Review of compliance

Quality Care (EM) Limited The Oaks Nursing Home	
Region:	East Midlands
Location address:	114 Western Road Mickleover Derby Derbyshire DE3 9GR
Type of service:	Care home service with nursing
Date of Publication:	October 2011
Overview of the service:	The Oaks is registered to provide the regulated activities of accommodation for people requiring nursing or personal care, treatment of disease, disorder or injury and diagnostics and screening. It provides care for up to 28 people of either gender who have Dementia.

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

Our current overall judgement

The Oaks Nursing Home 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 because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 12 - Requirements relating to workers
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 29 September 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and reviewed information from stakeholders.

What people told us

We are unable to communicate effectively with all of the people who live at The Oaks nursing home because of the nature of their needs. We used a specialist tool to observe them discreetly during the lunchtime period to check they were treated with dignity and respect and had their needs met by the staff in the way their care plan advised.

We found that although the staff showed an understanding of how to treat people with dignity and respect, they did not do this in practice. In several cases, they did not follow the written plans of care.

We found the staff had a very limited understanding of safeguarding and of local procedures. This meant that incidents involving people being assaulted by others had not been reported to the local authority placing people at risk of further incidents.

We found the recruitment procedures were not safe and that the staff were not being properly and regularly supervised to make sure they delivered good quality care. This showed that the service was not being properly monitored by the providers and the manager and there were significant risks to people living at the service as a result.

What we found about the standards we reviewed and how well The Oaks Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People do not understand the choices available to them and they do not have their privacy, dignity and choices respected.

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

People have their care appropriately planned and their health care needs are met well. The activities provided are not always appropriate to the needs and wishes of people who live at the service.

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

People are not protected against abuse or the risk of abuse.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The recruitment procedures are not safe and people cannot be assured that the people who are working at the service are suitable to work with vulnerable people.

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

Staff do not receive the training and supervision necessary to ensure they deliver appropriate care in line with the care plans and the company expectations.

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

People do not benefit from safe, good quality care, treatment and support. This is because the systems to manage the risks to people's health, welfare and safety are not effective.

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.

We have taken enforcement action against Quality Care (EM) Limited.

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

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are major concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We found the staff did not treat the people living at the service with the dignity and respect they deserved. We saw many examples of poor practice.

We found that the staff did not maintain people's right to confidentiality, and we saw staff repeatedly talking about people's needs in communal areas. This was usually to do with how much they had eaten but we also witnessed a member of staff asking someone if they had a continence pad on across the dining area. It was said in a loud voice and could be heard in the lounge area. This compromised the person's dignity.

We saw that staff often spoke about people in loud voices rather than to them; examples we heard were of staff saying, "he hasn't moved has he?" and "she's shouting out a lot isn't she?" This was whilst staff were assisting people and it compromised people's dignity. This approach was not in line with people's plans of care which stated as an aim, "to provide optimal quality of life, comfort and dignity, person centred approach. Use calm approach and explain everything."

We found the staff often talked about people as tasks to be done, (an example being, "I'm out of your way now so you can deal with them.") They also spoke loudly in communal areas about staff breaks and who was covering what aspect of care. This did

not contribute to creating a homely atmosphere.

We did not see people being offered choices at lunchtime, in terms of what they ate, where they sat or what they had to drink. The manager told us that catering staff asked people what food they would like in advance, but as some people would have difficulty remembering their choice it would be best practice to remind them. We did not hear any staff telling people what was for lunch.

When we spoke with staff they demonstrated a good understanding of how they should behave in order to maintain people's dignity, and one member of staff told us that they had attended training on dignity in care. We saw evidence that this training had been booked for other staff in the future. However, our evidence showed that although staff were aware of best practice, they did not follow this through in practice.

We observed people being assisted to eat, and with one exception this was done at an appropriate pace and people were not rushed to eat their meal. However, in some cases this meant people ate over a longer period (30 – 40 minutes) and we did not see any staff re-heat or replace their dinner, which would have been cold by the time they finished eating. This could have a significant impact on their appetite for the food and on the amount of food they were prepared to eat as cold food is less palatable. On two occasions we witnessed staff talking to each other about their personal lives whilst assisting people to eat, rather than focusing on communicating with the people they were helping. The senior carer had noticed this and she said she had spoken to the members of staff concerned as it was disrespectful to people living at the service.

Other evidence
We received information of concern from the local authority indicating there may be problems with staff being able to understand the people living at the service and about them being able to make themselves understood due to problems with speaking and understanding English. They told us their follow up enquiries had resulted in mixed evidence.

We spoke with staff and the manager about this concern and they all told us that there had been an issue with some staff, but they no longer worked at the service. We did not observe any problems with staff speaking or understanding people living at the service.

Our judgement
People do not understand the choices available to them and they do not have their privacy, dignity and choices respected.

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 minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We looked at five care plans to identify whether the needs of the people we observed were fully highlighted. We considered whether the plans gave clear guidance to staff about how to meet needs.

We found the plans overall to be clear and comprehensive. The staff we spoke with felt they had the guidance they needed. They demonstrated a clear theoretical understanding of people's needs. In practice they did not always follow the written plans of care (see outcomes 1, 14 and 16.)

We saw clear evidence that people had their health care needs identified, assessed and that staff contacted external health care professionals for expert advice and guidance. For example we saw evidence that the speech and language therapist, the occupational therapist, the physiotherapist, the dietician as well as more specialist advisors such as the Parkinson's Disease nurse were involved in people's care. We saw that the staff had incorporated their specialist advice into the plans of care to make sure that staff could meet people's needs in a consistent way.

All of the moving and handling manoeuvres we saw were safe and done well. We also noticed that the staff cared about people's comfort and regularly adjusted people's position, or added cushions to ensure they were seated comfortably.

We observed the activities being provided for people who had higher dependency needs. Staff gave people sensory toys for them to hold or stroke. We saw a number of

people holding or feeling these. We also saw the staff give one person a book to look at and staff sat for a short while looking at the pictures. As this was for such a short period it was not done in a meaningful way. The activities organiser tried to get people to play short netball but this was not successful as most people were asleep and those who were awake could not understand what he wanted them to do. We observed that the activity organiser's approach with people who were frail was not appropriate. We saw him waking people by saying "wakey, wakey," very loudly in people's ears. This did not succeed in rousing people but had the potential to shock them and some people appeared startled. We also saw him brushing people's hair without their permission and whilst they were asleep in communal areas. This was unnecessary and undignified.

We saw some visitors with people living at the service and observed they had a good rapport with the staff. The manager told us that people were encouraged to visit when they wanted.

Other evidence
We looked at the last report which was written about the home by the local involvement network (LINks) following a visit on 20 December 2010. This raised some concerns from survey responses about the range and variety of activities. An example of a comment we saw in the report was, "activities are the same week after week." One member of staff told us that they felt there could be a better variety of activities. "I think we could try and get them out more because they enjoy it. We went to the black country museum and it was a nice day out. It was 1:1 and we had a brilliant day. I think they still need that. I take some people for dinner, into town when I can but it's not often."

Our judgement
People have their care appropriately planned and their health care needs are met well. The activities provided are not always appropriate to the needs and wishes of people who live at the service.

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

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
When we looked at the care plan for one of the people we observed we saw they had a history of physical aggression. We saw two incident reports written by staff concerning this person. These involved three separate incidents of physical assault involving other people living at the service. They were very serious incidents resulting in injuries. There was no evidence that these had been referred to the safeguarding team at the local authority in line with local safeguarding procedures.

The staff we spoke with admitted the person had assaulted other people, but they did not consider these incidents to be safeguarding events. The nurse we spoke with told us she had not received safeguarding training and was not aware of her obligations under the safeguarding procedure other than to record what she saw.

When we looked at the training matrix we found that thirteen out of the eighteen care staff had received training on safeguarding in 2010 or 2011. Only two of the five nurses (who would be responsible for the shift) had. The nurses would be the staff responsible for reporting allegations and following local safeguarding procedures. The registered manager told us that training on safeguarding was "being arranged," though no firm booking dates had been provided. When we looked at the safeguarding policy we found this would be confusing for staff, implying that they should investigate any allegation themselves. This was not in line with local safeguarding procedures which stated that all allegations must be reported to the local authority. There was no information in the policy about who should report or about the preservation of evidence.

The nurse we spoke with told us that there were a significant number of people who had behaviour which may challenge living at the home, and our observations confirmed this. She told us, "we keep an eye on them. We get a lot of aggression. We do have an issue with three or four people who would leave the building. They can always go out into the garden. We have one person who will strip off and we try and explain why it is inappropriate."

Our observations showed that some incidents could be avoided if staff managed situations more effectively. For example, there was only one sitting for lunch. The lunchtime we observed was loud, busy and disorganised. Several service users were visibly distressed at the level of noise in the room. When we looked at five plans of care, several service users had plans in place which indicated they should eat in a quiet atmosphere. This did not happen. Several service users were consistently shouting out loudly, and this resulted in our seeing one of them verbally abused by two other service users. This showed that triggers for behaviour were being ignored, care plans were not being followed and staff had not considered how best to manage the difficult situations.

When we looked at the training matrix we found only four of the eighteen care staff had done training on supporting people with challenging behaviour (which had been done in 2008) and only two of the five nurses (again in 2008.) This shows that staff did not have the training they needed to be able to manage difficult situations effectively so they could keep people safe.

Other evidence

Our judgement
People are not protected against abuse or the risk of abuse.

Outcome 12:
Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are major concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We looked at three staff files to make sure that these contained all of the documentation and information required by law to make sure people were safe to work with vulnerable people.

In two out of the three we found people had not been safely recruited. Two people had been employed and were working at the service with only one written reference. We found that the manager accepted work references from personal addresses rather than the business address of the previous employer. We also found the referees highlighted were not the managers of the services the staff members had worked in. This meant that the manager would be unable to verify that the referees were who they said they were; she could not be certain that they were in a position of authority to be able to comment on the staff member's suitability to work with vulnerable people. We also found that in both cases the person's last employer had not been given as a referee and there was no written reason for this. This means the manager would be unable to seek written verification as to the reasons the person left their previous employment.

We spoke with the manager about this and she said she had not been aware of the risks this presented to people living at the service.

Other evidence
The local authority raised concerns with us about a member of staff employed at the service who had been dismissed from their previous employment. We were told the registered manager had not approached the staff member's former line manager for a

reference.

We looked at the staff member's file and found that their former line manager had not been asked for a reference. Another member of staff working at the service had been given as a referee. We found statements in their reference about the staff member's suitability that the staff member was not authorised to give. We also found the staff member had a start date recorded which was before the date the Independent Safeguarding Authority (ISA) First and Criminal Records Bureau (CRB) checks were received. Other documents we saw confirmed this was correct and the staff member started work before the necessary checks were in place. This meant that CRB guidance which is in place to protect vulnerable people from those who may harm them was not followed.

We also found the member of staff had only one written reference and no reference from their last employer. We asked the manager about this, she said she had contacted the staff member's last employer but the manager of the service was on maternity leave. The manager had not taken any steps to obtain a reference from another person in the company. This meant the person was working at the service without two satisfactory written references. We could not see any evidence in the person's staff file to indicate the reasons for the person's previous dismissal had been discussed with them or risk assessed. The registered manager said she had discussed the matter with the nursing and midwifery council (NMC) there was no evidence she had.

Our judgement
The recruitment procedures are not safe and people cannot be assured that the people who are working at the service are suitable to work with vulnerable people.

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 major concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We asked the manager how often supervision sessions were undertaken with staff and she told us this task had been delegated to the deputy manager. She checked with the deputy manager and informed us that they were done twice a year. A member of staff told us, "I should have supervision every three months mine was last done in January, I don't think it matters whether we have the supervisions or not. We have really general supervision anyway, if there is a good piece of work they speak to us."

When we looked at the files of two newly appointed staff (one employed in May 2011 and one in June 2011) we found no evidence of supervision or of any probationary period or induction. We asked the manager if supervision had been done and the records were located elsewhere. She confirmed that the deputy manager had not done any supervision of these staff. This meant no-one had assessed the competence of the new members of staff, nor their suitability to work with the vulnerable people in their care.

Our observations provided substantial evidence to show that staff were not providing care in line with the company's expectations and this was having a significant impact on service users. (See outcomes 1, 4 and 7.) This shows that the supervision arrangements were not effective and robust.

We looked at the training matrix and found that in some cases, almost all of the care staff had received training; examples of this were moving and handling (which we observed was very safely done), health and safety, infection control, fire and food hygiene.

In other significant areas fewer staff had attended training. Only three staff had received Dementia care training in spite of the service providing care to service users with this specific care need. We also witnessed some particularly poor examples of work with people with Dementia (see outcome 1.) There was no evidence recorded on the training matrix of people having received training on dignity issues, though one member of staff confirmed she had received this. The manager provided evidence that this training had been booked for all staff between October 2011 and March 2012. We also noted that not all of the nursing staff were up to date on key training such as Dementia care, supporting people with challenging behaviour and safeguarding. As can be seen from our evidence in outcomes 1, 4 and 7 the lack of understanding and training meant that staff were not always delivering care in line with care plans and expectations. This had not been identified as an issue.

Other evidence

Our judgement
Staff do not receive the training and supervision necessary to ensure they deliver appropriate care in line with the care plans and the company expectations.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
The manager told us that the company had just started using an audit tool. She said she was undertaking audits on her own service. This is not best practice. We could find no evidence that a representative of the provider (other than the manager who is also a director) had visited the service regularly to assess or monitor care. Staff told us when the providers did visit they did not speak with the staff or the people living at the service to assess the quality of care. One member of staff also told us that the manager was not readily available.

We looked at the audits which had been done so far and found only two were completed. These covered outcome 2 – consent to care and treatment and outcome 5 – meeting nutritional needs. There had been no audit of respecting and involving people, care and welfare, safeguarding, recruitment practices, or the arrangements for supervision and support our observations and findings showed a number of concerns in terms of how people were supported in these areas.

We looked at the audit on nutrition. The manager had developed an action plan to ensure compliance focused on the use of a nutritional assessment (MUST) tool. We assessed the information about people's dietary and nutrition needs and found that only eight of the twenty eight people living at the service ate a diet of a "normal" consistency. When we observed lunch we saw several areas negatively impacted on people's nutrition; this included the arrangements at lunchtime. The audit indicated people could choose when to eat their food. We saw that all of the people living at the service sat down together at the same time, but as the staff were very busy some of the people we

observed sat waiting for food for 50 minutes whilst others around them ate. The audit indicated that people were not disturbed when they were assisted to eat, but we witnessed one member of staff leave a person who was being assisted to eat to help with a moving and handling manoeuvre. This interruption lasted for ten minutes and the food was not heated up for the person on the staff member's return. This meant that when the manager audited against the outcomes on behalf of the provider she failed to identify that there were problems with meeting the legal requirements. As she failed to identify this she had not taken any steps to assess and manage the risks.

As can be seen in outcome 1, 4 and 7 we identified a number of shortcomings in the care being given. We could find no evidence that the provider or manager had monitored the delivery of care. We could not find any evidence that there were any systems in place and operating effectively to make sure that risks to people living at the service were effectively managed.

Other evidence
In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider and the Registered Manager on 17 October 2011.

Our judgement
People do not benefit from safe, good quality care, treatment and support. This is because the systems to manage the risks to people's health, welfare and safety are not effective.

Action
we have asked the provider to take

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People do not understand the choices available to them and they do not have their privacy, dignity and choices respected.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People do not understand the choices available to them and they do not have their privacy, dignity and choices respected.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People do not understand the choices available to them and they do not have their privacy, dignity and choices respected.	
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: People have their care appropriately planned and their health care needs are met well. The activities provided are not always appropriate to the needs and wishes of people who live at the service.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People are not protected against abuse or the risk of abuse.	
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: The recruitment procedures are not safe and people cannot be assured that the people who are working at the service are suitable to work with vulnerable people.	
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: The recruitment procedures are not safe and people cannot be assured that the people who are working at the service are suitable to work with vulnerable people.	
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: The recruitment procedures are not safe and people cannot be assured that the people who are working at the service are suitable to	

	work with vulnerable people.	
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: Staff do not receive the training and supervision necessary to ensure they deliver appropriate care in line with the care plans and the company expectations.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff do not receive the training and supervision necessary to ensure they deliver appropriate care in line with the care plans and the company expectations.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff do not receive the training and supervision necessary to ensure they deliver appropriate care in line with the care plans and the company expectations.	

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.

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People do not benefit from safe, good quality care, treatment and support. This is because the systems to manage the risks to people's health, welfare and safety are not effective.		14 November 2011
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People do not benefit from safe, good quality care, treatment and support. This is because the systems to manage the risks to people's health, welfare and safety are not effective.		14 November 2011
Regulated activity	**Regulation or section of the Act**	**Outcome**	

Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	People do not benefit from safe, good quality care, treatment and support. This is because the systems to manage the risks to people's health, welfare and safety are not effective.		14 November 2011

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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