Care Quality Commission

Review of compliance

Forget Me Not Residential Home Forget Me Not Residential Home	
Region:	South East
Location address:	151 Burnham Lane Burnham Slough Bedfordshire SL1 6LA
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Forget Me Not Residential Home is a care home without nursing located in the Burnham area of Slough. The service provides 16 beds over two floors in a detached property. Five of the rooms have an en-suite facility containing either a shower and toilet or a basin and toilet. All of the rooms have a wash basin. The service has a decking area and garden to the rear of the property

	with seating areas. The service provides residential care to older people some of who may be experiencing dementia.

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

Our current overall judgement

Forget Me Not Residential Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 3 February 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People who use the service told us that staff were very good at respecting their privacy and would knock on doors before entering and check if they wanted to receive visitors. When they needed assistance with such things as bathing they found it a dignified experience. They said that staff would always ask if they needed help and never assume. People told us they were able to make their own choices and decisions and that staff would assist them and encourage them but never make them do anything they didn't want to.

People said they or their relatives had been able to visit the service to see if it was suitable for them. They said they had been asked about their needs and staff displayed a good awareness of their needs and a knowledge of them as people. They told us there were activities arranged for them at the service which they were encouraged to participate in and visitors were made welcome. They said that when they experienced periods of ill health staff were attentive towards them. Some people told us the heating would often break down and it could get cold but they were provided with heaters for their rooms.

They told us they felt safe living at Forget Me Not Residential Home and that staff were good at responding to call alarms when they needed them. They said that a member of staff could mostly be located when needed and were always able to do what was required of them. They felt there were enough staff but that occasionally staff could have trouble keeping up with the workload. People said that staff appeared competent and were generally friendly and respectful with them and they were content with the way they were treated.

The people we spoke with said they had never had the need to raise a concern, but if they did they would feel confident and comfortable in approaching the manager or proprietor. They told us they were aware of residents' meetings they could attend. Some of the people and visitors we spoke with could also recall completing questionnaires asking for their views on their care and the service.

One person summarised her experience at Forget Me Not Residential Home by saying: "I'm comfortable here. It's not regimented". Another person said: "I'm well looked after here and have no complaints about the experience although I'd still rather be in my own home".

What we found about the standards we reviewed and how well Forget Me Not Residential 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 who use the service had their privacy, dignity and independence respected and were receiving information in relation to their care. People were participating in decisions relating to their care and they were having their consent or agreement to the decisions reached recorded.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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

People who use the service were experiencing safe and appropriate care. Their needs were being assessed and updated to reflect changing circumstances. People were involved in the planning of their care which was provided in a way they preferred by well informed staff. Some issues within the building could result in the discomfort, distress or the compromised safety of some of the people who use the service.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People who use the service were protected against the risk of abuse and appeared safe and secure. The service had procedures in place to protect people from abuse. Staff were trained and informed about how to monitor for signs of abuse and the requirements of the Mental Capacity Act (2005).

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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

At the time of our visit people had their health and welfare needs met by sufficient numbers of competent and qualified staff.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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

The service had arrangements in place to involve and include people in the running of the service. Quality monitoring systems were used to ensure that people experienced safe quality care. Staff were kept informed of the results and outcomes of the quality monitoring systems used to assist them in understanding where improvements were needed.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 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

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

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People who use the service told us that staff were very good at respecting their privacy and dignity and always knocked on doors before entering and checked if they wanted to receive visitors. They said that staff protected their dignity well when assisting them with personal care and bathing. One person said this had been particularly difficult for her to get used to but staff had worked at making her more comfortable. Another person said that despite requiring assistance for most personal care staff always asked if she needed it and never assumed. They told us that they weren't as independent as they would like but said this was more due to them not being as able as they once were. They said they were generally able to make their own choices and decisions and that staff would encourage them to do certain things but never force them. One person told us how she was able to live her life how she wanted but in the knowledge that staff were nearby to assist her.

Other evidence
During our visit we saw staff knock on people's doors before entering. We saw care being provided privately. When approaching people staff members announced the reason for their presence. Staff were seen to regularly engage with people offering them choices and asking about their preferences throughout our visit. We saw a number of examples of information provided to people who use the service such as a

notice board with a menu, the service's newsletter, and details of a financial advice service, the next church service and the next chiropody session.

The staff we spoke with gave examples that maintaining a person's privacy, dignity and independence meant keeping them covered during personal care, always knocking on a door before entering and assisting someone to do as much for themselves as possible. They said that elements of their training covered privacy and dignity. They told us they used their conversations with the people they support to gain feedback from each individual about their care, treatment and choices. Where people communicated in non-verbal ways they would monitor their body language, mood, behaviour and responses to actions and situations to gain their feedback. They said they felt people could make choices covering everyday life such as what to eat, what to wear, what to do and how. Staff displayed an awareness of the importance of asking for a person's opinion and permission and treating each person as an individual rather than making assumptions about their needs and preferences.

During our visit we carried out a review of care plans. The care plans we looked at contained considerable detail on each person's needs and preferences such as the personal care support they require. The assessments contained well completed sections identifying each individual's personal choices and level of independence. There were examples of people or their relatives signing their contribution to the care plans or consent to specific actions. There were details of each individual's wishes in relation to end of life care and where this had not yet been discussed with the individual this was noted. The care plans also contained correspondence from the service notifying people of alterations to their fees and charges.

Our judgement
People who use the service had their privacy, dignity and independence respected and were receiving information in relation to their care. People were participating in decisions relating to their care and they were having their consent or agreement to the decisions reached recorded.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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
The people we spoke with told us that they or a relative had been invited to look around Forget Me Not Residential Home before moving in and this involved a discussion with staff about their needs. This included being asked lots of questions and having the opportunity to ask questions of their own about their needs and requirements. One person told us she could remember staying for the day and having lunch with people who use the service to get a good idea of what it was like to live there. They said they were encouraged to participate in activities which some did and some didn't. Those that did said they enjoyed the activities and had recently enjoyed going to a show in Slough, celebrating Chinese New Year and celebrating the service's birthday with a party. They told us that their visitors were made to feel welcome.

They said staff displayed a good awareness of their needs and a knowledge of them as people. People told us that when they'd had periods of ill health the staff had been very good at providing additional care where necessary to assist in their recovery. One person told us how staff had helped her through a very difficult period and she was very grateful to them. Some people told us that they always felt warm in their rooms. Other people said that the heating would often break down and it could get cold, but they had always been provided with a heater for their rooms.

Other evidence
During our visit we saw staff and people who use the service regularly engaging in friendly conversation. All the staff knew everyone by name. People's rooms were personalised with family photographs, pictures, ornaments and personal items such as

furniture and televisions. The door to each individual's room contained their name in a colourful design. We saw an activities schedule on display detailing activities such as bingo, board games and a sherry and chat session. During our initial visit to the lounge people were sitting quietly listening to the radio through the television. Later a staff member played the keyboard and the proprietor facilitated a game of hangman which eight people appeared to be enjoying. At one point they were guessing the titles of soap operas and singing the theme tunes.

On a number of occasions during our visit we saw relatives visiting people in their rooms and in the lounge. The visitors were made to feel welcome by staff who often engaged them in friendly conversation. In general people looked clean and tidy. We saw examples of staff displaying an awareness of people's needs and preferences. On one occasion a person hadn't eaten her bowl of corn flakes from a late breakfast. A staff member asked her why she had corn flakes as she always had toast and blackcurrant jam. The person did not know why she had chosen corn flakes on the day of our visit.

During our visit we noted the door guard on one room's door was not working. The occupant was distressed at not being able to keep her door open and complained that it had been like it for some time. On a separate door the door guard was making a beeping sound. Staff appeared to ignore the beeping. We pointed this out to the manager who was accompanying us and were told that the batteries would need replacing in both door guards. By the afternoon of our visit the proprietor had sent an individual to purchase batteries and they were installed in the door guards. We saw the door guard to one room was missing. We noted that the door between the dining room and four rear facing rooms slammed noisily when closing. We saw one person woken from sleeping in her arm chair by the noise.

Before our visit we had been aware of several reports of the heating system breaking down at Forget Me Not Residential Home. The day of our visit was a particularly cold winter's day. When we first arrived the lounge was cool. We checked the radiator which was cool and the fire was displaying a flame but was not emitting heat. We noted that the proprietor had turned the fire on later in the day. We checked people's rooms which in general were much warmer. One room was very cold as the occupant had opened all his windows through choice. In one corridor area on the ground floor the radiator was cold. The corridor was also cold and ice was developing on the inside of the fire exit door. The corridor was the access between three rooms and a toilet. On the first floor part of the corridor and the shared bathroom was cool.

During our observations we noted a strong smell of urine on two occasions. In one room the occupant was in hospital at the time of our visit. The room had a strong odour of urine with no obvious signs of staining. We were accompanied by the manager who agreed the odour was considerable and was not aware of the cause. In a separate room we saw that the carpet had been replaced with easy clean flooring which was sealed around the edges. The manager displayed a good awareness of the situation and its causes. She told us about the measures taken to control the situation. However, the measures taken had not resolved the issue of the odour in the room. In a final room there was a non-specific unpleasant odour. Again, the manager displayed a good awareness of the circumstances of the room's occupant but any measures taken had not resolved the issue of the odour.

The staff we spoke with told us that people or their relatives were invited to visit the service for a look around before moving in and could stay for the day and have dinner if they wanted to. Each person received an assessment of needs to allow staff to familiarise themselves with their needs and preferences. The assessments were updated monthly as standard but could be updated more frequently if a change in needs was noted. Staff said they were clear that daily entries should be made to the database system and transferred to the care plans to include information about what each individual had been doing during the day, what they had eaten, and their health and mood. They also used staff handover meetings between shifts to update their colleagues about the individuals they provided support to. Staff were aware that if a person's health changed gradually they would involve the senior staff member and the general practitioner (GP) if necessary and take measures such as additional monitoring where appropriate. If the health change was more sudden or urgent they would call the emergency services. Staff told us that the heating at Forget Me Not Residential Home was unreliable and that a plumber was often called in to fix it.

During our visit we carried out a review of care plans. The care plans we looked at contained a detailed assessment recording each individual's needs in relation to mental health, social activity, nutrition, personal care and mobility among others. The plans contained clear and well documented risk assessments for such things as personal care, medication and the malnutrition universal screening tool (MUST). The care plans contained recent updates to the assessments to identify when and how needs were changing. Any allergies or intolerances were clearly identified. Daily entry records detailed the wellbeing, activity, personal care and any food consumed by each person on each day. These were well completed for the weeks we checked. Any changes in health were well recorded as was the involvement of any medical practitioners, hospital services or advocates.

We looked at the care plans of some of the people we spoke with. One person told us she needed staff assistance with washing and preferred this to be done without taking a bath or shower. The assessments in her care plan clearly noted her preference for a thorough wash as opposed to a bath or shower and the reasons for this. Another person told us of the foods she disliked and the activities she particularly enjoyed. She told us that she was never given the foods she disliked and staff encouraged her to participate in the activities she liked the most. Entries to her care plan clearly noted her dislike of certain foods and her preference for certain activities.

Our judgement

People who use the service were experiencing safe and appropriate care. Their needs were being assessed and updated to reflect changing circumstances. People were involved in the planning of their care which was provided in a way they preferred by well informed staff. Some issues within the building could result in the discomfort, distress or the compromised safety of some of the people who use the service.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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
People who use the service told us they felt safe and secure living at Forget Me Not Residential Home. They said they had call alarms in their rooms within easy reach. They said that staff were good at responding to them. They said they felt their personal possessions were secure and they were not aware of anything being interfered with at any time. People told us that staff were generally respectful and friendly with them and they felt content with the way they were treated.

Other evidence
During our visit we entered the premises through the main entrance. The door was secured and we were greeted by a member of staff. We were asked to sign in and out when entering or leaving the building. We checked other possible entrances to the premises and found them to be secured. We observed staff being engaging and friendly with people who use the service and their visitors. When people required assistance staff would accompany and guide them. We saw call alarms within easy reach in each of the rooms we checked. On one occasion at lunch time one of the people using the service became distressed. A member of staff guided the individual along the corridor to the dining room comforting and reassuring her. On reaching the dining room the person was far less distressed.

The staff we spoke with knew the definition of abuse and that it could be financial, physical, emotional or neglect. They knew to look for such things as a change in a person's mood and behaviour, fear around certain individuals, signs of withdrawal or physical marks such as bruises to identify potential abuse. They said they would speak

to their manager if they suspected abuse was taking place and they felt very confident and comfortable in doing so. They knew of the service's safeguarding and whistle blowing policies but could not recall when they had last reviewed them. Some of the staff said they had received safeguarding training during 2011 as part of mandatory training. Others knew they had received the training but could not recall when. The staff we spoke with displayed an awareness of the Mental Capacity Act (2005) and said they had received training on this in either 2010 or 2011.

During our visit we carried out a review of documentation. We looked at the safeguarding and whistle blowing policies which between them defined forms of abuse, how it should be reported and how any allegations would be investigated. We looked at some of the staff files. The files we checked contained questionnaires from 2011 completed as a test of each staff member's safeguarding knowledge. We looked at training records within the files which showed those staff members had received mandatory training on safeguarding in 2010 or 2011. The same staff had also received training in the Mental Capacity Act (2005) in 2008.

We spoke with the manager who displayed a good understanding of her responsibility to inform the safeguarding vulnerable adults (SOVA) team at the local authority, the Care Quality Commission (CQC) and the police and GP if necessary of any incidents of abuse or suspected abuse.

We checked the financial accounts of people who use the service. In each case there were completed transaction records to show how each person's money had been spent. The records were accompanied by receipts where necessary. The cash sums for each person kept in individual wallets in a locked cabinet matched the recorded balance.

Our judgement
People who use the service were protected against the risk of abuse and appeared safe and secure. The service had procedures in place to protect people from abuse. Staff were trained and informed about how to monitor for signs of abuse and the requirements of the Mental Capacity Act (2005).

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People who use the service told us they were mostly able to locate a member of staff when they needed one. They said that staff appeared competent and qualified and were always able to do what they needed them to. Some of the people we spoke with were aware of the type of training staff received. They said that when staff worked together they communicated and cooperated well to get things done. They said they felt there were enough staff at Forget Me Not Residential Home but that on some occasions the staff could have trouble keeping up with their workload. They said that the staff were always familiar to them and they were not aware of seeing anyone they did not recognise. They told us they felt the staff were friendly and helpful and also spoke highly of the proprietor. One person said: "Staff are very friendly and you can have a joke with them. They always ask what you want and how you want it".

Other evidence
During our visit we were aware of a constant staff presence. Staff were seen providing general care to people throughout the service, engaging people, and providing one-to-one support. Staff members looked busy and active throughout our visit particularly in the morning. They did not appear stressed and remained calm, patient and friendly with people. When staff members requested assistance from each other this was provided. Most of the time care workers were available to help when an individual required assistance.

The staff we spoke with had qualifications such as a National Vocational Qualification (NVQ) in health and social care. Those that could recall said that when they first arrived

at the service they had received an induction including an orientation to the service, training and supporting (shadowing) a colleague. They said they had been receiving a mandatory training program including health and safety, moving and handling, fire safety, dementia care and food hygiene. They said that the mandatory training covered everything they needed and didn't feel they needed any further training.

They told us they enjoyed being part of the team at Forget Me Not Residential Home and they experienced good working relationships. Some of the staff said their workload was manageable most of the time but that people's needs were becoming more demanding leading to periods when they felt pushed to complete tasks. Some staff said they were finding their general workload increasingly difficult to manage. They felt there was a need to increase staff numbers to assist in the additional workload. However, all the staff we spoke with said they enjoyed working for the service and looked forward to their shifts. They said that agency staff were not used by the service and absence was covered by permanent staff doing additional shifts. They told us they were clear about their line of management and felt they had a good relationship with their manager, although they didn't know her too well as she was relatively new to the service. One staff member summarised the general feeling saying: "I enjoy working here. It's a homely home like a nice big family".

We spoke with the manager who told us that Forget Me Not Residential Home operated with three shifts covering the morning/afternoon, afternoon/evening and night. Staff were required to arrive 15 minutes before the start of their shift to allow for handover before and after each shift. On the day of our visit there were three senior care workers covering the morning/afternoon shift. Two senior care workers covered the afternoon/evening shift and were joined by a junior care worker between 4.30pm and 7pm. One senior care worker was due to cover the night shift. Other staff who worked set hours and sometimes days throughout the week included the manager, a cook, an administrator and a cleaner. All of the staff on the day of our visit were permanent staff.

The manager told us that Forget Me Not Residential Home did not operate with a bank system and did not use agency staff. As most of the staff were not full-time, any planned or unexpected leave was covered by staff members swapping shifts or completing extra shifts. We were told that when not on the premises both the manager and proprietor were on call.

Our judgement
At the time of our visit people had their health and welfare needs met by sufficient numbers of competent and qualified staff.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People who use the service told us they had never felt the need to raise a concern but if they did they felt comfortable raising any issues with the manager or proprietor and felt confident either of them would deal with any concerns appropriately. Some people told us they could recall completing a questionnaire asking for their views on their care and the service. We spoke with a relative visiting a person using the service who had also completed a questionnaire. The people we spoke with who had completed a questionnaire said their response had been positive. People said they were aware of a residents' meeting they could attend. They said they were always invited but often chose not to attend.

Other evidence
During our visit we saw the complaints and concerns procedure available on a notice board outside the lounge. We also found small cards briefly detailing the complaints and concerns procedure available on display in some people's rooms.

The staff we spoke with were aware of the proprietor completing monthly reviews of the service. They said that the proprietor would complete a report and make this available for them so they knew what was being done well and what needed changing. They said they had staff meetings once each month and this was also an opportunity to discuss issues, concerns and review each individual's care at the service. They told us they were aware of an accident and incident reporting procedure and said they had been kept informed by the manager and received feedback on any issues. They also knew that details of each incident were transferred to the relevant individual's care plan.

They said they felt confident and comfortable with the prospect of raising any concerns about the service with the manager or proprietor. The staff we spoke with were aware of regular meetings for people who use the service to attend to share their views. They said that the manager and proprietor operated with an open door policy with people who use the service and their relatives. Some of the staff we spoke with were familiar with questionnaires that were provided to people who use the service and their relatives to request their feedback on their care and the service. They could recall these being used at some point in 2011.

During our visit we carried out a review of documentation. We looked at a report following an inspection completed by the proprietor on 16 November 2011. The inspection report reviewed areas such as care plans, medication, infection control and health and safety. The report identified areas of compliance and areas for improvement and any necessary actions to be taken. We also looked at some examples of the weekly audits on infections, accidents, hospital admissions and pressure sores. Any incident or occurrence was accompanied by the details for each person affected and any further action required by the service to prevent recurrence.

We asked to see examples of people who use the service raising concerns and any incident reporting procedure used by the service. We were shown the correspondence relating to two concerns raised by relatives of people using the service. The documentation showed how both concerns had been investigated and any recommendations or changes made following the investigation. Agreement to the decisions reached or satisfactory conclusion of the concerns was also recorded. We were also shown the accident and incident book used by the service. The entries we checked were detailed and well completed. We checked to see that the details of one person's falls had been transferred to her care plan. This had been completed and a care chart had been commenced with specific instructions and actions for staff concerning the individual's mobility.

We looked at the minutes of the residents' meeting on 22 April 2011. The minutes recorded the attendance of 10 people who use the service, the manager and the proprietor for a discussion on food, staff and activities. We asked to see more recent minutes but these were not available during our visit. We also looked at the quality assurance report for 2011 formulated from the responses given to the quality assurance questionnaires provided to people who use the service, their relatives and any professionals involved in their care. The questionnaires requested feedback from people on care, wellbeing, staff and the environment among others. The report showed that 85% of people who use the service had rated their care positively and 92% had rated staff positively.

Our judgement
The service had arrangements in place to involve and include people in the running of the service. Quality monitoring systems were used to ensure that people experienced safe quality care. Staff were kept informed of the results and outcomes of the quality monitoring systems used to assist them in understanding where improvements were needed.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard.

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.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:
People who use the service were experiencing safe and appropriate care. Their needs were being assessed and updated to reflect changing circumstances. People were involved in the planning of their care which was provided in a way they preferred by well informed staff. Some issues within the building could result in the discomfort, distress or the compromised safety of some of the people who use the service.

Overall, we found that Forget Me Not Residential Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.</td></tr>
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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 14 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.

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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