Review of compliance

Willow Residential Care Limited Willow House	
Region:	South East
Location address:	2 Reading Road Farnborough Hampshire GU14 6NA
Type of service:	Care home service without nursing
Date of Publication:	March 2012
Overview of the service:	Willow House is located in a quiet residential road in Farnborough, within easy reach ofthe town centre and other local amenities. Willow House offers personal care for up to eighteen older people over the age of sixty-five years who may have dementia care needs. Communal areas in the home include a sitting room, a dining room and a quiet room. There is a passenger lift to enable residents to access all areas of the

	home.

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

Our current overall judgement

Willow House was not meeting one or more essential standards. Improvements are 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, carried out a visit on 12 January 2012, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

A number of the residents at Willow House had dementia and therefore not everyone was able to tell us about their experiences. To help us to understand the experiences of people have we used our SOFI (Short Observational Framework for Inspection) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

Residents who could express a view told us they were very happy at the home. They said that the staff were "kind" and " helpful.

They told us their bedrooms were kept clean and tidy.

Relatives told us that there had been problems in the past but that they were now happy with the care provided at the home. They told us they believed their relatives were safe living at the home.

Relatives told us they felt able to raise any complaints and that they would be responded to and dealt with.

What we found about the standards we reviewed and how well Willow House 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

Where able, residents and their advocates are involved in the decisions about their care.

There are instances where resident dignity is not protected and promoted.

Overall we found that Willow House was meeting this essential standard but, to maintain this we suggested that some improvements were made

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

The home has a care planning system in place to support people who use the service. However, the system is ineffective, because not everyone has an up to date care plan that is based on individual assessment.

Care plans are not sufficiently detailed to provide staff with the guidance required to ensure that people receive safe and effective care.

Residents are not given sufficient opportunities to take part in meaningful activities.

Overall we found that improvements were needed for this essential standard.

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

Systems are in place to ensure that staff know how to recognise abuse and how to act if they had any concerns.

Some incidences of injuries, sustained by residents, following falls, have been not reported to the appropriate health and social care professionals.

Overall we found that Willow House was meeting this essential standard but, to maintain this we suggested that some improvements were made

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

There are systems in place at the home to prevent the control of infection; however these systems are not always effective. The provider is not taking account of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance

Appropriate standards of cleanliness and hygiene in some areas of the home are not adequately maintained.

Overall, we found that improvements were needed for this essential standard.

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

Staff receive the necessary training and support to care for people who use service.

Records are not available to evidence that staff have supervision and appraisals to support them in their role.

Overall we found that Willow House was meeting this essential standard but, to maintain this we suggested that some improvements were made.

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 operation to monitor the quality of the service and to manage risks are ineffective.

There is no evidence to show that residents, relatives and other health and social care professionals had been asked about the care provided at the home.

Overall, we found that improvements were 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 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

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

Our findings

What people who use the service experienced and told us
Residents who could express a view told us they were supported and enabled to do things for themselves.

Relatives informed us that they were consulted about their relative's care needs, as and when appropriate.

Other evidence
We looked at the care records for three residents, and found that various sections of the plan had been signed by a resident or their advocate, for example, permission to take a photograph, personal details, night care arrangements and agreement to administration of medicines. This indicated that residents, their relatives and advocates had been involved in discussions about their care needs.

Care staff spoken with told us that residents and their relatives were invited to care reviews. They explained that this was to ensure that their choices, likes and dislikes could be discussed, and plans amended accordingly.

The care plans and risk assessments we looked at had been reviewed; however we noted that one of the care records recorded no change in need between February 2010

and November 2011. This was discussed with the registered manager at the time. She informed us that this person's care had been reviewed, however she was unable to provide a reason for this not being recorded.

We saw that bathroom and toilet doors did not have locking mechanisms fitted to them. Therefore residents could not be sure that their privacy would be respected. This was discussed with the staff and registered manager at the time. They told us that when any residents used the bathroom or toilets, a member of staff would always support them and ensure privacy was maintained.

As discussed at the beginning of this report a number of the residents who live at Willow House had dementia and therefore not everyone was able to tell us about their experiences. To help us to understand the experiences of people have we used our SOFI (Short Observational Framework for Inspection) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences. Through out our visit we observed the interactions between residents and staff.

We observed staff knocking on doors prior to entering a room and we heard residents being addressed in a respectful manner.

We saw that one resident was asleep with their head on the dining room table; Staff had failed to notice that they required a handkerchief. We had to bring this to the attention of the registered manager before it was addressed.

We saw other residents slumped in their chairs asleep, their mouths were open and no one had attempted to ensure that their faces were kept clean and comfortable

Our judgement
Where able, residents and their advocates are involved in the decisions about their care.

There are instances where resident dignity is not protected and promoted.

Overall we found that Willow House was meeting this essential standard but, to maintain this we suggested that some improvements were made

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

Our findings

What people who use the service experienced and told us
Residents who could express a view told us they were happy with the care provided at the home.

Relatives told us their relative was happy and contented at the home. They said staff were kind and caring.

Another relative told us that staff talked to them about their relatives care, and always kept them informed about any changes in their relatives needs.

Relatives told us that they never saw their relative take part in any activities, nor had they seen any activities going on at the home.

Other evidence
We discussed the admission procedure with the registered manager. She informed us that, prior to a person's admission to the home; they would source as much information as possible about the person to determine if their care needs could be met by the home. She said that the information would be sought from different sources, for example from social services care management teams, GP or hospital. She told us that she would undertake the pre-admission assessment of the prospective resident. She also told us that the assessment could be undertaken at the persons home, hospital or at the care home. Relatives, we spoke with, confirmed this.

During our visit the registered manager left the home to carry out a pre-admission

assessment on a prospective resident.

We looked at the pre-admission assessment of a resident admitted to the home on 17 November 2011. The assessment was undertaken by the registered manager. The assessment included a number of areas for assessment, for example; general health, personal hygiene, mobility and safety, activities likes and dislikes.

However, when we looked for this resident's care plan we were informed that a care plan had not been completed. This means that care staff had no guidance as to how to meet this resident's needs. We asked staff how they knew what this residents' needs were, they informed us that they "looked at the pre admission assessment" and "just got to know what his needs were by talking to him and watching him". We discussed our concerns with the registered manager at the time. She instructed a member of staff to work on developing a care plan. Staff showed us the records they kept of this person's daily living activities; these were detailed and gave an overview of this person's day.

We looked at two further care plans and found they had been completed. However they were lacking in detail, and did not provide the reader with clear guidance, as to how resident's needs should be met.

We discussed care planning with the care staff. They talked about the "Key Worker" system in use at the home. They told us that they were directly involved in developing and reviewing the care plans. They said they had responsbility to report any changes in a resident's needs to the manager.

We saw that risk assessments reflected the care needs assessments and care plans, for example; falls risk assessments, skin integrity risk assessments, and mobility assessments. The risk assessments had been reviewed and updated as necessary.

As discussed earlier in this report a number of the residents who lived at Willow House had dementia and were therefore unable to tell us about their experiences. To help us to understand the experiences of people, we have we used our SOFI (Short Observational Framework for Inspection) tool. The SOFI tool allows us to spend time watching what is going on in a service and helps us to record how people spend their time, the type of support they get and whether they have positive experiences.

We spent time observing staff interact with residents at different times of the day, but more specifically between 10.00 - midday and the lunch time period.

We spent a considerable amount of time in the main lounge area of the home. We noted that the television was on through out this period, and it was very loud. We saw that children's programmes were being shown. Residents moved in and out of this room as they wished. Some watched the television, others spoke with each other. However, we observed that some residents were asleep in this room. Between 10.00am and 10.40am no care staff came into the lounge to check on the residents. At 10.40 one member of staff came in to the room to give the resident's a drink and a biscut. No one interacted with the resident's again untill 10.59. One member of staff, spoke with one resident, sat down and held their hand, this person responded with a smile.

We spoke with the care staff and the registered manager about the lack of supervision

of, and staff interaction with residents. The care staff told us that they had been "doing the beds and tidying up". The registered manager told us that she observed the residents from her office. This office was adjacent to the lounge room door.

During the morning we noted that no activities had taken place. We spoke with the registered manager and staff about this. Again staff told us that they had to ensure that the beds were made and other tasks were attended to They showed us the daily dairy where they had recorded some activities on previous days. They said that an activities person was employed to work on Wednesday, Thursday and Friday afternoons.

We observed the activities co-ordinator in the lounge area in the afternoon. We heard them trying to get people involved in doing jigsaws. Two people joined in. Three other residents were slumped in their chairs asleep, others were walking around the home or looking in the direction of the television.

We spoke with the activity co-ordinator, she told us that it was difficult to get all of the resident's engaged in activities. She discussed the need for reminiscence materials, as none were available for her to use. We asked where the activity equipment was kept, she informed us that she had to store the equipment in her own home due to the lack of space at Willow House. The provider later informed us that activity equipment was stored at Willow House, for example; reminesence DVD's, jigsaw puzzles, bingo and art and craft materials, board games and musical equipment.

Our judgement
The home has a care planning system in place to support people who use the service. However, the system is ineffective, because not everyone has an up to date care plan that is based on individual assessment.

Care plans are not sufficiently detailed to provide staff with the guidance required to ensure that people receive safe and effective care.

Residents are not given sufficient opportunities to take part in meaningful activities.

Overall we found that improvements were 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

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

Our findings

What people who use the service experienced and told us
Residents who were able to express a view told us they felt safe living at Willow House.

Relatives commented that they believed their relative was safe and well cared for at the home, and that no restrictions were placed on their relative, apart from the main front door being kept locked to protect them.

Other evidence
Social care professionals told that they had received allegations about poor care provided at the home. However, when these concerns were investigated they were not substantiated.

Staff informed us that they were aware of the home's protection of vulnerable adults' procedures and they had access to them as required. We discussed scenarios with them in respect of potential safeguarding issues. They were clear as to the procedure to be followed if they suspected or observed someone was being abused. They informed us that they would contact the registered manager immediately and ensure the person was kept safe from harm.

We also talked about the homes whistle blowing procedures. Staff were unclear as to how the whistle blowing procedures differed from the safeguarding procedures. This was discussed with the registered manager at the time.

We looked at the safeguarding policy and procedure and found that it included the local

authority multi-agency safeguarding procedures.

The registered manager told us she worked in collabaration with the local authority to safeguard and protect the welfare of people who live at the home. However, we saw from the records of incidents and accidents, that some injuries sustained by residents following falls, had not been referred to the appropriate health and social care professionals. This was discussed with the registered manager at the time.

Staff told us they had undertaken training regarding protecting vulnerable adults from abuse. We saw training records that confirmed this.

We asked the registered manager and staff if they had undertaken any training regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. They informed us that they had. We looked at training records and they confirmed that staff had undertaken this training. This means that they would have an understanding of the issues that may arise in respect of people who do not have the mental capacity to make decisions about their health and daily life.

We looked at daily care records written by staff, and did not see any entries that gave us cause for concern.

Our judgement
Systems are in place to ensure that staff know how to recognise abuse and how to act if they had any concerns.

Some incidences of injuries, sustained by residents, following falls, have been not reported to the appropriate health and social care professionals.

Overall we found that Willow House was meeting this essential standard but, to maintain this we suggested that some improvements were made

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

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
Residents who could express a view told us their rooms were kept clean and tidy.

Relatives told us the home was clean and tidy and that they could not fault anything.

Other relatives told us that at times there were unpleasant odours in the home.

Other evidence
During our visit we walked around the home, we looked in all of the bedrooms, bathrooms, toilets, communal areas, the kitchen and the laundry.

We found that there was an odour of urine in a number of bedrooms.

We looked at mattresses and pillows in the bedrooms and found that those without waterproof covers were stained. We were shown replacement pillows that had been bought for some of the rooms.

In the upstairs bathroom, we saw that the bath seat was extremely dirty, and was covered with a black substance, also there was a used bar of soap sitting on this seat, it was dirty with a gritty substance on it. This was brought to the registered manager's attention at the time. She arranged for these items to be removed.

We observed that there was a receptacle for antimicrobial hand gel; however we found that this was empty.

We noted that the lid on the receptacle for soiled incontinence pads was broken. We

also observed that a swing top bin was in use in the downstairs bathroom for soiled incontinence pads. The resident's would have been able to remove soiled items from these bins, putting themselves at risk of harm to their health. There was also an infection control risk posed by staff having to touch the lid of this bin with their hands.

We noted bottles of shampoo and bath/shower gel in the bathroom. This indicated to us that staff used the same shampoo and shower gel for some residents. We discussed this with the manager at the time; she told us that all of the residents had their own toiletries. We did see toiletries in individual bedrooms.

The upstairs communal toilet did not have any soap or hand towels. This means that residents using this toilet would not be able to wash and dry their hands properly. This issue was addressed by the registered manager at the time.

We saw, that there were containers of antimicrobial hand rubs in place at various areas in the home. However, all but the one of these was empty. We observed that the one sited by the front door, was being used by visitors to the home. The registered manager showed us that there were considerable stores of cleaning equipment and antimicrobial hand rubs in place at the home, clearly staff had not replenished the empty containers when required.

We observed that disposable gloves and aprons had been supplied for staff to use.

The flooring in the laundry was cracked; this meant that it could not be properly cleaned. The registered manager informed us that she had requested that this flooring be renewed.

In the kitchen we saw that grouting was missing from some of the tiles behind the sink unit. This meant that this area could not be properly cleaned.

We asked the registered manager if they had a copy of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance. The manager told us that she was aware of the Code of Practice; however we were shown an out of date infection control document. We asked if anyone had been delegated the responsibility for monitoring infection control. We were told that no one had been delegated this responsibility.

We were shown the cleaning schedules that were being used. The registered manager told us that the housekeeper was responsible for monitoring and auditing the cleaning in the home. However we observed that the audit was ineffective, because a number of areas of poor cleaning and poor infection control were identified during the visit.

Staff told us they had undertaken infection control training. This was confirmed by training records

Our judgement
There are systems in place at the home to prevent the control of infection; however these systems are not always effective. The provider is not taking account of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance

Appropriate standards of cleanliness and hygiene in some areas of the home are not adequately maintained.

Overall, we found that improvements were needed for this essential 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

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Residents who could express a view told us they were happy with the care provided at the home, and said that staff were good.

One relative told us that the staff were very good and seemed to know what they were doing. They said that their relative was well cared for.

Other relatives told us that some staff were good, but that others were not

Other evidence
Staff spoken with told us that they had undertaken a structured induction course which lasted for twelve weeks. We saw the induction paperwork used at the home, and this confirmed what staff had told us.

During our discussions with staff they talked about the training they had undertaken for example; health and safety, moving and handling, infection control, first aid, control of substances hazardous to health (COSHH), food handling safeguarding vulnerable adults, coping with aggression, dementia pathway, stroke awareness, equality and diversity and Mental Capacity Act (MCA) training. We looked at training records, which confirmed this training had taken place.

We asked staff how the registered manager supervised them. They told us that they had regular meetings with the registered manager, and that she spent a good deal of time working with them, and that she was always around if they required help.

We asked the registered manager to show us the records of one to one staff supervision. She told us that she had carried out one to one support meetings with staff; however she was unable to produce the records of these meetings.

Staff told us that they had regular team meetings, where they discussed rosters, care plans and other issues regarding residents. We saw the handwritten record of the most recent meeting dated 11 January 2012.

Our judgement
Staff receive the necessary training and support to care for people who use service.

Records are not available to evidence that staff have supervision and appraisals to support them in their role.

Overall we found that Willow House was meeting this essential standard but, to maintain this we suggested that some improvements were made.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Residents who could express a view told us they saw the registered manager on a daily basis.

Relatives told us that they had not received a survey regarding the standard of care at the home. However, they told us that if they had any issues with the standard of care then these would be discussed with the registered manager.

One relative told us that they had the provider's email address and in the event of any concerns they could contact him. However, they said they had not seen him in the home.

Other evidence
We asked the registered manager about the arrangements in place at the home for monitoring the quality of care at the service. She told us that she spent a considerable amount of time talking to residents and supporting staff. This was confirmed by staff.

The registered manager also told us that the provider visited the home once a week, to speak with resident's family's and staff. This was confirmed by staff. We asked the registered manager if the provider completed a report following his visit, we were told he did not. The manager said that if issues had been identified by the provider, they would be addressed at the time. However no records could be produced regarding these visits.

We were told that a service user questionnaire had been sent to people in 2010, and that any responses went to the provider. The registered manager told us that she had not seen the results of the survey. She also told us that surveys were not sent to residents, relatives and other health and social care professionals in 2011.

We saw evidence of some audits being undertaken; for example, house keeping audits, health and safety audits, kitchen audits and three monthly care plan audits. However, some of these audits were ineffective, as they had not identified issues detailed under other outcomes within this report

The registered manager also discussed a falls audit that was in the process of being implemented in collaboration with a local health care professional. This tool had been developed to identify individuals at risk of falling. This was later confirmed by the health professional involved.

We asked the registered manager if resident meetings were held. She told us that they did not have dedicated meetings, but that she spent time speaking with residents

We looked at the complaints log; it showed us that no complaints had been logged during 2011.

Our judgement
The systems in operation to monitor the quality of the service and to manage risks are ineffective.

There is no evidence to show that residents, relatives and other health and social care professionals had been asked about the care provided at the home.

Overall, we found that improvements were needed for 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.

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
	Why we have concerns: Where able, residents and their advocates are involved in the decisions about their care. There are instances where resident dignity is not protected and promoted.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Systems are in place to ensure that staff know how to recognise abuse and how to act if they had any concerns. Some incidences of injuries, sustained by residents, following falls, have been not reported to the appropriate health and social care professionals.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: Staff receive the necessary training and support to care for people who use service. Records are not available to evidence that staff have supervision and appraisals to support them in their	

	role.

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.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The home has a care planning system in place to support people who use the service. However, the system is ineffective, because not everyone has an up to date care plan that is based on individual assessment. Care plans are not sufficiently detailed to provide staff with the guidance required to ensure that people receive safe and effective care. Residents are not given sufficient opportunities to take part in meaningful activities	
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: There are systems in place at the home to prevent the control of infection; however these systems are not always effective. The provider is not taking account of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance Appropriate standards of cleanliness and hygiene in some areas of the home are not adequately maintained.	
Accommodation for persons who require nursing or personal care	Regulation 10	Outcome 16: Assessing

	HSCA 2008 (Regulated Activities) Regulations 2010	and monitoring the quality of service provision
	How the regulation is not being met: The systems in operation to monitor the quality of the service and to manage risks are ineffective. There is no evidence to show that residents, relatives and other health and social care professionals had been asked about the care provided at the home.	

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.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
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