Care Quality Commission

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:	May 2012
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 to check whether The Oaks Nursing Home had made improvements 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 14 - Supporting staff
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 21 March 2012, 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 carried out this review to check whether there had been any improvements in the quality and safety of care being provided following action we had taken to protect the safety and wellbeing of people living at the service. We found that there had been some improvements in some areas as detailed below but we continued to be concerned that there were ongoing breaches of the regulations in specific areas. Where areas of non-compliance were identified during inspection they are being followed up and we will report on that action when it is complete.

Most of the people who live at The Oaks Nursing Home would find it difficult to help us understand their views about the quality of the care being provided to them. We used a special tool designed to help us understand how people who have Dementia experienced the care being provided to support them. We carried out our observations in the lounge and in the dining area over the lunchtime period. We looked at how staff interacted with people and how care was being provided to support people with their needs. We looked for clear and observable signs which would show us how people felt about the care they

were receiving.

We saw care staff were better at communicating and interacting with people and we saw that people were being treated with more respect for their privacy and dignity. As a consequence we saw that the people living at the service looked more contented. We observed that the staff seemed better at supporting people when their behaviour was challenging.

However, we were very concerned about the quality of the work undertaken by the nursing staff at the service. We had serious concerns about their practice in respect of preventing and managing pressure areas. We also found that the changes the providers had made were not sufficient to ensure compliance with the warning notice previously issued.

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

There had been improvements but further work was needed to ensure that all staff treated people with respect for their dignity and privacy.

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

People did not experience safe, effective and appropriate care and treatment in relation to the prevention of pressure sores. This meant they were not protected against the risks of receiving unsafe care and treatment.

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

People were not fully protected from the risk of harm or abuse as safeguarding incidents were not always reported in line with local procedures.

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

The providers could not be assured that people had their care and welfare needs met by staff who were fit, appropriately qualified and physically and mentally able to do the job. This is because the providers had not ensured that their recruitment procedures fully complied with legal requirements.

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

Despite there being improvements to the support being delivered by care staff, people could not be assured that their needs would be met by competent nursing staff.

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 did not benefit from safe care, treatment and support. This was because the systems to manage the risks to people's health, welfare and safety were not sufficiently effective in bringing about the necessary improvements in all of the areas of concern.

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 minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We identified major concerns in this outcome area following our last inspection of the service on 2 February 2012. We wanted to assess whether there had been any improvements in this outcome area since our last inspection.

Most of the people who live at The Oaks Nursing Home would find it difficult to help us understand their views about the quality of the care being provided to them. We used a special tool designed to help us understand how people who have Dementia experience the care being provided to support them. We observed four people who live at the service in one of the lounges over an hour starting at 11.40am. We looked at how staff interacted with people and how care was being provided to support people with their needs. We looked for clear and observable signs which would show us how people felt about the care they were receiving.

We saw evidence of improvements in this outcome area. We saw some positive interactions between staff and people living at the service during our observations. We saw that the staff took time to chat to people and supported them to be involved in a range of activities. One person we observed did not want to join in and chose to rest, we saw that the staff respected this. We also saw that they roused the person gently from their sleep when it was time for them to have a drink or snack. The people we

observed seemed relaxed and happy.

We saw that the staff explained what they were doing when assisting people to move and we also saw that they made sure people were covered and their dignity was protected as they were assisted to move.

At lunchtime we observed that people were asked which food option they would like to eat. People appeared to enjoy their meals and they were given plenty of time to eat at their own pace. We saw that the staff assisted people in a relaxed and unhurried manner. We saw staff respecting people's choices and interacting well with them.

We saw two staff enter a person's bedroom without knocking on one occasion. The person who occupied the room was in bed asleep at the time and we were concerned that this showed a lack of respect for the person's privacy. We saw evidence that staff had been told in supervision that they must knock on people's doors before entering. The staff had not followed the guidance in this case.

We spoke with a relative of a person using the service and they told us they felt staff were kind and treated their relative with respect.

Other evidence
Since our last inspection of the service we have been in regular contact with the local authority and the primary care trust who commission the service. They have reviewed the care of all of the people whose care they fund and they took steps to make the relatives of people who live at the service aware of the concerns we had following our last inspection of the service. This has been to make sure that the people living at the home were properly safeguarded from any harm to their health and welfare.

We have also had meetings with the providers and they have assured us that they would take action to comply with this outcome. They told us they would achieve compliance by ensuring staff were supervised appropriately; that their performance was assessed; by ensuring staff understood they were visitors in people's homes and by employing a dignity in care officer to work alongside staff.

We spoke with two members of care staff and they told us they had received recent guidance and advice on how to maintain people's dignity. One member of staff told us they had learned a lot from this and they, and other staff had put the learning into practice saying, "we have learned to treat people as we would like to be treated." They told us they felt this had improved the lives of people using the service and that care was more person centred now. They also told us the service manager had been offering them guidance and advising them to think of The Oaks as people's home rather than a care home.

We saw evidence in some files that this supervision had started, but this was not found to be the case in respect of the nursing staff who were responsible for leading shifts. We were concerned about the things nurses wrote about people who live at the service in their records. We saw entries such as, "maintaining a low profile today," "compliant to all interventions," "accepted diet and fluids," "maintains the same presentation," such entries were not person centred, respectful or informative. Please also see outcome 4

Our judgement

There had been improvements but further work was needed to ensure that all staff treated people with respect for their dignity and privacy.

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 major 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 identified major concerns in this outcome area following our last inspection of the service on 2 February 2012. We wanted to assess whether there had been any improvements in relation to the care and welfare of people living at the service since our last inspection. We found mixed evidence in this outcome.

We observed lunch being served and eaten in the dining room. We saw that the providers had purchased specialist equipment to help people eat without assistance since our last inspection. This meant people using the service were being supported to eat independently where appropriate.

We also saw that there had been improvements in respect of how people living at the service were assisted to move by care staff. We saw two members of staff assisting people to move into a wheelchair using a hoist. This was done safely and the staff followed the appropriate moving and handling procedures.

We spoke with the relative of a person who lives at the service and they told us staff always contacted them to keep them up to date with their loved one's health care. This enabled them to remain involved in their relative's care and indicated they were kept up to date with their care.

Other evidence
Following our last inspection of the service we had meetings with the providers and they assured us that they would take action to comply with this outcome. They told us they

would achieve compliance by providing support to the activity co-ordinator to assist in developing a person centred practice; to develop more person centred care planning; and by providing specialist equipment to enable people to eat more independently.

We looked at the care plan of a person living at the service who had a specific health care need. We saw that the nurses were performing the diagnostic tests which were recorded in the care plan. We saw that these records were well maintained. This meant this person was receiving safe and appropriate health care as planned for their specific healthcare need.

However, we were extremely concerned about the health and welfare of people living at the service who have developed pressure sores. Following our inspection on 2 February 2012 we told the manager and the provider that there was inconsistent information in the care plan of one person in relation to pressure sores on their heels. We looked at this persons care plan again during this inspection and found the information was still inconsistent, with one document stating there was a pressure sore and another stating there wasn't. This meant this persons care records did not reflect their current care needs in relation to pressure care and could cause confusion to nursing and care staff in the delivery of their care.

We looked in depth at the care plans of two people who had developed pressure sores. These were being overseen and managed by the nurses working at the service. In both cases the nurses recorded that it was "reported by staff," that people had developed pressure sores. This is in spite of both people having been identified by nurses as being at "high risk" of pressure areas developing and of reviews and care plans indicating that skin integrity should be "closely monitored." This would appear to indicate that the nursing staff are not following the plans of care and doing regular checks on skin integrity.

In one case we could find no evidence to demonstrate that the person's skin integrity had been reviewed for a period of three months, during which time they developed a grade 2/3 pressure sore. In the other file, the care plan reviews indicated that the nurses were doing daily dressings on an existing pressure sore. In spite of this the progress sheet completed by the nurses indicates that the care staff "reported" that the person had developed a grade 2 – 3 pressure sore in the near vicinity of the one already being treated daily by nurses.

When we spoke to the care staff they told us they always reported any changing skin conditions to the nurses. One staff member said that these reports sometimes "slipped their (the nurse's) mind," and they had to "nag" them about it. This meant the nurses were relying on untrained staff to report changes in skin integrity to them rather than taking professional responsibility for ensuring they followed plans of care they had written.

We saw evidence that the tissue viability nurse had visited and in one case had asked for a wound swab to be taken and for the nurses to report the results to him. There is no record to demonstrate that this was done and no record of the results from the swab if it was taken. This means that there is no evidence to demonstrate that a diagnostic test requested by a professional expert advisor to assist in the treatment of a healthcare need was conducted.

The care plans of both people stated that on the advice of the tissue viability nurse, they needed to be supported to change their position every two hours when they were in bed. There was some evidence in the records to demonstrate that staff followed the care plan during the day if the person was resting in bed, although we found there were gaps in these records. We looked at records and spoke with the manager and the nurse in charge of the shift who confirmed that there was no evidence to demonstrate that staff changed the position people were lying in whilst in bed during the night. This could lead to further tissue damage.

In both cases, the tissue viability nurse had advised that dressings must be changed every day. We looked at the records kept by the nurses to show when the dressings for the two people with pressure sores were changed. We saw on several occasions there were gaps in the records for odd days and sometimes up to four days, indicating the dressings had not been changed as specified in the care plan. This meant the care plans of these two people were not being adhered to and there was no evidence that pressure sore care was being managed appropriately and as directed by an expert.

We saw that photographs of the wounds were being taken and that nursing staff were recording the measurements of the wound and where appropriate the depth of the cavity. The nurse in charge informed us that the tissue viability nurse had supplied them with a measuring probe to measure wound cavities accurately. There was no evidence to demonstrate that this equipment had been used in the photographs to ensure that the measurements were correct. This meant that the nurses had failed to follow best practice when assessing pressure sores.

We looked at the records of training for qualified staff and could not find any evidence that they had undertaken further training on any clinical issues.

Where areas of non-compliance were identified during inspection they are being followed up and we will report on that action when it is complete.

Our judgement
People did not experience safe, effective and appropriate care and treatment in relation to the prevention of pressure sores. This meant they were not protected against the risks of receiving unsafe care and treatment.

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 moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We identified major concerns in this outcome area following our last inspection of the service on 2 February 2012. We wanted to assess whether there had been any improvements in relation to safeguarding the people living at the service. We found mixed evidence in this outcome.

We observed the care staff giving support to a person who had needs around their behaviour. We saw the staff use different techniques to manage the behaviour and this person responded well to the techniques used. The support we saw delivered was in line with what was recorded in the person's care plan as being the best approach to use.

We spoke with a relative of a person using the service and they told us they felt their relative was safe in the home. They told us they had never had any cause to complain but knew who to speak with if they had any concerns.

Other evidence
Following our last inspection of the service we had meetings with the providers and they assured us that they would take action to comply with this outcome. They told us they would achieve compliance by appointing a safeguarding officer to oversee safeguarding arrangements.

When we inspected the service in February 2012, we spoke with three staff and one nurse about safeguarding vulnerable adults. They all knew how to respond to incidents

and allegations of abuse and all recognised what would need to be referred under local safeguarding procedures.

During this inspection we looked at the care plan of one person using the service who could displayed challenging behaviour. We saw that these challenging incidents had been well documented and there was evidence of the incidents being referred to the safeguarding team in line with local procedures. This meant other people using the service were protected against the risk of abuse by this person.

However we saw evidence to demonstrate there had been an injury to the leg of a person who lives at the service and to the toe of another with no indication or investigation as to how the injury had been sustained. We spoke with the nurse who the injury had been reported to and they told us they had not referred these unexplained injuries to the safeguarding in line with local procedures. We raised concerns about the failure to report unexplained injuries to the safeguarding team following our inspection on 2 February 2012. This meant that the nurses were still not always following locally agreed procedures and reporting unexplained injuries and bruising to the safeguarding team. As a result people were not fully protected from the risk of harm or abuse.

Our judgement
People were not fully protected from the risk of harm or abuse as safeguarding incidents were not always reported in line with local procedures.

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 moderate concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We identified major concerns in this outcome area following our last inspection of the service on 2 February 2012. We found there was information and documentation missing from staff files which was required by Law to protect people from staff who may be unsuitable to work with vulnerable people. We wanted to assess whether this information had been obtained and whether there had been any improvements in relation the recruitment of staff.

Other evidence
Following our last inspection of the service we had meetings with the providers and they assured us that they would take action to comply with this outcome.

When we inspected the service on 2 February 2012 we found that staff files were not complying with legal requirements as some did not contain a full employment history with a satisfactory written explanation of any gaps in employment. We saw that one of the three files we looked at still did not contain this information and this should have been addressed.

We also saw that the job application form the company used indicated that staff had to complete a pre employment medical questionnaire to make sure they were physically and mentally fit to do the work. We found this was not completed on two of the three files we looked at. We have raised this before and this issue should have been addressed.

During this inspection we looked at the file of a staff member and could find no evidence to show that they were authorised to work legally at the service. We could also find no evidence that the member of staff had a valid Personal Identification Number registered with the Nursing and Midwifery Council. We spoke with the staff member who said these documents could be supplied the same day. These documents were not produced. The representative of the provider contacted the appropriate authority for guidance but was not satisfied that the staff member had the documents they would wish as employers to see. As a result he took action to prevent them working until the documents were available.

Following our visit the representative of the provider informed us he had assessed all of the staff files to make sure the necessary documents were in place to authorise them working at the service following our inspection.

Our judgement
The providers could not be assured that people had their care and welfare needs met by staff who were fit, appropriately qualified and physically and mentally able to do the job. This is because the providers had not ensured that their recruitment procedures fully complied with legal requirements.

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 identified major concerns in this outcome area following our last inspection of the service on 2 February 2012. We wanted to assess whether there had been any improvements in relation to supporting workers.

Our observations of the care staff provided evidence to demonstrate their performance has improved. See outcomes 1, 4 and 7. We remained concerned about the skills and competence of the nursing staff working at the service. See outcome 4.

Other evidence
Following our last inspection of the service we had meetings with the providers and they assured us that they would take action to comply with this outcome. They told us they would achieve compliance by holding regular staff and management meetings; by providing appropriate supervision of staff and appraisals of their performance and by providing training to ensure they were competent and confident in their role.

We saw evidence to demonstrate that there had been recent training about caring for people with dementia, including how to support people with challenging behaviour. We saw evidence to demonstrate that there had also been recent training on how to safeguard vulnerable adults from abuse and how to ensure people using the service were not deprived of their liberty.

We spoke with two members of care staff and they told us there had been improvements to the training they had received. They said they were being given more training and they felt this was helping them to do their job properly. Our observations

provide evidence to support this view.

We saw evidence that care staff received formal supervision to discuss how they were working in December 2011. The staff we spoke with told us they said they felt they could approach the new service manager with any issues and they felt he was open and honest with them about their performance. They felt positive about the changes to staff meetings and said they felt their opinion was wanted and listened to.

We saw that steps had been taken to obtain a second reference on a person who had worked with vulnerable adults in a previous position. This reference had entries on it which raised some concerns, the risk assessment which had been completed was of poor quality and there was no evidence to show what steps would be put in place to mitigate against the risks of any repetition of the issues. When we looked at the person's supervision we found similar issues had emerged following the person's employment with no evidence of formal target setting or action. We passed these concerns on to the service manager for him to take action and to ensure he was satisfied with the quality of supervision of performance being undertaken.

We could not find any evidence that there had been a sufficiently robust and frequent clinical supervision of the nursing staff in the files we saw. As can be seen from outcome 4 we were concerned about the skills and competence of nurses employed to work at the home.

Our judgement
Despite there being improvements to the support being delivered by care staff, people could not be assured that their needs would be met by competent nursing staff.

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
We found evidence which suggested there may be continuing breaches of this regulation.

Other evidence
We issued a warning notice to the providers of this service stating they must become compliant in this outcome area by 17 November 2011.

On this inspection we found there had been some improvements in checking on the quality of the service being provided to make sure people were being treated with dignity (outcomes 1 and 14).

However, we found serious and ongoing concerns about the safety of people living at the service in relation to their care and welfare and the effectiveness of the systems for recruiting and supporting staff. This was in spite of the action plans the provider told us they had in place to address these issues of concern. This evidence demonstrated that if the providers did have systems in place to protect people living at the service from the risks of inappropriate or unsafe care or treatment these were not operating effectively. It also demonstrated that they had failed to identify, assess and manage the risks to the health and welfare of people living at the service.

We found examples of issues reoccurring which we had previously brought to the attention of the providers in our reports in September 2011 and February 2012 (see outcomes 7 and 21.) The fact that the providers failed to make the necessary

improvements as indicated in their action plan provided evidence to demonstrate they either failed to have regard to our reports or failed to ensure that effective systems were in place to prevent previously identified errors from reoccurring.

Where areas of non-compliance have been identified during inspection they are being followed up and we will report on that action when it is complete

Our judgement
People did not benefit from safe care, treatment and support. This was because the systems to manage the risks to people's health, welfare and safety were not sufficiently effective in bringing about the necessary improvements in all of the areas of concern.

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: There had been improvements but further work was needed to ensure that all staff treated people with respect for their dignity and privacy.	
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 were not fully protected from the risk of harm or abuse as safeguarding incidents were not always reported in line with local procedures.	
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 providers could not be assured that people had their care and welfare needs met by staff who were fit, appropriately qualified and physically and mentally able to do the job. This is because the providers had not ensured that their recruitment procedures	

	fully complied with legal requirements.	
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 providers could not be assured that people had their care and welfare needs met by staff who were fit, appropriately qualified and physically and mentally able to do the job. This is because the providers had not ensured that their recruitment procedures fully complied with legal requirements.	
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 providers could not be assured that people had their care and welfare needs met by staff who were fit, appropriately qualified and physically and mentally able to do the job. This is because the providers had not ensured that their recruitment procedures fully complied with legal requirements.	
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: Despite there being improvements to the support being delivered by care staff, people could not be assured that their needs would be met by competent nursing staff.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met:	

	Despite there being improvements to the support being delivered by care staff, people could not be assured that their needs would be met by competent nursing staff.	
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: Despite there being improvements to the support being delivered by care staff, people could not be assured that their needs would be met by competent nursing staff.	

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.

<table>
<tr><th colspan="4">Enforcement action taken</th></tr>
<tr><td colspan="4">Warning notice
This action has been taken in relation to:</td></tr>
<tr><td>Regulated activity</td><td>Regulation or section of the Act</td><td colspan="2">Outcome</td></tr>
<tr><td rowspan="3">Accommodation for persons who require nursing or personal care</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td colspan="2">Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td>How the regulation or section is not being met:</td><td>Registered manager:</td><td>To be met by:</td></tr>
<tr><td>People did not experience safe, effective and appropriate care and treatment in relation to the prevention of pressure sores. This meant they were not protected against the risks of receiving unsafe care and treatment.</td><td></td><td>04 May 2012</td></tr>
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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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