice to be met by 30 November 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 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records** **How the regulation was not being met:** The registered person did not ensure that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information recorded about them.

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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