Review of compliance

Rushcliffe Care Limited Partridge Care Centre	
Region:	East
Location address:	Partridge Road Harlow Essex CM18 6TD
Type of service:	Care home service with nursing
Date of Publication:	November 2011
Overview of the service:	Partridge Care Centre is registered to provide accommodation for up to 117 people who require nursing or personal care. The Kingfisher and Mallard suites specialise in care of the elderly, including people living with dementia. The Eider and Teal suites offer specialist nursing care for adults requiring specialised neurological support.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Partridge Care Centre was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Partridge Care Centre had made improvements in relation to:

Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 11 - Safety, availability and suitability of equipment
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 10 October 2011, observed how people were being cared for, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

Two people with whom we spoke told us they felt very safe living in Partridge Care Centre. People using the service and their relatives told us that the laundry service had improved considerably in recent times.
People using the service told us: "Most of the time it's alright here but the carers are rushed off their feet, it's a shame that a lot of the good staff are leaving."
We spoke with relatives of people living in Partridge Care Centre and they told us "Things are a lot, lot better; there are more staff and more awareness of peoples' needs." and "They seem to be getting to grips with everything, my relative is very happy here and I am much happier with their care now."

What we found about the standards we reviewed and how well Partridge Care Centre was meeting them

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

We have minor concerns with this outcome. Improvements need to be made to the care planning system so that records clearly identify those people who lack capacity and what arrangements have been made to support those people with decisions about their daily life and treatment.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

We have moderate concerns with this outcome group. Improvements need to be made to ensure people have positive interaction and receive consistent care from the care staff team.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider is compliant with this outcome. People using the service are protected from abuse and the risk of abuse.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

We have minor concerns in relation to this outcome. Daily practice needs to improve so that people live in a clean and pleasant environment.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

We have major concerns with this outcome. People are not protected against the risks associated with the unsafe use, management, recording, safe keeping and safe administration of medicines. There is insufficient guidance in care plans for the use of some medicines.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

We have minor concerns with this outcome. People living in Partridge Care Centre have access to equipment in sufficient supply to meet their needs. However, improvements are needed to make the bathing facilities more warm and welcoming spaces for the people using them. Peoples' safety and well being needs to be protected by sluice facilities being locked when not in use.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

We have minor concerns with this outcome. Continued efforts are needed to ensure that a stable staff team are available to meet peoples' needs.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

We have minor concerns with regard to this outcome. The staff training provision has improved however staff are not receiving regular supervision from line managers to support them in caring for the vulnerable people living in Partridge Care Centre.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider is compliant with this outcome. Improvements are needed to ensure that staff continue to consider the confidentiality of people's records.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we took enforcement action to protect the safety and welfare of people who use services for the following essential standards:

- Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are minor concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
We did not speak with any of the people living at Partridge Care Centre about this outcome during our visit of 10 October 2011.
Visiting relatives with whom we spoke told us they were involved with their relative's care and that they felt that they were consulted and involved.

Other evidence
At our visit to Partridge Care Centre in July 2011 we found there were moderate concerns with regard to this outcome. There was a system in place to gain consent from people who use services about their care, treatment and support. However, the system did not always transfer into practice to ensure that people's capacity was accurately assessed and their rights considered and respected.

Staff training records and discussion with staff and management informed us that 62 of the 71 care staff employed to work at Partridge Care Centre had attended training on the Mental Capacity Act and 13 of the 16 nursing staff had also attended this training.

During our visit we noted some good positive interaction between staff and people using the service in a communal lounge/diner. One example being when an agency carer came into the room to move a person seated in a wheelchair. They spoke with the person, explained what was going to happen and asked if the person was happy with

this. They then gently placed the person's feet on the footplates of the wheelchair before they wheeled the chair out of the room. We also observed a member of the nursing staff team kindly and patiently supporting and encouraging a person to agree to take their medication. This took some considerable time however the nurse did not rush the person and eventually the person felt comfortable enough to take their medication.

Overall we found that the service had made progress towards meeting this outcome since our previous visit to the home. However, we found examples where care records did not consistently identify where people lacked full mental capacity to make decisions about their own care and support. An example being, one person living with vascular dementia had not had a mental capacity assessment undertaken and the care plan records did not indicate who would support the person to make the necessary decisions about their lives.

Our judgement
We have minor concerns with this outcome. Improvements need to be made to the care planning system so that records clearly identify those people who lack capacity and what arrangements have been made to support those people with decisions about their daily life and treatment.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People living in Partridge Care Centre did not share their views with us about the care provided at the home.
Relatives of people living in the home with whom we spoke told us "Things are a lot, lot better; there are more staff and more awareness of peoples' needs." and "They seem to be getting to grips with everything, my relative is very happy here and I am much happier with their care now."

Other evidence
At our previous inspection visit to Partridge Care Centre on 14 September 2011, we found that overall the provider was compliant with this outcome. We found that people received safe and appropriate care according to their assessed needs. However, we found that improvements were needed to ensure that care plans and care practice continued to be monitored to ensure people consistently benefited from good care.

At our visit of 10 October 2011 we looked at care records held by the home, observed care practice throughout the home and talked with people using the service and their relatives to assess what improvements had been made.

We found that care records were improving however remained work in progress at this time. We found that care plans did not always include the most up to date information to instruct staff how to support individuals. For example, care records for a person demonstrating behaviours that challenged included instruction for staff to follow to support this person; these were dated 01 September 2011. Further on in the person's

records we saw more recent information regarding special support measures that had been put in place however these had not been incorporated into the care plan, therefore information available for staff was not current. The person's care records identified that they should be stimulated appropriately to walk in the garden/fresh air daily. Records did not confirm that this took place. We spoke with staff who confirmed that this aspect of the care plan was not followed because the person was reluctant to re-enter the home once outside. There were no suggestions in the care plan for how staff could manage these behaviours so that the person was supported to access the outdoors, mobilise and receive fresh air.

On other care records we found that management audits had identified that risk assessments for falls, medication and mouth protocols had not been reviewed. We looked at the areas identified in the audit found that action had been taken to address the identified shortfalls. This shows that care plans are being monitored to ensure people benefit from consistent care.

We looked at a care plan for a person risk assessed as being physically and verbally aggressive to staff and other people using the service. Training records showed us that 60 of the 70 support workers employed to work at Partridge Care Centre at the time of our visit had attended training to give them the skills and knowledge to manage behaviours that may challenge. However, there was no specific care plan to provide staff with the information they need to support this person's behaviours.

We looked at care records for one person assessed as being at risk from malnutrition. The person had been recently seen by a dietician and there was a care plan in place for eating and drinking, this was supported by a risk assessment. We requested records of the person's food and drink intake. A staff member found these on top of the wardrobe in the person's room. These records were incomplete and there was a lack of clarity regarding portion and drink sizes.

It was positive to note the general improvements being made towards more person centred care planning. For example we saw clear and detailed instruction how to assist a person to settle into bed at night. This was good information however the handwriting was not always easy to read and needed three different people to try to work out what some of the entries were.

We noted that advance care planning to address people's end of life wishes had not always been completed. This could mean that people's own wishes may not be taken into account regarding their end of life care.

Overall we found there was a strong generic aspect to the care plans we viewed, there was little person centred information to enable staff to deliver consistent care to meet people's individual needs. We also noted that care plans were not being used as 'working documents' and that staff had good knowledge of peoples' needs but did not work closely with the care plans.

At our previous visit to Partridge Care Centre on 14 September 2011 it was positive to note the way the unit functioned with good and positive interactions between staff and people living there. Our observations at our visit of 10 October 2011 were less positive. We spent three hours in the morning in the communal lounge diner of one unit. During that time we noted just two examples of positive interaction, this was between the

training manager and two people who use the service. We noted care staff walking through communal areas without acknowledging the people seated there and saw that people were not as well groomed and well presented as at our previous visit in September 2011.

We saw an example where a staff member placed a cup of tea on a low table in front of a person using the service. The person started to drink but a great deal of the tea was spilt down the front of them because they were shaking badly whilst trying to drink it. Eventually the cup and saucer fell to the floor spilling the remainder of the tea. At this time there was no staff presence supporting people in the lounge/diner. When a staff member returned some five minutes later, they picked up the cup and saucer and took them to the servery, they did not make the person another drink or speak with them at all.

In another unit later in the day we noted some good positive interaction between staff and people using the service in a communal lounge/diner. An agency carer came into the room to move a person seated in a wheelchair. They spoke with the person, explained what was going to happen and asked if the person was happy with this. They then gently placed the person's feet on the footplates of the wheelchair before they wheeled the chair out of the room.

In the afternoon we saw a birthday tea was being enjoyed by eight of the 11 people living on the unit. They all seemed to be enjoying pleasant interaction and appeared happy.

Our judgement
We have moderate concerns with this outcome group. Improvements need to be made to ensure people have positive interaction and receive consistent care from the care staff team.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Two people with whom we spoke told us they felt very safe living in Partridge Care Centre.

Other evidence
Staff members with whom we spoke told us they were booked to attend a refresher course in adult safeguarding, we were provided with records to confirm this training was planned.
Staff members also told us that the whistle blowing procedure had been updated. Five people with whom we spoke demonstrated that they were aware of what constituted abuse and what actions they would take to report any suspected abusive practice.

The Essex County Council Vulnerable Adult Safeguarding Unit confirmed that improvements have been made, in that appropriate referrals were now being made in a timely manner.

Our judgement
The provider is compliant with this outcome. People using the service are protected from abuse and the risk of abuse.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are minor concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People using the service with whom we spoke told us that the laundry service had improved considerably in recent times. One person said " Laundry was a problem in the past but it has improved a great deal."

Other evidence
Overall we found the home to be generally clean and fresh with some minor concerns. For example, we noted that some dining chairs on Mallard 2 and the communal lounge area on Kingfisher 2 did not smell clean and fresh.

The acting manager told us she had identified that agency staff infection control practices were not always 'up to scratch'. This was confirmed by an incident we observed whereby a member of staff wiped a person's eyes with a table napkin and then placed it back on the dining table.

The service has undertaken a recruitment drive, including for domestic staff members, in order to reduce the numbers of agency staff working in the home. We saw that five people were in the process of being recruited to the domestic staff team as a result of this.

We found many examples where bathroom bins were open topped, with no lids. This did not support good infection control practice.

Our judgement
We have minor concerns in relation to this outcome. Daily practice needs to improve so that people live in a clean and pleasant environment.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not speak with anyone who uses the service about the way the home manages their medicines.

Other evidence
Medicines were stored securely for the protection of people who use the service. The areas where medicines were stored were temperature controlled to ensure the quality of medicines in use. Although the temperatures were acceptable, the records made to demonstrate that medicines were stored under suitable conditions were either not being made or being recorded inaccurately. The cupboards used to store controlled drugs were not fixed to a wall in the way required by the regulations. These issues have been raised before with the provider.

Systems were in place to records when medicines were received into the home, when they were given to people and when they were disposed of. However, there were a number of discrepancies with these records. The records of the receipt of medicines were sometimes incomplete and there was sometimes no record of the stock balance of medication carried forward to a new recording period. It was therefore difficult to account for all medicines in use. The records made when medicines were given to people carried unexplained omissions giving no indication of whether medicines had been administered or not, and if not, the reason why was not always recorded. When medicines were given at different times to those printed on the medication record forms, the actual time it was given was not recorded. In some cases we saw that there was

over three hours difference in the times and this could result in people receiving medicines too close together. When medicines were prescribed in variable doses, for example, one or two tablets, the actual quantity given was not always recorded. This could result in people receiving to much or too little medication. There were some discrepancies in the stock balances remaining if the records were accurate so people may not have received their medicines as prescribed. Some people had not received their medicines as supplies had run out, one for a period of four days. Nursing staff were signing records for creams administered to people which they had either done or witnessed themselves.

We observed medicines being given to some people during the morning. This was done with regard to people wishes but we saw that some medicines were left unattended on a dining table in front of a person to which other people sitting at the table could have had access.

When medicines were prescribed on a "when required" basis or in variable doses, for example to control people's challenging behaviour, there was insufficient guidance for staff in care plans to ensure medicines were given appropriately. One person was prescribed medical oxygen to help breathing but the care plan did not contain sufficient detail for staff to ensure this was used correctly. There was no risk assessment or risk management plan in place.

The home carried out regular checks on the quality and accuracy of medication records and we saw evidence to support this. Many of the discrepancies referred to above have been identified by these checks previously but actions taken have not resulted in changes in practice to ensure people received their medicines safely and as prescribed.

Improvements seen in the management of medicines during our visit of 09 September 2011 have not been sustained.

Our judgement
We have major concerns with this outcome. People are not protected against the risks associated with the unsafe use, management, recording, safe keeping and safe administration of medicines. There is insufficient guidance in care plans for the use of some medicines.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

There are minor concerns with Outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We did not speak with anyone who uses the service about the safety and availability of equipment.

Other evidence
We found that sluice facilities in each unit of the home were unlocked. This had the potential to compromise the safety and welfare of the people living on the unit.

In one bathroom we saw two lifting hoists, one walking frame, a shower chair and a laundry hopper. This gave the room a cluttered and untidy appearance, not conducive to providing a relaxing bathing experience.

Overall we found the bathing facilities stark and institutional in appearance. In one bathroom we viewed there were a number of notices on the wall relating to staffing issues. For example, one notice informed staff not to place pads, gloves and aprons in red bags, another notice referred to the 'unit based laundry system' and there were guidelines for colour coding waste bins. These notices created an institutional feel to the room and did not provide a warm and welcoming environment for people using services.

Previously it had been identified that equipment such as shower chairs, hoists, over bed tables and footstools were not provided in appropriate numbers to meet the needs of the people living at Partridge Care Centre. At this visit we saw that this had been

addressed.

Our judgement
We have minor concerns with this outcome. People living in Partridge Care Centre have access to equipment in sufficient supply to meet their needs. However, improvements are needed to make the bathing facilities more warm and welcoming spaces for the people using them. Peoples' safety and well being needs to be protected by sluice facilities being locked when not in use.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People using the service told us: "Most of the time it's alright here but the carers are rushed off their feet, it's a shame that a lot of the good staff are leaving."

Other evidence
When we undertook an inspection of this service in July 2011 we found minor concerns with this outcome. We found that efforts were needed to continue to recruit permanent nursing and care staff members so that people received their care and support from a consistent staff team.

At this visit in October 2011 we found that there was a system in place to assess the level of support that each person needed, this process then fed into an overall assessment for each unit in order to determine the number and skills of staff needed to meet peoples' needs.

Overall we found that there were sufficient numbers of staff available in the home however there was a lack of effective leadership and deployment due to the large numbers of agency staff working there.

We found that the recruitment process was still ongoing with a positive result. There were newly appointed nursing and care staff that were starting to work at the home in a phased manner. This means that agency staff usage will gradually decrease and that people using the service will benefit from staff that will be familiar to them and have a good understanding of their needs.

Our judgement
We have minor concerns with this outcome. Continued efforts are needed to ensure that a stable staff team are available to meet peoples' needs.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak with anyone who uses the service about how the service supports staff.

Other evidence
We looked at the training records for the staff team working in Partridge Care Centre. These showed that training had been provided for many of the staff team in the basic core areas such as moving and handling, medication awareness and infection control.

Discussion with staff members and looking at records showed that supervision was not taking place regularly at the home. This means that staff may not have a formal route to discuss any concerns they may have or to receive support from a line manager.

The home has experienced upheaval in it's management arrangements over the past six months, this has not had a positive contribution to the way the home runs. The provider organisation (Rushcliffe Care Limited) has seconded senior management from other services within the organisation to assist in supporting staff to care for the people living in the home. However, this has not been consistent with various managers taking over the running of the home and working in their own style to try to achieve best outcomes for people. This has resulted in the staff team becoming weary of continual change and in a state of confusion as to what is wanted from them.

Our judgement
We have minor concerns with regard to this outcome. The staff training provision has improved however staff are not receiving regular supervision from line managers to

support them in caring for the vulnerable people living in Partridge Care Centre.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak with anyone who uses the service about the way the home manages their personal records.

Other evidence
People's personal and private records were stored in offices (referred to as nurses stations) on each unit. We found that each of these rooms were left unlocked when staff were not working in there. This meant that people's records were not securely stored to promote confidentiality. A senior management representative at the home ordered key pad locks as soon as we raised this as a concern and assured us the locks would be fitted as soon as they were received. A subsequent telephone call with the home confirmed that the keypad locks had been received and installed.

Our judgement
The provider is compliant with this outcome. Improvements are needed to ensure that staff continue to consider the confidentiality of people's records.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	Why we have concerns: The provider is compliant with this outcome. Improvements are needed to ensure that staff continue to consider the confidentiality of peoples' records.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

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 within 7 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: We have minor concerns with this outcome. Improvements need to be made to the care planning system so that records clearly identify those people who lack capacity and what arrangements have been made to support those people with decisions about their daily life and treatment.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: We have moderate concerns with this outcome group. Improvements need to be made to ensure people have positive interaction and receive consistent care from the care staff team.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: We have minor concerns in relation to this outcome. Daily practice needs to improve so that people live in a clean and pleasant environment.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008	Outcome 09: Management of

	(Regulated Activities) Regulations 2010	medicines
	How the regulation is not being met: People are not protected against the risks associated with the unsafe use, management, recording, safe keeping and safe administration of medicines. There is insufficient guidance in care plans for the use of some medicines.	
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 11: Safety, availability and suitability of equipment
	How the regulation is not being met: We have minor concerns with this outcome. People living in Partridge Care Centre have access to equipment in sufficient supply to meet their needs. However, improvements are needed to make the bathing facilities more warm and welcoming spaces for the people using them. Peoples' safety and well being needs to be protected by sluice facilities being locked when not in use.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: We have minor concerns with this outcome. Continued efforts are needed to ensure that a stable staff team are available to meet peoples' needs.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: We have minor concerns with regard to this outcome. The staff training provision has improved however staff are not receiving	

	regular supervision from line managers to support them in caring for the vulnerable people living in Partridge Care Centre.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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 within 7 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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