Review of compliance

Keychange Charity Keychange Charity Rose Lawn Care Home	
Region:	South West
Location address:	All Saints Road Sidmouth Devon EX10 8EX
Type of service:	Care home service without nursing
Date of Publication:	June 2012
Overview of the service:	Rose Lawn provides personal care and accommodation for up to 29 people over retirement age. It is owned by Key Change, a not-for-profit organisation, which has a Christian and spiritual ethos. It does not provide nursing care other than that which the local community nursing services can provide, and it does not provide intermediate care. The home is a few minutes walk from the town centre,

	shops, local amenities and Sidmouth seafront. The home has a hairdressing room for visiting hairdressers.

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

Our current overall judgement

Keychange Charity Rose Lawn 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 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, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We visited Rose Lawn on 16 May 2012 from 10-17.00 and briefly on 18 May 2012 to collect further information. On the day of our visit there were 25 people living at the home.

We spent time with seven people who lived at the home and observed care delivery throughout the home and in the communal areas. We spoke to the manager, head of care, administrator, chef and six care staff and looked at records.

Although we saw that staff were caring and had a good rapport with people living at the home we were told that staff were 'rushed', 'we have to wait' and 'it's the system that counts'. Some people were independent and able to come and go as they pleased. They said that they enjoyed living there and regularly went out to town or to the sea front. There was some evidence of topical activities going on such as a VE Day supper, shop with Lily, Friends coffee morning and a springtime song show from an external entertainer but we heard that generally there was not much going on. There was an activities co-ordinator who showed lovely rapport with people and was taking people out on a one to one basis. However, there was no regular system showing how each persons' leisure and wellbeing needs were being met.

We looked at three care plans in depth. These were not kept up to date, read thoroughly by staff or easy to identify people's changing needs from. Staff generally felt that they did their best but that they did not have the information consistently to be able to know whether they were meeting people's needs at all times.

The building had a high standard of décor and was kept clean and well maintained. People living at the home enjoyed visiting the bantham hens, who live outside the front of the

home. There was a lovely outdoor patio that looked across the parish church and rugby ground.

What we found about the standards we reviewed and how well Keychange Charity Rose Lawn 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 but people did not have the opportunity to be involved in the care planning process. They also felt rushed or had to wait for staff to assist them when staff were free, which does not promote person centred care.

The provider was not meeting this standard.

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

Although staff were caring and tried to meet people's needs, people did not consistently experience care, treatment and support that met their personalised needs, putting them at risk.

The provider was not meeting this 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 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

There were not enough skilled staff to meet people's needs.

The provider is not meeting this standard.

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

The provider did not safeguard high standards of care by ensuring that staff felt supported to deliver good care.

The provider was not meeting this 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 quality assurance systems at the home are not robust enough to ensure that good quality care is delivered consistently.

The provider is not meeting this 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 non-compliant with Outcome 01: Respecting and involving people who use services. 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 spent time in the communal areas at Rose Lawn and spent time with four people living there and also with three other people during lunch. They told us that staff were 'very nice' and tried to do the best for them but that sometimes they had to wait a long time for assistance. We saw that staff seemed very busy but when they were with people living at the home they treated them with care and respect.

We saw that staff were very busy assisting people to get up but that they knocked on doors before entering and paid attention to people's dignity. We were introduced to people by staff before speaking to them.

None of the people we spoke to had been involved in their care planning or had seen their care plan. We spoke to six staff who all said that they did not know that people were supposed to be involved in the care planning. None of the care plans were signed by the people they were about. The provider may find it useful to note that people were not involved in the care planning process and reviews. This means it can not be ensured that people understand their care and treatment and are able to have their views and experiences taken into account.

We looked at three people's care plans. We saw that plans were not very personalised or kept up to date. Most reviews were dated 10/10/11. There was little information about what people liked and did not like to do, how they liked to spend their day. One plan under the heading 'daily routine' said 'likes to keep to their daily routine' but did not document what this was. It went to say that the person liked chats 'one to one' with staff as they were very deaf but did not state whether this happened in a meaningful way. This person had said to staff that they 'sometimes felt very isolated'. However, family details were good and detailed how the person stayed in contact with family.

There was some evidence of topical activities going on such as a VE Day supper, shop with Lily, Friends coffee morning and a springtime song show from an external entertainer but we heard that generally there was not much going on. There was an activities co-ordinator who showed lovely rapport with people and was taking people out on a one to one basis. However, there was no regular system showing how each persons' leisure and wellbeing needs were being met. All the people we spoke to said that they did get 'bored' as there was not much 'going on'. Staff told us that they did not have time to sit with people. We did not see this happening during our visit and there were no activities going on except a couple of people going out with the activities co-ordinator. Other than external entertainers, there was no regular activities programme for people or opportunity for one to one sessions with staff. One staff member said that they did sometimes do activities with people but that not many people turned up. There was no discussion about what people would like to do instead or how people who stayed in their rooms were engaged with regularly.

When staff brought people down to the communal areas we saw that on more than one occasion they did not ask the person where they would like to sit but asked the senior care worker 'where would you like me to put them?' However, people are able to choose to have a lie-in or to eat in their rooms if they wish. We asked the kitchen staff if they were aware of people's likes and dislikes but they did not have comprehensive knowledge about this other than if people had a particular kind of diet such as pureed.

Care plans had a small box for people's life history but this was limited to what job people may have had in the past, general hobbies such as reading and family information. We did not see how any of this information had been used to benefit people's life at the home, other than people were enabled to go to church services. Staff said that they did take people out sometimes but there were no records about how everyone at the home was supported to enjoy leisure time and social interaction or whether this had been discussed.

We heard from staff that sometimes they were too busy to pay full attention to people's personal care needs. This was also noted in staff meeting minutes on two occasions. Staff had been issued with prompts in the past but they said that it was not about remembering but having time to do care. All the people we spoke to said that staff were very rushed and that there was no such thing as a 'relaxing bath'. We heard staff repeatedly saying 'sorry', 'we'll be with you soon', 'there's x number of baths to go' and when we spoke to staff they said that they felt embarrassed about having to keep people waiting. One person living at the home said that they always do a strip wash in the morning themselves as 'you can never be sure that you will get a bath before lunchtime'.

People were able to move freely around the home, including the outside areas. The

home was in a good position for town and the sea front and people were able to sign in and out when they liked, if they were independently mobile.

Other evidence
We spoke to staff about how the home prepares for new admissions. We heard that sometimes new admissions are rushed and that staff do not have enough information to be able to meet people's needs properly. This could happen especially on a Friday we were told. The manager felt that the home was sometimes pressured to take new admissions. We saw that one person's pre-admission information was very brief and did not direct staff as to how that person liked to be cared for in a person centred way. For example, one comment on the pre-admission form said that the person 'thinks they are going to die' but did not elaborate on this comment or inform staff about how to manage this person's needs.

The home do speak to relatives/advocates before admissions but information is not shared fully with staff and people's life histories and personal preferences are not asked for from relatives or the person in an ordered way.

Our judgement
People's privacy, dignity and independence were respected but people did not have the opportunity to be involved in the care planning process. They also felt rushed or had to wait for staff to assist them when staff were free, which does not promote person centred care.

The provider was not 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 non-compliant with Outcome 04: Care and welfare of people who use services. 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's needs were not fully assessed and care and treatment was not planned and delivered in line with their individual care plan.

We looked at three care plans in depth. Care records were not very detailed or in a person centred way. Staff meetings minuted that records were important but that staff should focus on meeting people's care needs first. Staff said that there was not time to read care plans, handover sheets and the diary as well as daily records. When we spoke to staff they told us that they felt frustrated and not well informed about people's needs. There were 33 staff employed at the home. Information about changes in people's needs was not easily found in the care plans. Information was written in the daily records, which means that staff would need to read pages before discovering that someone now had a possible chest infection, sore leg or was at higher risk of skin damage. When we spoke to staff in a group, some staff knew that someone had a bad hand but this was not in the care plan, other staff knew that they had a sore foot. None of the staff on duty knew why someone admitted a week ago was there or were clear about what their needs were, such as how to manage an oxygen condenser.

Although the initial care plan written on admission was good, all three care plans we looked at were last reviewed on 10/10/11. One person was now 'poorly' but staff could not explain why. When looking at the care plan daily records we could see that they were no longer independent for personal care, now needed two staff to assist, needed their skin monitoring, creamed and bed elevated, had painful legs and was on

antibiotics for a possible chest infection. The care plan had not been updated to ensure that changes were clearly monitored. An entry in the daily records by a staff member said 'as I have not seen this person's legs for some time I am not sure how swollen they are'. Care records did not describe the condition of the legs.

Staff were individually unable to describe all this person's needs and how they were to meet them. One staff member had been on holiday and did not feel up to date about the people they were caring for. Staff said that the handover period was not enough time to fully give them the information they needed as they did not have time to read the care plans too. Staff meeting minutes also showed that there had been a problem with staff not listening during handover. Staff said that they felt 'frustrated', 'embarrassed' and that they were 'doing their own thing the best they could'.

We saw that areas of risk were not monitored safely or with enough reviews and information such as weight, skin integrity, nutrition and fluids and falls. One care plan had the last nutritional assessment done on 10/10/11, the last falls risk assessment done on 14/9/11 (this person had fallen very recently and become more dependent) and the last manual handling assessment had been done on 20/10/11. On 20/11/11 this person was assessed as being at risk of pressure area damage but there was no action plan as to how to minimise this risk. A daily record entry stated recently that they had a sore area on their leg but this was not mentioned again to show that it was being monitored or that any pressure relieving equipment or creams were being used for example. Other entries included vague descriptions such as 'had a bit of an episode' and 'blood pressure'. However, we did note that health professional referrals appeared to be timely.

Although all falls are reported to the surgery there was no auditing or risk management action taken to ensure that falls were minimised.

We saw that meal time was a social event in a lovely setting. We saw people being assisted to eat and drink in a discreet, patient way. The food was good quality and well presented. People living at the home said that the food was nice and that they could choose a fry up in the morning for example.

We saw in care records that people regularly saw a variety of health professionals such as opticians, dentists and chiropodists. However, district nurse records were not always kept by the nurses and when we showed staff recommendations given by health professionals, such as check skin four hourly or mobilise regularly and bed rest after lunch, they did not know about them. Appointments were kept up to date in a separate file. However, staff said that people were escorted to their medical appointments often at the health centre or hospital next door.

Other evidence
We looked at how the home monitored what the overall dependency levels for people at the home were. This information is important for assessing whether the home has capacity to meet new people's needs and to monitor staffing levels. There was one form in the care plan for dependency level monitoring but this was mostly not totalled up or the information was not up to date. We showed staff dependency level information that is used for fire evacuation purposes only and we heard that some people needed more or less assistance that documented.

Dependency levels were not used to inform the running of a safe service.

We looked at how self-medication for some people was managed. We saw that there was no assessment as to whether this was safe and appropriate for some people to manage their own medication and that there was no system to monitor this over time. One daily record stated 'please check medication as I'm not sure if the person has taken them'. This puts people at risk from self-medicating.

Our judgement
Although staff were caring and tried to meet people's needs, people did not consistently experience care, treatment and support that met their personalised needs, putting them at risk.

The provider was not meeting this 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
People told us that although staff were busy that they did feel safe at the home. We asked staff about what they knew about safeguarding. All staff had had training in safeguarding and knew that there was a local process to follow. All staff said that they would inform their manager about any issues that were raised. The local phone number to call to make an alert about safeguarding was clearly displayed in the office.

There had been no safeguarding referrals other than relating to poor practice by one staff member and this had been managed well, reported appropriately and people were kept safe.

We saw that one person was admitted with multiple bruising. The provider may find it useful to note that there was no clear body map to show staff where bruises were on admission so that staff could monitor bruising. The staff therefore could not ensure that further bruising is minimised and monitored safely.

Other evidence
People were able to choose whether they prefer a female care worker to assist them with personal care and staff said that this was followed. Although if a male care worker was on duty this could limit where they could assist at times. There was no list showing who these people were so that staff could be sure that they were following people's preferences. However, people did not raise this as an issue when we spoke to them.

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 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 moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
All the staff we spoke to were very concerned that there were not enough staff on duty to meet people's needs. All the people we spoke to living at the home also said that this was the case. On our visit we saw that some people were not assisted to have a bath and get up until 11.30, which was not their choice.

We heard from staff that many people at the home required two people to have a bath or to go downstairs or to the toilet. We saw that there were 21 bedrooms upstairs and that there was one adapted bath and one normal bathroom. No-one on that floor was able to use the normal bathroom. All six people who wished to have a bath needed two staff to assist them. We heard that there was always a queue for the bath and that each bath took at least 30 minutes and often 45 minutes as there was no toilet in this bathroom, meaning that staff then had to assist people back to their rooms to use the toilet and then return to the bathroom. Staff agreed that a hydraulic bath chair in the normal bathroom would help.

There are usually five care workers on duty in the mornings with three care workers working upstairs for 21 people. Two care workers were occupied in the bathroom. Although, the two care workers from downstairs come upstairs when they have assisted those people, we could see that the atmosphere was very rushed. Staff felt that morale was low due to frustration as if someone needs help to sit up for breakfast or to get in a chair this usually needed two care workers and so their time was spent looking for a second care worker. Call bells were constantly sounding during our visit and staff took a long time to answer the door. The first time we visited the chef opened the door and

then the maintenance man on our second visit after some waiting.

At lunchtime most people living at the home like to eat in the dining room. We saw that in order for staff to assist people to go downstairs the first person at the dining tables arrived at 12.25pm and lunch was not served until 13.10 meaning that there was a considerable wait for people at the tables. People commented on this during our lunch with them and said that the staff were 'always rushed and we have to wait'.However, the home told us that sometimes people living at the home did like to sit and wait in the dining room before a meal.

Other evidence
The manager was unable to show that there were enough staff to meet people's needs as there were no clear and up to date dependency level details or monitoring. It had not been recognised that there were not enough staff to meet people's needs when on most days six people had a bath every day in one bathroom.

We were told that there were no vacancies at the home other than for a cleaner. The manager said that they are able to book agency for sickness/leave but that this did not often happen.

Our judgement
There were not enough skilled staff to meet people's needs.

The provider is not meeting this standard.

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

The provider is non-compliant with Outcome 14: Supporting staff. 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
People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Staff who we spoke to said that they did not feel well supported and that sometimes their concerns were not listened to. This mainly related to communication and information sharing about people's needs and all staff that we spoke to felt that there were not enough staff to do their job properly. Comments included feeling 'embarrassed', 'frustrated', 'rushed' and upset'. Another staff member said that they did not understand the role of management and that 'it feels like chaos around here'. Other staff said that they did not feel respected or entirely know what their role was.

We saw that there were staff meetings that were recorded. However, meetings were approximately every six months and staff said that they did not feel that this was enough. Staff did not feel that they worked as a team. Most staff had received staff one to one supervision sessions and appraisals but they did not feel that these were useful or that their concerns were listened to. The Head of Care had not had supervision or an appraisal for the five years that they had worked at the home. Staff all said that they respected this member of staff as they worked very hard to support them. All staff said that there was not enough time to meet people's needs or to communicate people's needs so that they knew what to do.

Record keeping was seen as something to do if there was time or some staff stayed over their allocated shift time to complete records. When shown a key worker list staff did not know that they were a key worker for individual people living at the home or

what the role was.

Staff told us that each shift could be managed differently depending who was on duty. They felt that sometimes they did not know who was doing what. For example, one toileting chart was not filled in during our visit and staff said that they did find the person to be incontinent in their chair at times.

Other evidence
In general staff training was good. A training staff matrix showed that the home keeps staff up to date with mandatory training such as manual handling, infection control, fire safety and health and safety. Staff are also able to undertake other training such as spiritual care, vascular dementia and nutrition and supplements. However, most staff told us that 'we learn as we go'.

Our judgement
The provider did not safeguard high standards of care by ensuring that staff felt supported to deliver good care.

The provider was not meeting this 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
The home did not have effective systems to regularly assess and monitor the quality of service that people receive.

We asked staff about whether they felt prepared for new admissions. We heard that often people were admitted with needs that some staff did not feel confident about such as catheter care, colostomy and MRSA. Staff had had to look up these topics once a person was admitted. We heard that re-assessments were not always completed when people returned from a hospital stay, meaning that staff could not be sure how their needs had changed, especially if they arrived at the weekend.

We looked at the accident book and saw that appropriate and immediate action was taken at the time of the accident. However, there was no regular audit to ensure that accidents/falls are minimised and action plans drawn up to ensure that people remain as safe as possible.

When we asked staff about CQC essential standards staff did not know what they were and therefore did not know what standards they should be meeting.

The home does not have a clear system to ensure that they have the right amount of staff to meet people's assessed needs. Staff told us that people's needs were becoming increasingly higher and that it was difficult to manage to meet their needs in a timely way.

People living at the home felt that they were not involved in the general running of the home. One person commented that they had to follow the systems. For example, day staff do not assist people to get up until approximately 08.45 as they have to do breakfasts first. They said that they had to make an appointment with the night staff if they needed to get up earlier, commenting that 'it's the system not choice'.

Other evidence
The provider has a quality assurance system in place to enable people to be able to give their views using a survey method. Staff said that this had been done in the last year but they did not know of any comments that may have been acted upon as a result.

There are resident's meetings which is good practice. The last meeting was a couple of months ago and one is scheduled for August.

There was a comprehensive fire safety system and a recent fire risk assessment done by an external company had shown low risk in this area.

A new health and safety manual was being done by the provider and this will include policies in manual handling, expectant mothers and stress, which were previously assessed as needing adding. A recent health and safety audit found no major issues.

Our judgement
The quality assurance systems at the home are not robust enough to ensure that good quality care is delivered consistently.

The provider is not meeting this 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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People's privacy, dignity and independence were not always respected. People did not have the opportunity to be involved in the care planning process and felt rushed or had to wait for staff to assist them when staff were free, which does not promote person centred care.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Although staff were caring and tried to meet people's needs, people did not consistently experience care, treatment and support that met their personalised needs, putting them at risk.	
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 skilled staff to meet people's needs.	

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The provider did not safeguard high standards of care by ensuring that staff felt supported to deliver good care.	
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 quality assurance systems at the home are not robust enough to ensure that good quality care is delivered consistently.	

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

Document purpose	Review of compliance report
Author	Care Quality Commission
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