Review of compliance

Romney Cottage Residential Care Home Romney Cottage Residential Care Home	
Region:	South East
Location address:	Madeira Road Littlestone New Romney Kent TN28 8QX
Type of service:	Care home service without nursing
Date of Publication:	May 2012
Overview of the service:	Romney Cottage is registered to provide care and accommodation for up to 22 people. It is a large detached home, in a quiet residential area of the seaside village of Littlestone, New Romney.

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

Our current overall judgement

Romney Cottage Residential Care Home was not meeting one or more essential standards. Action is needed.

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 Romney Cottage Residential Care Home had taken action in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
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 9 May 2012, talked to staff and talked to people who use services.

What people told us

We spoke individually with six people using the service. Some people were unable tell us about their experiences of living at the home because they had complex needs, so we used some other methods of to gain information about what it was like to live there. We spoke with four relatives who were visiting, spoke with staff, read records including care plans, and observed people during the day.

People we spoke with told us that they liked the home and that staff gave them the support they needed. They were happy with their bedrooms and said they were comfortable. People said they liked the meals provided and they could choose what they did during the day.

The people living at the home who were most independent said they liked helping out, for instance with laying tables and washing up. A person who was being supported to move to independent living in the community said he had reached that stage due to the support the home had given him.

One person we spoke with said they would like to be offered more activities and that there was not enough to do. People said they liked going out for local walks or shopping with staff if they were not able to go out by themselves

Relatives we spoke with told us that the care given at the home was good, communication was good and staff always informed them if there were any concerns.

Some comments made by people living at the home were,

"Can't fault the staff, they are lovely people"

"My room is clean and comfortable"

"They have done work to motivate me"

"I sometimes help to make cakes, I like helping in the kitchen"

Comments made by relatives included,

"We are very happy with the care"

"We feel it is a family home"

" He enjoys his meals"

"The staff are very,very,patient"

"There is enough for him to do, he did gardening last year but found it too much"

What we found about the standards we reviewed and how well Romney Cottage Residential Care 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's privacy, dignity and independence were respected.

The provider was meeting this standard.

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

People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 05: Food and drink should meet people's individual dietary needs

There was insufficient consistent written evidence that people who were at risk of not eating or drinking enough were being supported to have adequate nutrition and hydration, and that their food intake was being monitored.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

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

The provider was meeting this standard.

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

The systems in place to reduce the risk and spread of infection were not being effectively followed.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The provider had not taken steps to make sure that care was provided in an environment that was suitably designed and adequately maintained.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

There were not enough qualified, skilled and experienced staff to meet people's needs. The home was not employing enough staff to make sure that people were provided with opportunities to take part in enough activities especially at weekends, and it did not have an up to date analysis of people's needs.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for 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 systems in place to assess and monitor the service that people received were not effectively identifying where improvements were needed.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for 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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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 told us that they chose what they did each day and that staff respected their wishes.

Relatives said that people were cared for well and in the ways that they preferred.

Other evidence
When we last visited the home in November 2011 we found that there were moderate concerns with this outcome. We saw that a shared room occupied by two people that had been redecorated had not had the curtaining that provided people with privacy replaced. This meant that people in the room could not have their personal care given in private, or that they needed to leave the room whilst the other person occupying it was attended to by staff.

On this visit we saw that the curtain was in place and there was suitable curtaining in other shared rooms. We noticed that the names of two people who no longer lived at the home were still on the doors of shared rooms, the registered manager said they would make sure they were removed without delay.

During the visit we saw that people's privacy, dignity and independence were

respected. Staff assisted people with personal care discreetly. Staff spoke respectfully to people and supported them in a sensitive way. People living at the home had differing needs, most people were independent with their personal care, others needed some assistance or prompting and a small number needed full support in all areas of their lives. Staff demonstrated that they knew each person well and how to support and communicate with them.

People who used the service, or their representatives, understood the care and treatment choices available to them. We read five people's care plans and saw that people or their representatives had been consulted about and involved in planning their care and support. We saw evidence that relatives had been involved in making decisions about people's care when people had not been unable to make fully informed decisions themselves.

We saw evidence in people's care plans that they had been asked about their preferences, such as if they preferred a shower or a bath, if they liked to choose their own clothes each day, and what they liked to do.
We saw that one person who was recorded as liking to have their nails painted had nail varnish on.

The home encourages people to be as independent as they could, one person told us they had been supported to regain confidence and independence skills and was preparing to move back into the community. As part of the planning for moving they were being supported to prepare some of their own meals, they told us what they were preparing for their lunch that day. Another person said they enjoyed helping in the kitchen, others said they liked gardening or laying the tables.

Some of the staff had attended Mental Capacity Act training so that they understood what action to take if a person did not have the capacity to make fully informed decisions about significant aspects of their care. The manager told us that the training was planned for other staff later in the year. We saw examples of assessments of people's capacity on care plans.

Our judgement
People's privacy, dignity and independence were respected.

The provider was meeting this 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

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that the staff supported them well and that they had no complaints about the way they were cared for. One person said that there could be more activities on offer. However, others felt that there was enough to do.

Relatives we spoke with said people received good care and support overall and that people were supported in the ways they preferred.

Other evidence
People's individual needs were assessed and their care and support was planned and delivered safely and in line with their individual care plan. During this visit we spent time with staff, spoke with some of the people living at the home, and observed daily routines.

We saw that people's needs had been assessed and a care plan had been developed for each person. We read five people's care plans and saw they were personalised and kept up to date, any changes to the support people needed were recorded and needs were regularly reviewed. If people's needs had changed the care plans had been brought up to date to reflect the changes. For instance, one person was recorded as needing additional support with mobility due to deterioration in their sight. Changes had been made to information about a person who was fairly new to the home as staff became more aware of the person's needs and abilities, as they had settled in to the home.

Visits from health professionals were recorded and people were supported to see health and social care professionals for routine appointments and if there were any concerns about their health. On the day we visited staff took three people who had minor health concerns to see the G.P. Relatives said that health concerns were promptly referred to health professionals when necessary and they were always informed about them promptly.

Individual risk assessments were in place such as to make sure people were safe when accessing the community, smoking or mobilising. They had been reviewed and updated when necessary.

People's interests were recorded on care plans and we saw that they had been consulted about what activities they would like to do. An activity programme was in place, we saw evidence on care plans and daily records that people were involved in activities when they were provided. During our visit there were no activities during the morning, people mostly watched television, dozed, walked about the home or spent time in their rooms. Others spent time with visitors, sought out staff to chat with and those more independent helped with tasks such as laying the table. Activities provided in afternoons included going out locally for walks, playing cards, quizzes and one to one reminiscence. All the people we spoke with except one said they had enough to do, and they especially liked going for walks.

Staff told us that they had time to spend with people and to provide activities during the afternoons, and that they tried to engage people in the things that interested them. There were less staff on duty at weekends, the manager had employed a member of staff to provide three hours of activities at weekends although due to staff sickness this had not been happening for several weeks. We saw from records that people had engaged in activities when they were provided at weekends. The manager was hoping to improve the staffing for activities at weekends. The provider may find it useful to note that whilst overall people were satisfied with the amount of activities, those on offer were limited, there was no external provision of activities, and if staffing did not allow they did not always take place.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is non-compliant with Outcome 05: Meeting nutritional needs. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we spoke with told us that they liked the meals at the home and they had enough choice of what to eat.

People we spoke to spoke to after lunch said they had enjoyed their meal.

The views of relatives were mixed about meals some felt there was not enough variety.

Other evidence

We looked at the weekly menu. There was a variety of meals and always choices available. There were no fresh vegetables provided, only frozen vegetables were used and there was limited use of fresh fruit on the menu. We saw that there were some salad items such as lettuce and cucumber in the fridge, some meals included salad. Staff told us that the menu was changed each week on a four weekly rotation and that people living at the home were consulted about meals at residents meetings. Staff told us that due to the needs of the home it was not appropriate to put out bowls of fresh fruit for people, and that the overall provision of fresh fruit for them had reduced.

As well as the meals from the daily menu staff said people could choose to have left overs from the previous day heated up as a meal option. On offer on the day we visited was left over mashed potato, vegetables and liver and bacon from the day before. No one had chosen it so it was to be thrown away. The provider may find it useful to note that the left over meal looked unappetising.

Some people had been assessed as being underweight and at risk of not eating and drinking enough. It was recorded on their care plans that they needed additional snacks and high calorie drinks during the day. We saw from care plans that people who were at risk of not eating and drinking enough had been gaining good amounts of weight, for instance one person had gained nine pounds since the beginning of the year and another had gained a similar amount. A person who had lost weight in hospital had regained a satisfactory amount since returning to the home. Weights were well recorded and checked regularly, although there was inconsistent recording of the food and drink people had each day.

Charts were available so that the amounts people ate and drank each day, including the extra drinks and snacks, could be recorded. The charts did not give enough clear information to show that people were supported to be able to eat and drink enough to meet their needs. When the cook was off duty the charts were often not completed at all, and sometimes staff had just ticked the forms rather than specifying actual meals and drinks taken. Where it was recorded someone had a drink entries did not state the actual amount, for instance a whole glass or cup, or just a few sips. It was also not recorded if people finished all of a meal or not. Entries in daily recording also referred to meals and snacks taken, but without recording amounts.

The home had two dining areas attached to the two lounges; people took meals in the areas they preferred. People were provided with appropriate sized meals and those we spoke to afterwards said they had enjoyed their lunch.

Our judgement
There was insufficient consistent written evidence that people who were at risk of not eating or drinking enough were being supported to have adequate nutrition and hydration, and that their food intake was being monitored.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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
We did not speak directly to people about this outcome.

Relatives we spoke with had no concerns about the safety of the home.

Other evidence
revent abuse and people were safely cared for.

The home had policies and procedures in place to make sure that people were kept safe and that staff knew and understood the correct procedures to follow should they suspect abuse. The registered manager had very recently provided staff with updated information on how to report safeguarding concerns as there had been gaps in the information. This had been necessary as following recent incidents where a person's behaviour had impacted on the safety of others living at the home, the service had omitted to notify us about them. They had informed other people who needed to know, including the Local Authority, but had not been aware of the form they needed to use to raise a safeguarding concern with the Local Authority. The manager was now ensuring all staff were fully aware of procedures.

Clearer guidelines for staff had been developed and all staff were scheduled to have their safeguarding training renewed, we saw that some staff had already had the training and the manager planned to have it all completed by the end of May 2012.

We saw that other training was updated that equipped staff with the skills and

knowledge to keep people safe in the home, such as manual handling, infection control, fire safety and first aid.

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

The provider was meeting this standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

The provider is non-compliant with Outcome 08: Cleanliness and infection control. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We did not speak directly to people about this outcome.

Other evidence
We saw that there were areas of the home that were not being effectively cleaned, and that the homes' infection control procedures were not always being followed. We found a commode in one room that had dried brown stains on it and that there were areas of a mould on bath mats used in shared bath and shower rooms. The stains remained on the commode after the room had been cleaned.

There were areas of flaking paint on radiator covers in two bathrooms. The mattress in one bedroom was stained and smelt unpleasant.

The two hand soap dispensers in the room used by staff and that medicines were stored in were both empty. We found hand soap and a flannel left in one shared bathroom, and a bar of soap left in a shared shower room. Staff said they should not have been there and did not know whose they were. They explained that people had their own toiletries and they did not share them. Cleaning schedules and hygiene procedures were in place and staff we spoke with were aware of them, however there was evidence they were not always being effectively followed.

Staff confirmed that they had received infection control training and were aware of infection control, procedures. We saw that when directly working with people they supported them safely and in line with procedures.

Our judgement

The systems in place to reduce the risk and spread of infection were not being effectively followed.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us they liked their bedrooms and found them comfortable.

Other evidence
The provider had not taken steps to make sure that care was provided in an environment that was suitably designed and adequately maintained. When we last visited the home in November 2011 the manager told us that the carpet in one of the lounges was due to be replaced, it was very dirty, stained and worn.

On this visit we found that the carpet was still in place and had become more worn and shiny with dirt in places. The manager said that they were waiting to hear from a contractor about aspects of fitting the carpeting and some other new flooring, they were liaising with them so that the work could be arranged to minimise disruption to people. There was no date for the work to start.

The overall standard of the furnishings in shared rooms had deteriorated. The two lounges were shabby and in need of new furnishings, all of the front lounge chairs needed replacing, and carpeting and curtains were tired and shabby looking in other shared areas. The chairs in the front lounge had dirty stained arms, some cushions were stained, some cushions were torn in places and throughout the home flooring was cracked in places. There was a dirty, stained lace tablecloth on a side table.

Improvements that had been made to the environment since we last visited were the fitting of two new fire doors, and the provision a new large screen television for each lounge. Two bedrooms had been redecorated and flooring had been replaced in two

bedrooms. Some new fencing had been fitted

We looked at most of the bedrooms in the home, they were adequately decorated and furnished, and rooms were redecorated when new people moved into them. People had personalised the rooms to their tastes. Most of the rooms were cleaned to an acceptable standard. We found that one room had an unpleasant odour, the source was dirty washing in the washing basket in the room, and another room contained a stained chair cushion.

The garden had become unkempt and overgrown and was not an inviting space. There was a smoking area outside the patio windows. This was an unattractive and unkempt area, the two buckets that people and staff used to put out cigarette ends in were unsightly, smelt very unpleasant and contained a large amount of soggy cigarette ends. This area was directly outside and in full sight of a lounge/ dining room where people relaxed and ate meals. The manager said that they were planning to purchase plants to improve the garden and a new smoking area was planned.

Our judgement
The provider had not taken steps to make sure that care was provided in an environment that was suitably designed and adequately maintained.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for 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 non-compliant with Outcome 13: Staffing. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
The people that we spoke with said that they liked the staff and staff were friendly.

Relatives said that staff were kind and caring and that the standard of care and support they provided was good.

Other evidence
When we last visited the home we found that there were not always enough staff on duty to make sure that people's health and welfare needs were fully met. There were sometimes fewer staff on duty at weekends, they felt stretched then and did not have the time to provide any activities for people so less independent people had nothing to do.

During this visit we found that there was no up to date written analysis of people's needs to identify the number of staff needed to meet them. However, some people's needs had increased and there had been changes to the population of the home since our last visit.

At the time of this visit the home was not fully occupied, there were 18 people living there, most of whom were fully or partially independent with their own personal care. During the morning two senior care staff were on duty, the manager assisted them if necessary. There was also the cook and two domestic staff who were on duty in the morning.

Staff told us that most of the time there were enough staff on duty but they could be stretched at weekends and when the home was busy. Records showed that a member of staff had been providing three hours of activities at weekends, the arrangement had ended early this year due to lack of staff availability. The manager said they hoped to reinstate the hours but there was no date for this.

Staff we spoke with said they liked working at the home and they felt well supported. They said they received the training they needed for their roles and it was renewed when it needed to be. They said they received regular supervision and could always ask the manager for advice.

Staff understood how people preferred to be supported and when we asked them about people's needs and routines they confidently gave us detailed information about them.

Our judgement
There were not enough qualified, skilled and experienced staff to meet people's needs. The home was not employing enough staff to make sure that people were provided with opportunities to take part in enough activities especially at weekends, and it did not have an up to date analysis of people's needs.

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for 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 non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We used a number of different methods to help us understand the needs of people living at the service. This was because some people living there had complex needs, which meant that they were not able to tell us about their experiences.

People who were able to express their views told us that they were satisfied with the service. We saw that people were confident in approaching staff and staff listened to and reassured them when this was needed. People told us that residents meetings were held.

Other evidence
We saw records that showed that the provider visited the home regularly and a record of the visit was made. During the visits the provider spoke with people living at the home and with staff, and checked the environment, areas for improvement were noted. Over recent months they had focussed on the external environment. We found that whilst the provider had systems in place to regularly assess and monitor the quality of service that people received, they did not always effectively identify where improvements were needed, for example to the furnishings, staffing, and activities provided at weekends at the home.

The manager undertook internal audits such as for fire safety and procedures, care plans, staff competence with giving medicines, and a monthly environmental risk assessment.

Residents meetings were held and people living at the home and their relatives and representatives were provided with annual surveys so they could give their views on it. To make sure an overall annual picture of people's views was gained relatives and people living at the home were surveyed at different times of the year. We read some of the survey forms given to residents in February this year, some forms had been completed by relatives on their behalf. Overall people said they were satisfied with the service and there were comments that they felt happy to raise any concerns with the manager or staff.

Our judgement
The systems in place to assess and monitor the service that people received were not effectively identifying where improvements were needed.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: There was insufficient consistent written evidence that people who were at risk of not eating or drinking enough were being supported to have adequate nutrition and hydration, and that their food intake was being monitored. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: The systems in place to reduce the risk and spread of infection were not being effectively followed. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008	Outcome 10: Safety and suitability of

	(Regulated Activities) Regulations 2010	premises
	How the regulation is not being met: The provider had not taken steps to make sure that care was provided in an environment that was suitably designed and adequately maintained. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There were not enough qualified, skilled and experienced staff to meet people's needs. The home was not employing enough staff to make sure that people were provided with opportunities to take part in enough activities especially at weekends, and it did not have an up to date analysis of people's needs. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
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 is not being met: The systems in place to assess and monitor the service that people received were not effectively identifying where improvements were needed. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was	

	needed for this essential standard.

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

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

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

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

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

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

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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