Review of compliance

Sure Health Care Limited Derwent House Residential Home	
Region:	Yorkshire & Humberside
Location address:	Riverside Care Complex, Hull Road Kexby York North Yorkshire YO41 5LD
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	Derwent House Residential Home provides personal care and support for 32 older people, some of whom may be assessed as needing nursing care. There is currently no registered manager in post. Information about the service and how it operates can be obtained by contacting the home.

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

Our current overall judgement

Derwent House Residential 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, carried out a visit on 5 April 2012, carried out a visit on 10 April 2012, checked the provider's records, 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 spoke with five people who live at Derwent House. All provided us with positive comments about the home. One person said "I think this home is very good. I miss my own home, but as a second choice then this is very good." They added. "The food's good and the home's clean. The staff are very kind and the residents are friendly."

A second person told us "The place is fine. The staff are kind and polite. And I feel safe here." Another said "We are looked after so well and cared for so well, here. That's the best thing about living here.".

A third person added "The staff are fine. They'll do anything to help you." They explained that they chose which clothes to wear each day, but that care workers showed them different options from their wardrobe, to make it easier for them to decide.

One person said that there were "more plusses than minuses" about living there, although did add that the way care workers spoke to them did vary sometimes. This was the one negative comment we received.

All the people we spoke with told us they would tell someone if another person had been unkind to them. This is important, so that things can be looked into properly and put right, if necessary.

What we found about the standards we reviewed and how well Derwent House Residential Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People's privacy, dignity and independence were respected.

The provider was meeting this standard

Outcome 03: People who pay for a service should know how much they have to pay, what they are paying for, how to pay, and when to pay for it

People receive relevant written information about fees and contracts.

The provider was meeting this standard

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

People told us that they received good care, in line with what they needed. However risk assessments and associated risk management care plans provided insufficient information. Some individuals were being placed at risk of harm because following a fall, changes were not being considered, or advice sought, to reduce the incidence of another fall.

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

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

People told us that they felt safe and trusted the staff they came into contact with, and staff recognised the need to keep people safe from harm.

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 enough qualified, skilled and experienced staff to meet people's needs. Training records needed to be in place to ensure staff attended essential refresher training in a timely way. This would ensure their knowledge is up-to-date.

The provider was 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

There was no evidence of an effective quality audit process in place in order to identify, monitor and manage risks to people who used, worked in or visited the service.

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

Outcome 17: People should have their complaints listened to and acted on properly

Although the service had a complaints policy there was no evidence that comments and complaints made by people were responded to appropriately.

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

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People's care records were not stored securely to prevent unauthorised people having access to them.

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

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

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

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

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

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

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

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People's diversity, values and human rights were respected. People made comments like "the staff are kind and polite" and "The staff are very good. Very kind." Two people explained how care workers provided them with choices when they got up each morning, and how they were also offered choices at mealtimes. Three people said they went to bed when they wanted to. They said there was no set routine there, which they were expected to follow.

Two people we spoke with needed help with personal care. They confirmed that this was carried out in a way that respected their privacy and dignity.

One person told us their faith was very important to them. They had attended church twice in the relatively short time they had lived at Derwent House. This shows the service is recognising people's diverse needs and working to ensure these are being met.

Other evidence
We observed the way care staff communicated and generally behaved towards the people living there. The care workers were friendly and kind, and people were comfortable and relaxed in their presence.

We spoke with a healthcare professional who said that when visiting the home they had only ever witnessed positive interactions between the staff and the people living there.

We spoke with a visitor who similarly had always observed staff being polite and courteous, whenever they visited. They said that in their experience the staff were always kind and considerate.

We looked at four care records and found the daily monitoring records included information about people being provided with choices in their day-to-day routines. This helps to show that people are supported to remain in charge of their lives as far as possible. We spoke with two people living there and they told us that care staff had never discussed their care records with them. The provider could consider discussing people's care records with them, where appropriate, as this would enable people to say what matters to them, and they can be included in decisions about their care and support.

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

The provider was meeting this standard

Outcome 03:
Fees

What the outcome says

This is what people who use services should expect.

People who use services, or others acting on their behalf, who pay the provider for the services they receive:
* Know how much they are expected to pay, when and how.
* Know what the service will provide for the fee paid.
* Understand their obligations and responsibilities.

What we found

Our judgement

The provider is compliant with Outcome 03: Fees

Our findings

What people who use the service experienced and told us
We spoke to people using the service but their feedback did not relate to this standard.

Other evidence
We looked at this outcome as we had received information that people responsible for paying for their own care at Derwent House do not receive a contract. A contract describes both the home's and the individual's responsibilities and obligations whilst the individual lives there. It includes the terms and conditions agreed by both parties.

We spoke with one visitor who confirmed that their relative had agreed to, and received a contract when they moved to the home. They explained that they had a copy of the document at their home address.

We looked at the contracts for two people, one of whom had moved to the home in the last few months. We saw that these records were appropriately completed and signed by the individual, or their representative. And also signed by the home manager.

Our judgement
People receive relevant written information about fees and contracts.

The provider was meeting this standard

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is 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 we spoke with told us they received good care, which was in line with what they were wanting. One person said "We're looked after so well. And cared for so well. That's the best thing about living here." Another person told us "I tell the staff if I don't feel well. They get the doctor. He has always seen me in private in my room."

Other evidence
A visitor told us that their relative had "improved incredibly", since moving to the home. They said they weren't able to walk around at their previous care home, but now were able to walk around independently. They said this was due to 'good care'. They also added that the service telephoned them straightaway if their relative was unwell, or had had a fall.

We spoke with a healthcare professional who said they had no concerns about the care people living there received. They provided the example of how they had been given a good handover on their first visit to a person living there who was very sick. This is good practise and meant the professional knew how best to communicate with the individual.

We looked at four people's care records. Whilst we saw some good documentation, we also found some dates and signatures had not been recorded. We wanted to check that people's needs had been properly assessed before they moved to the home. These omissions meant we could not be certain, in those records we looked at, that this

assessment had been completed in a timely way.

We found daily monitoring records were completed for both day and night. These recorded people's activities and well-being. We also found the records documented visits from healthcare professionals like the doctor, district nurse or chiropodist.

However although we saw that risk assessments were in place these were not well completed, so that people may have received different levels of support from different care staff. For example 'Bath with 1 or 2' or 'Transfer from bed to chair with 1' doesn't state how these manoeuvres were to be managed in a safe, consistent manner.

We found that the falls risk assessment and the plans of care to minimise falls used a tick-box format, which in effect meant that the management of all the people's risk of falls was broadly the same.

We looked at the accident records, which the service has to complete. We found that there had been more than 45 instances over a four month period, where people had fallen. A few people had fallen a number of times. The evidence from these records showed that people's care needs were not being reviewed following these incidents, to see whether changes were needed to try to reduce the risk of the individual falling again. This meant that the service was not taking proper steps to keep people safe by ensuring they received appropriate care.

Our judgement
People told us that they received good care, in line with what they needed. However risk assessments and associated risk management care plans provided insufficient information. Some individuals were being placed at risk of harm because following a fall, changes were not being considered, or advice sought, to reduce the incidence of another fall.

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

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
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. All the people we spoke with told us they would tell either their relatives or a staff member if someone was unkind, or mistreated them. One person said "I'd definitely tell someone. But it's never happened to me."

Other evidence
We spoke with one care worker and one ancillary worker about abuse. Both were very clear that people needed to be protected from abuse and both recognised that they needed to report an incident promptly if they witnessed or were told of an allegation of abuse, even if they were asked not to report it. This is good practise and means staff recognise they cannot keep secrets in those circumstances.

We saw that contact details for the safeguarding team were displayed in the home so that staff could easily locate these details, should it be necessary. The service has also in the past referred appropriately to the local authority safeguarding team, who hold the responsibility to look into such allegations. We did though see one instance where the service had not reported an incident to the safeguarding team in a timely way.

The provider may find it useful to consider Mental Capacity Act assessments and Deprivation of Liberty safeguards when determining how best to provide care, in order to keep people safe from harm.

Our judgement
People told us that they felt safe and trusted the staff they came into contact with, and staff recognised the need to keep people safe from harm.

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 compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
There were enough qualified, skilled and experienced staff to meet people's needs. People we spoke with said they trusted the staff who worked there. The told us they were kind, polite and competent. One person told us "Yes. The staff are very good. They know what they're doing." People we asked thought there were enough staff working which meant they received care and support when they needed it.

Other evidence
The staffing levels on the day we visited were good. There were six care staff, a cook and three ancillary staff on duty. There were five people working the late shift. Thirty people were living there. The service has an activities person though we didn't see them on our visit. Staff were a visible presence and were attentive and available for people. We looked at the rota and found these care staff numbers were consistent through the week.

The rota showed that there was a reliance on several agency nurses to provide a high proportion of the cover, during the day. The care workers we spoke with were experienced and knowledgeable about people's care needs. The home manager informed us that she was recruiting new staff.

We found no evidence of any training records or a training plan, to demonstrate that care staff were supported to attend essential refresher courses in a timely way.

We were given no indication, both from talking to individuals and from observing the

way that staff interacted with the people living there, to suggest that staff were not suitably qualified. The provider may find it useful to re-establish and maintain robust training records to determine when staff need refresher training. Attending training in a timely way helps to ensure that the staff team's knowledge is up to date. This would help to demonstrate that people's health and welfare needs are being met by appropriately trained staff.

Our judgement
There were enough qualified, skilled and experienced staff to meet people's needs. Training records needed to be in place to ensure staff attended essential refresher training in a timely way. This would ensure their knowledge is up-to-date.

The provider was 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 minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using the service but their feedback did not relate to this standard.

Other evidence
A visitor told us that the service had quarterly Resident's meetings, but said that the last meeting had been cancelled. They didn't know why. They couldn't recall being asked to complete any type of survey, which would have given them the opportunity to give their views about how the service was running.

We didn't see any displayed information about past or future events, where people could provide their views about the service. Nor any other process, like for example a Comments book where people could write down what they think about the service and how it could be improved.

We saw some care plan audit forms, where nurses monitor their colleague's record-keeping. These were not recent though and there was no evidence that checks were then done to make sure that any shortfalls identified in the audit had been properly corrected.

We couldn't find any other evidence of any processes in place to monitor how the service was operating. There was no record of any changes made as a result of any comments or complaints made about the service.

Systems to assess and monitor the quality of the service provided needed to be implemented and properly maintained. People using the service needed to be consulted and be assured that their views were being listened to and taken into account when changes were discussed. A robust quality audit system will help to ensure that risks relating to the health, welfare and safety of people living there were being properly considered.

Our judgement
There was no evidence of an effective quality audit process in place in order to identify, monitor and manage risks to people who used, worked in or visited the service.

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

Outcome 17:
Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

The provider is non-compliant with Outcome 17: Complaints. 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 we spoke with told us they would tell someone if an individual was unkind to them. One person said if they had concerns about the service then they would tell their family. But they reassured us that they were happy there.

Other evidence
We looked at this outcome because we had received information since our last visit that a complaint made to the service had not been looked into properly.

We spoke with a visitor during our visit who said they would definitely speak with the manager if they had any concerns about the service. They said they had discussed some 'minor niggles' in the past and these had been sorted out to their satisfaction.

We also saw a leaflet in the reception area of the home which told people what they needed to do if they have a concern or complaint about any aspect of how the service was being run.

We found that the service has an appropriate complaints policy, which details how complaints about the home will be managed and the timescales by which complainants should receive a response from the service.

We looked at the complaints file and found five complaints received by the service in the past six months. We could find no evidence of any responses to these complaints. Nor any evidence that the concern had been properly investigated. We spoke with a

healthcare professional following our visit and found that one complaint had been dealt with appropriately, but we saw no record of this response, during our visit.

The service needs to evidence that it has an effective complaints system in place and that complaints are properly investigated, and wherever possible resolved to the satisfaction of the individual raising the concern. This would demonstrate compliance with the regulation.

Our judgement
Although the service had a complaints policy there was no evidence that comments and complaints made by people were responded to appropriately.

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

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We did not talk in detail to people about records kept at the service. One person told us they presumed they had care records, though they had never seen them.
Another two individuals expressed interest in the information their records contained, but said they had never seen them, nor been asked if they would like to see them.

Other evidence

There has been a change of manager at the service in the last month. On our visit we could not find many of the records that are needed for the service to demonstrate compliance. We could not find any policies and procedures. These are needed to provide guidance and support for all the staff working there, to ensure care practices and other processes are being managed in a safe, consistent way.

The service uses a tick box template for different care needs, like washing and dressing, or mobility. Although there was room for more individual information to be recorded, this part of the record was not well utilised. This means different people's care plans are often very similar, although their care and support needs are likely to be very different. This though has not affected people's positive views about the service and care staff we spoke with appeared knowledgeable about people's needs and about how the service operates.

Personal records were not always being held securely. We found that the care records for those people living on the first floor are stored in drawers on the upstairs landing. These are not kept securely. Once people get up and dressed each day then most of the staff's time is spent downstairs. This means any people living, working or visiting the service can readily access these records. They need to be kept securely so that only authorised people can access them and personal information remains confidential.

The home manager told us this would be addressed immediately. However when we contacted the home manager the day after our visit this had still not been actioned, so we have set a compliance action.

Our judgement
People's care records were not stored securely to prevent unauthorised people having access to them.

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

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
People told us that they receive good care, in line with what they need. However risk assessments and associated risk management care plans provided insufficient information. Some individuals were being placed at risk of harm because following a fall, changes were not being considered, or advice sought, to reduce the incidence of another fall.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.</td></tr>
<tr><td rowspan="2">Diagnostic and screening procedures</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
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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: People told us that they receive good care, in line with what they need. However risk assessments and associated risk management care plans provided insufficient information. Some individuals were being placed at risk of harm because following a fall, changes were not being considered, or advice sought, to reduce the incidence of another fall. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: There was no evidence of an effective quality audit process in place in order to identify, monitor and manage risks to people who used, worked in or visited the service. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
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: There was no evidence of an effective quality	

	audit process in place in order to identify, monitor and manage risks to people who used, worked in or visited the service. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
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Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 17: Complaints
	How the regulation is not being met: Although the service had a complaints policy there was no evidence that comments and complaints made by people were responded to appropriately. The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.	
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Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People's care records were not stored securely to prevent unauthorised people having access to them. The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
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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 28 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
Audience	The general public
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