Inspection Report

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

Prospect Park Hospital

Honey End Lane, Tilehurst, Reading, RG30 4EJ

Tel: 01189605000

Date of Inspection: 25 October 2013

Date of Publication: November 2013

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

Respecting and involving people who use services	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✔ Met this standard
Safety and suitability of premises	✔ Met this standard
Supporting workers	✔ Met this standard
Assessing and monitoring the quality of service provision	✔ Met this standard

Details about this location

Registered Provider	Berkshire Healthcare NHS Foundation Trust
Overview of the service	Prospect Park Hospital is part of Berkshire Healthcare NHS Trust. It has six wards which offer care and treatment to people living with various forms and degrees of mental illness.
Type of service	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

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'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 October 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 staff and reviewed information given to us by the provider.

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

What people told us and what we found

On this inspection 25 October 2013 we visited Sorrel Ward, one of the six wards on the Prospect Park Hospital site. Sorrel Ward is a psychiatric intensive care unit which offers a service to people who are acutely unwell and consequently detained under the Mental Health Act 1983. The ward provides a low stimulus environment for those people who have specific needs and associated risks that cannot be managed on other wards. The average duration of stay is 30 days but this can vary from a few hours to a year.

We found that people were not always helped to understand the care and treatment they were offered. We saw that there were few records kept to show that people had put forward their views or that their choices were explained to them.

We saw that care plans were not always designed to meet the needs of the individual. Staff members told us that the care planning system was very complex, we found that this was the case.

The hospital followed safeguarding policies and procedures to protect people from abuse.

The environment was safe, clean and well maintained.

Staff were well trained and supported to enable them to care for people. People told us, " the staff are okay."

The hospital listened to people's views on their daily living conditions and acted on them. There were, generally, ways of checking that the standard of care was maintained or improved.

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

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✖ Action needed

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was not meeting this standard.

It was not clear if people's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

People who used the service did not always understand the care and treatment choices available to them. People we spoke with did not always understand what was written in their plans of care and were not aware that they had the right to access their records. There were limited records with regard to staff discussions with people about their care and treatment. Plans of care did not contain any information to show what steps staff had taken to check that people understood what would happen to them during their stay on the ward.

Staff told us that they were mindful of including patients in decisions about their care and treatment. When asked how people were involved in developing their plans of care one staff member told us that they print out a copy of the care plan and discuss it with the patient on a regular basis. However, people's views were not recorded in their plans of care and there were no notes of any discussions or communications with people to show that these conversations had occurred.

People who used the service were not always given appropriate information and support regarding their care or treatment. There was a range of display boards throughout the corridor areas. Some information was out of date and the activities board was disorganised and underutilised.

People's diversity, values and human rights were not always respected. We looked at four care records which contained little individual information about how people's diverse needs were to be met. An example included one person whose plan of care simply noted their country of origin and first language. It did not note their language of preference (not their first language) or any actions to take to consider their culture, ethnicity or values.

Staff told us that issues of equality and diversity were well managed. Examples provided

included the use of interpreters and supporting attendance at religious celebrations. This was not reflected in plans of care or daily notes. We found that there were no interactions with community groups, no different language newspapers or other reading materials and no record of culturally appropriate food being obtained.

Training records showed that all staff had completed equality and diversity training. We saw an equality analysis template provided by the Trust as part of the admission, transfer and discharge policy. It noted several areas to be looked at, under race it noted that cultural traditions, food requirements communication styles and language should be considered. These considerations were not reflected in the care plans we looked at.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

It was not clear that care and treatment was planned and delivered in a way that ensured people's safety and welfare.

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

People's needs were assessed but it was not clear if care and treatment was planned and delivered in line with their care plan. We looked at four individual care records which were kept on computer. Records were variable in quality. Some were not detailed and they were not always person - centred. An example was that none of the four plans of care identified people's preferences and personal wishes. Part of the care plan included 'clients expectations and goals' but these were not completed. Plans of care included an admission check list, assessments, risk management and some areas of personalised care planning. Elements of the plans of care were generic and had not been altered to meet the needs of the individual. An example included a care plan which stated 'this plan is not relevant to this patient'.

Staff told us that the computer based care planning system was complex, cumbersome and time consuming. We saw that the entries in the system were often repeated, entered in a variety of places and not cross referenced. This meant that information could not be found quickly and some information could be easily overlooked because it was 'buried' in the system.

All changes on the ward were communicated to staff in a handover period between shifts. The ward did not record their shift handovers for the benefit of people who had been unable to attend, or been off duty.

Throughout the inspection we saw that staff were interacting positively with people. Examples included staff participating in activities with people and addressing them respectfully. Staff told us that the standard of care on the ward was good.

There were limited activities provided by the ward. The activities timetable noted activities five days a week but these did not always take place. There were plans in place to increase the half time hours of the ward Occupational Therapist to full time which would increase the opportunities for group and individual work. The ward had lost the part time hours of a psychologist. This had resulted in reduced group and one to one sessions with

patients.

It was not always clear if care and treatment had been planned and delivered in a way that was intended to ensure people's safety and welfare. People's mental and physical health needs were looked after by a doctor who worked on the ward on a full time basis. The provider may find it useful to note that it was not always clear why medication had been prescribed or what treatment an individual was receiving. An example was a person who had been on the ward for 11 days with no treatment. However, they had been prescribed medication. We were told by staff that the individual was being 'assessed' but it was not clear from plans of care what the assessment entailed and when/how it would be competed. Two qualified staff members were unable to describe the assessment process or explain why medication had been described.

We saw that a complex risk assessment and management system was in place. There were several elements to the system, including a risk summary. However, the system did not specifically describe risks, up-date them or note the action to take to minimise them. An example was people who were 'on leave' from the ward did not have an up-dated risk assessment for their change in location. There were no written records of how the risks were to be managed. A staff member told us that people had made verbal agreements about how they would be monitored by the ward.

Risks were rated on a seven point word scale numbered from very low to very high and observation levels were assessed on a scale which informed staff of the observation schedule necessary. The risk summaries we saw did not always 'match' the daily notes. An example was daily notes which described someone as '…pleasant and amenable' and a risk summary which said' 'calmer but refusing to engage……'.These entries were dated on the same day within a short time frame. There was no cross referencing from the risk summary to the daily notes or other areas of the care plans.

Seclusions which generally included restraints were clearly recorded. However, they were not always cross referenced to the daily notes. They did not include what staff did to manage the situation to try to reduce the necessity for restraint. An example was a record written in October which fully recorded the restraint and seclusion. However, we could not find any records of what happened prior to the seclusion. The only notes said, 'staff made an effort to distract' with no details given of how. This meant that there was no record of what the individual did or didn't respond to and/or what may have 'triggered' the event.

There were arrangements in place to deal with foreseeable emergencies. We saw resuscitation equipment and an emergency medication box provided for use in an emergency located in the office. We saw that the emergency equipment had been regularly checked and signed by staff. All staff were trained in emergency procedures and qualified staff were able to give emergency medication.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who used the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. The four staff we spoke with demonstrated a good understanding of the potential for abuse and safeguarding issues in general. They were able to provide a clear account of what action they would take if they witnessed any abuse or suspected that abuse had taken place. The inter-agency policy and procedures for the safeguarding of adults was readily accessible to staff together with a range of relevant contact numbers. Most staff spoken with knew the names of the designated safeguarding leads for the trust.

The provider responded appropriately to any allegation of abuse. Staff we spoke with provided some examples of identified abuse and the response that had resulted. On one occasion a patient was suspected of being financially abused by a relative. This was reported and addressed appropriately. Another example involved a patient targeting and bullying another. This did not result in a formal safeguarding referral but was addressed through additional support and guidance to both patients in order to safeguard the victim. We saw that the ward had made a child protection referral to the appropriate local authority.

The trust had implemented a six day block training schedule for all staff covering a range of core training. Staff training records were provided following the visit and confirmed that safeguarding children and safeguarding adults were topics included in the core training. Staff had also received training regarding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff told us that issues relating to the mental capacity of individuals was regularly discussed in ward rounds, this was not reflected in daily notes. Due to the nature of the care provided on Sorrel ward all patients were detained under the Mental Health Act 1983.

People who used the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. All incidents of restraint including seclusion were recorded and monitored on the ward. Monthly returns were completed by the ward and a formal annual seclusion audit was undertaken by the trust.

Safety and suitability of premises ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The provider had taken steps to provide care in an environment that is suitably designed and adequately maintained. The ward had been specifically designed for the purpose of assessing and treating patients who were in an acute phase of mental illness. The environment was ligature free in relation to bathroom fittings and door handles etc. There was a designated cleaner on the ward and it was seen in general to be clean and tidy throughout. People said, "the hospital is very clean".

The trust used an external maintenance contractor whose personnel were based on the hospital site. Maintenance visits were routinely made to the ward on an approximately weekly basis. The contractor was described as responsive when repairs were required. Any work that required specialist attention was out sourced without delay. Records for any requested repairs or maintenance issues were recorded mostly as email correspondence. An inventory of all equipment and furnishings was maintained.

There were a range of health and safety risk assessments and management plans in place. These covered areas such as COSHH (control of substances hazardous to health) risks to patients and staff, windows, adverse weather and spillages. There were comprehensive in-house checks of the fire safety system and fire safety equipment. This was supported by regular servicing of all fire equipment and the fire alarm by an external contractor. We saw internal audits of hazards that could lead to slips, trips and falls.

We were told that the ward manager regularly attended health and safety meetings which were external to the ward environment. Records seen confirmed that these meetings took place. The provider may wish to note that health and safety records and meeting minutes were not always easy to access. This could mean that evidence that checks have been undertaken could get mislaid or overlooked.

A range of internal checks and external servicing contracts were in place. Evidence we saw included, portable appliance checks, legionella testing and hazardous waste storage and removal.

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 to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

There were comprehensive systems in place within the service designed to support staff in their role. Examples included, regular ward round meetings which were held to discuss individual patient's needs. Team meetings were held approximately monthly. However, due to the nature of the demands of the ward and the needs of the patients these were not always well attended. The ward manager ensured that all staff had sight of the minutes so that important information was passed on. We saw meeting minutes which followed a set format and actions required of all staff. Staff spoken with told us that they felt well supported in their role and the manager was supportive, approachable and acted upon concerns or requests without delay. The manager told us that they were well supported by their line manager with whom they had regular meetings about the running of the ward.

Staff told us that the staff team as a whole were very supportive of each other. Communication was described as good between staff members and shifts. We observed a staff handover where incoming staff were updated about developments, concerns about or the progress of all patients on the ward. People told us "the nursing staff are okay. None of these staff are a problem to me, here".

Staff training was organised and monitored by the trust training department. A block training programme had been introduced which provided six intensive days of training covering a wide range of topics. These included safeguarding vulnerable adults, Mental Capacity Act, moving and handling, health and safety and the Mental Health Act 1983. Staff told us that training was readily available and updates were regularly held. The service maintained a staff training record which was provided following the visit. This recorded all training undertaken and highlighted where refresher training was due for individual staff members.

The ward used agency staff to cover shortfalls in staffing. Only agency staff familiar with the ward were used. They always received a comprehensive induction on to the ward. Agency staff we spoke with confirmed this and said that they were well supported by the qualified staff. They told us that despite not receiving formal supervision they were always asked how they were getting on during each shift.

Staff received appropriate professional development. Senior staff were allocated junior

staff to supervise. All senior staff were supervised by the ward manager. Supervision took the form of one to one meetings which according to the trust policy should have been held approximately every two months. We noted that staff told us that they received formal recorded supervision at various intervals ranging from three to six monthly. We were told that group clinical meetings had been introduced but generally had not been felt to be helpful. These meetings had not been held for some time. Despite the infrequency of formal supervision staff told us that they felt well supported and could approach senior staff at any time for guidance and advice. One junior staff member told us that the systems of guidance and support on the ward resulted in them feeling safe at all times.

The provider may wish to note that the ward was not following the Trust's policy in relation to supervision of staff. This could mean that support and performance issues were not addressed in a timely manner.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

The hospital had a quality assurance system which operated at organisational and ward level. The ward manager audited aspects of treatment and care. Audits included weekly care plan audits, admission audits and Mental Health Act paperwork audits. A clinical governance nurse audited all aspects of the care given on the ward. The provider may find it useful to note that the care plan auditing system had not identified the omissions and shortfalls in the planning process.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. The hospital had a method of collecting people's views on a weekly basis and prior to discharge. People completed a simple computerised question and answer survey, with help if necessary. We saw records of the questionnaire that covered two weeks in September 2013. Three people completed the questionnaire and rated the care as excellent or good. The provider may find it useful to note that it was not clear what action was taken, if necessary, as a result of the feedback from questionnaires.

Weekly 'community' meetings were held where people were encouraged to discuss any issues about their environment and daily life. We saw that actions had been taken as a result of people's views. These included more walks, repair of a TV, shorter smoking breaks and no music channels on the main TV in the day time.

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We found that ward staff were supported by the ward doctor, on a daily basis.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. We saw that accidents and incidents were recorded and were reported using a computerised system. The information was detailed and included actions taken to minimise recurrence. However, the provider may find it useful to note that these were not cross-referenced to individuals care plans, if necessary.

The provider took account of complaints and comments to improve the service. The hospital had a formal complaints procedure. The record of complaints showed that one

informal and three formal complaints had been received since January 2013. Complaints were appropriately investigated and the resolution was clearly recorded. It was clear from the nature of the complaints that people knew how to use the complaints procedure.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010** **Respecting and involving people who use services**
	How the regulation was not being met: The provider did not enable people to participate in making decisions about their care. They did not take due regard of people's diversity when providing their care and treatment. Reg.17 (1)(b),(c)(i) (ii) and (h)
Regulated activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 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 always ensure the planning and delivery of care to meet people's individual needs and/or ensure their welfare and safety. Reg.9 1 (b) (i) and (ii)

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 12 December 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.

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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