Review of compliance

Treloar Trust Treloar College	
Region:	South East
Location address:	London Road Holybourne Alton Hampshire GU34 4EN
Type of service:	Doctors consultation service Care home service with nursing Specialist college service
Date of Publication:	April 2012
Overview of the service:	Treloar College is a term time residential further education establishment for up to 163 students with physical and/or learning disabilities. There are five residential houses and independent living flats on the campus and these are registered to provide

	personal care and/or nursing for the students 24 hours a day. The service is also registered to provide treatment of disease, disorder and injury and diagnostic and screening procedures. The campus is large with varied facilities.

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

Our current overall judgement

Treloar College 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 to check whether Treloar College had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 13 September 2011, carried out a visit on 29 September 2011, carried out a visit on 30 September 2011, 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

All the students we spoke with, whether new or returning students, enjoyed being at college. They told us they had the support they needed and they liked the staff and the environment.

The staff told us there had been many improvements over the summer. These included the introduction of the 'young person's plans', although one manager said these were still being worked on to improve the information they held. The improvements also included the way staff communicated between different areas of the college to keep up to date with the needs of the students and the way safeguarding was managed.
Most of the relatives we spoke with were happy with the service their family member received and the way they could communicate with the staff. However, two relatives were very dissatisfied with the service their family members had received and both these instances were being investigated by the Local Authority.

What we found about the standards we reviewed and how well Treloar College was meeting them

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

Although there have been some improvements in the assessment of care needs and the care being provided to students, the provider is still not protecting the students sufficiently against inappropriate care. This is because the planning and delivery of their care needs is inconsistent.
Overall, therefore, we found that there were areas of non-compliance with this outcome.

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

We found that improvements have been made to ensure the students are protected from the risks of harm or abuse. However, we need to see further evidence that the safeguarding systems are properly embedded.
Overall, we found the college to be compliant with this outcome but we have made improvement actions to ensure that this is maintained.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The college does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of appropriate arrangements for the obtaining, handling, using and safe administration of medicines.
Overall, therefore, we found that there were areas of non-compliance with this outcome.

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

We found the provider has a system for assessing and monitoring the quality of the service. However, the provider has not ensured this has been used effectively to make improvements and we are concerned that the systems are still not robust enough to identify concerns over the quality of the service being provided.
Overall, therefore, we found that there were areas of non-compliance with this outcome.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

Although improvements have been made to the way the college notifies us of incidents, we are concerned that there has been insufficient time to assess this fully. We need to monitor this over a longer period.
Overall, therefore we found the service to be compliant but we have made an improvement action to ensure they sustain this.

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 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with 11 students during the inspection visits. All the students said they enjoyed being at college. All the students told us they had the care and support they needed. Two students said the staff responded quickly if they used their call buzzer. Four students we spoke to said they were offered a shower every day and they chose when they got up and went to bed.

Other evidence
For information regarding 'other evidence' for this outcome please refer to the full text in the review of compliance report dated January 2012. This report includes the evidence that relates to the review carried out in September 2011.

Our judgement
Although there have been some improvements in the assessment of care needs and the care being provided to students, the provider is still not protecting the students sufficiently against inappropriate care. This is because the planning and delivery of their care needs is inconsistent.
Overall, therefore, we found that there were areas of non-compliance with this outcome.

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
All the students we spoke to, except one, told us they felt safe at college, and they all knew who to go to if they had any concerns. The students said they had been told about safeguarding and this had been discussed at house meetings and in lessons. One student said there had been some concerns about how safe they felt with another student and this was a continuing worry, but they said it was being dealt with by the staff.

Other evidence
When we visited the college, earlier in the year, we identified major concerns with the safeguarding systems. Since then, the provider sent us a safeguarding improvement plan and an interim report on progress towards compliance prior to our September inspection visits. These documented how and by when the college would become compliant with this outcome.
When we re-visited in September 2011, we found the college had made a considerable amount of progress in line with the plan and all the available staff had completed safeguarding training over the summer period. Agency staff had also been invited to attend the training and had been given induction books containing safeguarding information. We spoke to six members of staff, including two senior members of staff, during our inspection visit on 13 September 2011 and all the staff we spoke with could describe what they had understood from the training. They were also very clear about how they would report and record any safeguarding concerns and that they all had a responsibility for safeguarding the students. Mental Capacity Act training had also been delivered to staff over the summer period and this was aimed at developing staff

understanding. When we met the Principal during our inspection visit on 13 September 2011, she confirmed that all available staff had received 11 hours of training over the summer period since we had completed our last review in July. It was clear that this training had had a positive impact on staff.
New written safeguarding guidance had been issued over the summer by the college to staff and the training had been recorded on DVD so staff could watch this again if needed. We saw evidence that staff had signed to confirm they had received and understood the new guidance. However, when we spoke to staff during our inspection, most said that their managers had not tested their understanding of the new guidance with them to date and one senior manager confirmed they had not yet tested their team's understanding of the new guidance. Following feedback from staff, this guidance was being reviewed and was due to be re-issued later in September 2011.
The college had also reorganised the management team which had resulted in the creation of a new Safeguarding Manager role at the college. At the time of our visits, the role had been advertised and interviews of the applicants were ongoing. However, subsequent to our visits, we were told that the college had been unable to find a suitable candidate for the role and this job had now been re-advertised. In the meantime, a consultant had been employed to cover the vacancy. It was of concern that this vacancy had not yet been filled substantively.
During our inspection visit, the Principal explained that the senior management team had all received Level 3 training in safeguarding and we were advised that the senior managers were now all involved in handling disclosures made at the college. There was an 'on call' rota being put in place to handle calls from staff and students about safeguarding issues and this was due to be staffed by the senior managers at the college. Guidance to support staff on the 'on call' rota was also being developed. In the meantime, the safeguarding consultant was covering this. One member of staff described how they had used this new system to raise a concern. The staff we spoke with during our inspection also showed us the out of hours contact numbers attached to their identification badges that had been distributed to them before the last term ended. It was evident that the importance of reporting and the systems for reporting had been communicated to staff.
The Principal told us that the local authority had visited in early September to review the college's safeguarding improvement plan and check the safeguarding files and they had given feedback on this.
The safeguarding consultant told us they had been reviewing all of the college policies relevant to safeguarding but it was not clear whether these had been re-issued or communicated to staff yet.
During our visit we saw there were displays around the college and the houses, about how students and staff could report any safeguarding concerns with contact numbers for them to use. However, the name of the safeguarding officer was still on the displays, despite the fact that she was on long-term sick leave at the time. We raised this with the Principal during our inspection.
We were told that there had been three safeguarding reports raised since the start of term and these had been referred to the local authority. The safeguarding consultant confirmed that at least two of the cases had been referred to her within 24 hours of the incident occurring. The safeguarding consultant explained how the case referred to above by a student was being managed by staff.

Our judgement
We found that improvements have been made to ensure the students are protected from the risks of harm or abuse. However, we need to see further evidence that the

safeguarding systems are properly embedded.
Overall, we found the college to be compliant with this outcome but we have made improvement actions to ensure that this is maintained.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not, on this occasion speak to people about this outcome, so cannot report what people using the service said.

Other evidence
We had visited the service in May 2011 and found non-compliance with this outcome. As a result of our judgement, we issued an urgent compliance action to the college and made a compliance action in our report. The college sent us an action plan stating how and by when they would become compliant with the regulation.
Since that time, the college had employed a specialist pharmacy consultant, to advise the provider, and implement the action plan. The consultant had contacted our CQC pharmacy team on several occasions seeking advice. The questions being asked led us to be concerned about the consultant's ability to provide accurate and appropriate medication guidance to the college. We wrote to the provider in September 2011 informing them of our concerns.
The local authority told us they had also, on several occasions, used their pharmacy specialist to advise the provider.
As part of this review of medicines management, we visited the college. We talked to staff and looked at medicine records. We visited two of the houses and the health centre.
Students who used the service had their medicines given at the times that they needed them whilst on the college site. However, we had concerns that some students did not have access to the medicines prescribed for them to use in emergency situations when

they were away from the college. For these students care staff had to rely on the normal emergency services should the need arise. The college's policy made no reference to the use of medicines to treat medical emergencies either on site or off site.'
Information about how these medicines were handled off site was conflicting. Some staff said that students would be accompanied by care staff trained to give them their medication, whilst others said that no medicines for medical emergencies went off site and care staff would call 999 in an emergency.
Most medicines were prescribed and supplied for individual students. In addition to these, the college held a small stock of some prescription only medicines. When these were supplied to students, this was not done in a way that complied with the law.
Students were supported to self-administer their medicines independently where they were able and wished to do so. Any risks that this might present had been identified and minimised.
While some medicines were now being given to students in their houses, some students still had to go to the health centre to get their medicines. We saw students being given their medicines in a public area outside the health centre treatment room. This meant that, although the students received their medication, this was not being carried out in a way that met the students' need for privacy and dignity.
When students were prescribed medicines to be given only when needed, PRN (when required medicines) protocols were available in addition to the medicines care plans.
We found that procedures were in place for investigating adverse events, incidents, errors and near misses. The college said that they were aware of two incidents this term. One had been investigated and a second was under investigation.
One relative spoke to us and told us about an incident where staff had attempted to give their family member the wrong medication on more than one occasion. This student had recognised the errors. The investigation into this incident was still ongoing at the time of writing this report.

We looked at the medicines storage and found that all medicines were safely locked away. However, the cupboard provided for the storage of medicines liable to abuse, known as controlled drugs, did not comply with the law, as it was not correctly secured to a solid wall.

Our judgement
The college does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of appropriate arrangements for the obtaining, handling, using and safe administration of medicines. Overall, therefore, we found that there were areas of non-compliance with this outcome.

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
The students told us they had opportunities to contribute their views. They said there were regular house or corridor meetings and they had a card they could use to contact senior staff.

Other evidence
During the last inspection, we had major concerns that the college was failing to assess and monitor the quality of the service. Therefore, there was a failure to identify concerns and take action to improve the service.
The college sent us an improvement plan and an action plan after the last inspection. These documents detailed how and by when the college intended to become compliant with this outcome. The college had also introduced a quality audit calendar that outlined what aspects of its service it intended to audit and review over the year ahead. However, we did not see evidence of how this had been implemented at the college nor any findings from the audits for the first month, apart from a sample of the 'young persons plans' that had been audited. Therefore, this has not yet been embedded fully. During the latest inspections, we also found the college had failed to meet a number of their own deadlines for improvement that were included in the improvement and action plans.
We found there had been a change in the way the college monitored its own systems and took action to improve the service. The senior staff told us how they now monitored safeguarding issues and how they ensured these were notified to external agencies without delay. The staff told us they had started to audit the 'young persons plans' and there was a plan for continuing to do this and to make improvements to the plans. We

saw a sample of these audits and some action had been taken as a result, However during our September inspections we found there were still considerable improvements to make.
The college had employed a number of consultants who were responsible for setting up new systems that should have improved the service provided by the college. However, the consultant pharmacist had sought our advice on a number of occasions until we raised this as a concern with the Principal in September 2011. The local authority told us the pharmacy consultant had also required advice from them whilst developing a new medication policy and this policy had contained errors. Another consultant employed by the college had also sought our advice on several occasions about how to meet our regulations. This meant the people the Principal had charged with monitoring quality and making improvements had also needed guidance from us and other agencies. This did not give us confidence that the provider was proactively managing the quality of the service, identifying non-compliance and taking appropriate action to become and remain compliant.
During our recent inspections, the Principal told us how they regularly reported the results of quality monitoring to the trustees. We were also told that a task group met twice weekly to update action plans and check progress and a report was produced weekly to a Trustee and Governor Task Group. However, we did not see any evidence of the work of these groups and their reports during our inspection visits.
During our inspection visit on 13 September 2011, the Principal explained the new electronic notification system that was due to be introduced shortly. However, the Principal was unclear at the time of our visit, when we asked, about whether this system would be able to provide analysis of any trends. Therefore it was not clear how the college would be able to identify trends and themes arising from notifications and use this information to improve the service provided by the college. The provider has since informed us after our visit that trend analysis will be a function of the new system.
The local authority had also continued to provide considerable support and guidance to the college since our last review and throughout the last few months.
Prior to our previous inspection in May 2011 and the involvement of the local authority, the college had failed to identify for itself the failings we identified or to effectively assess and monitor the quality of the service being provided. Since then, although the college had put in place some measures to improve its quality monitoring, we did not have evidence that compliance had been achieved or sustained.

Our judgement
We found the provider has a system for assessing and monitoring the quality of the service. However, the provider has not ensured this has been used effectively to make improvements and we are concerned that the systems are still not robust enough to identify concerns over the quality of the service being provided.
Overall, therefore, we found that there were areas of non-compliance with this outcome.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

The provider is compliant with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We did not, on this occasion speak to people about this outcome, so cannot report what people using the service said.

Other evidence
We analysed the information we had about whether the provider had notified us about incidents without delay, as they are required to do.
We found the provider had sent us notifications since the start of term and further incidents had been notified since the visits in September 2011. We were told that the Principal now had shared responsibility for reporting notifications alongside the Nominated Individual.
Although not all of these notifications had been sent without delay, there were reasons for this, such as the Principal not being aware of an incident until some time afterwards or the incidents not having a specific date but being over an unspecified period of time.

The local authority informed us of one incident which the college had failed to notify to us as they were required to do.
The Principal explained to us the new system for notifying us of incidents. This included a new electronic system that was nearly ready to be implemented. We were told that senior staff were being trained in how to send notifications to us and senior staff we spoke with confirmed they had seen demonstrations of this new system. However, a paper system was still in use at the time of the latest inspection.
During our inspection visit on the 30 September 2011, we saw examples of incidents and, where appropriate, these had been sent to us as required.

Since this review we were told, by senior college staff, during a meeting to update us on progress, about an incident that was notifiable. However the college had failed to inform us. The college staff had not recognised this incident as notifiable. This is further evidence that although systems were in place they were not being used consistently. However this example confirms our judgement that we need more time to assess whether the intended improvements are working in practice.

Our judgement
Although improvements have been made to the way the college notifies us of incidents, we are concerned that there has been insufficient time to assess this fully. We need to monitor this over a longer period.
Overall, therefore we found the service to be compliant but we have made an improvement action to ensure they sustain this.

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
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: We found that improvements have been made to ensure the students are protected from the risks of harm or abuse. However, we need to see further evidence that the safeguarding systems are properly embedded. Overall, we found the college to be compliant with this outcome but we have made improvement actions to ensure that this is maintained.	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: We found that improvements have been made to ensure the students are protected from the risks of harm or abuse. However, we need to see further evidence that the safeguarding systems are properly embedded. Overall, we found the college to be compliant with this outcome but we have made improvement actions to ensure that this is maintained.	
Accommodation and nursing or personal care in the further education sector	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: We found that improvements have been made to	

	ensure the students are protected from the risks of harm or abuse. However, we need to see further evidence that the safeguarding systems are properly embedded. Overall, we found the college to be compliant with this outcome but we have made improvement actions to ensure that this is maintained.	
Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	Why we have concerns: Although improvements have been made to the way the college notifies us of incidents, we are concerned that there has been insufficient time to assess this fully. We need to monitor this over a longer period. Overall, therefore we found the service to be compliant but we have made an improvement action to ensure they sustain this.	
Diagnostic and screening procedures	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	Why we have concerns: Although improvements have been made to the way the college notifies us of incidents, we are concerned that there has been insufficient time to assess this fully. We need to monitor this over a longer period. Overall, therefore we found the service to be compliant but we have made an improvement action to ensure they sustain this.	
Accommodation and nursing or personal care in the further education sector	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	Why we have concerns: Although improvements have been made to the way the college notifies us of incidents, we are concerned that there has been insufficient time to assess this fully. We need to monitor this over a longer period. Overall, therefore we found the service to be compliant but we have made an improvement action to ensure they sustain this.	

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
Treatment of disease, disorder or injury	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 there have been some improvements in the assessment of care needs and the care being provided to students, the provider is still not protecting the students sufficiently against inappropriate care. This is because the planning and delivery of their care needs is inconsistent. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Diagnostic and screening procedures	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 there have been some improvements in the assessment of care needs and the care being provided to students, the provider is still not protecting the students sufficiently against inappropriate care. This is because the planning and delivery of their care needs is inconsistent. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Accommodation and nursing or personal care in the further education sector	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 there have been some improvements in the assessment of care needs and the care being provided to	

	students, the provider is still not protecting the students sufficiently against inappropriate care. This is because the planning and delivery of their care needs is inconsistent. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The college does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of appropriate arrangements for the obtaining, handling, using and safe administration of medicines. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The college does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of appropriate arrangements for the obtaining, handling, using and safe administration of medicines. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Accommodation and nursing or personal care in the further education sector	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The college does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of appropriate arrangements for the obtaining, handling,	

	using and safe administration of medicines. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Treatment of disease, disorder or injury	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: We found the provider has a system for assessing and monitoring the quality of the service. However, the provider has not ensured this has been used effectively to make improvements and we are concerned that the systems are still not robust enough to identify concerns over the quality of the service being provided. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Diagnostic and screening procedures	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: We found the provider has a system for assessing and monitoring the quality of the service. However, the provider has not ensured this has been used effectively to make improvements and we are concerned that the systems are still not robust enough to identify concerns over the quality of the service being provided. Overall, therefore, we found that there were areas of non-compliance with this outcome.	
Accommodation and nursing or personal care in the further education sector	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: We found the provider has a system for assessing and monitoring the quality of the service. However, the provider has not ensured this has been used effectively to	

	make improvements and we are concerned that the systems are still not robust enough to identify concerns over the quality of the service being provided. Overall, therefore, we found that there were areas of non-compliance with this outcome.

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

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