Review of compliance

Somerset Redstone Trust Newstead House	
Region:	West Midlands
Location address:	43 Venns Lane Hereford Herefordshire HR1 1DT
Type of service:	Care home service with nursing
Date of Publication:	November 2011
Overview of the service:	Newstead House is located in Hereford and provides nursing care for older people.

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

Our current overall judgement

Newstead 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 to check whether Newstead House had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 11 - Safety, availability and suitability of equipment

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 September 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited Newstead House to check whether the home had made the improvements which we had required following a review in July 2011. We found that some of the improvements had been carried out, but in some other key areas, there had been a deterioration in standards, which had led to people receiving an unsafe standard of care.

We spoke to some people who live at the home and some relatives whose family members live at the home. Most of the people we spoke to were not happy with the service at Newstead House. They told us about times when people's privacy and dignity were not respected or promoted. Although people spoke highly of some of the staff, saying that they were "kind" and "very helpful when they have time", other people told us that they felt that the staff were too busy to spend time with them.

We saw that people's care needs were not always being met, and there was evidence that the home was not providing a safe standard of care to meet people's assessed needs.

People were at risk of not receiving enough to eat or drink at the home, because hydration and nutrition were not being managed safely. We saw that drinks were out of people's reach, and a relative told us that their family member was "always thirsty".

There had been improvements in the management of infection control risks, and also in the way in which equipment was maintained and serviced.

People were at risk of not receiving their medication as prescribed, because the home was not ensuring that records were accurate and that staff completed them fully.

There were not enough staff on duty at all times to meet people's needs in a timely manner. There was only one nurse on duty to meet the nursing needs of 32 people.

The home was not providing safe quality care and support, because the systems for monitoring the quality of the service were not effective.

What we found about the standards we reviewed and how well Newstead 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

The home does not ensure that people's privacy and dignity are respected and promoted.

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

The home does not provide a safe standard of care to meet people's assessed needs.

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

People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.

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

The home manages infection control safely.

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

Medication is not managed safely at the home.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

The home ensures that equipment is properly maintained.

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

There are not enough staff on duty at all times to meet people's needs in a timely manner.

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 home does not provide safe quality care and support, because the systems for monitoring the quality of the service are not effective.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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 major concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with a relative of a person who lived at Newstead House. They told us that staff were sometimes dismissive of their family member's feelings and said "they don't listen". They told us that staff did not always treat their family member with respect and said "they talk over (name of person) and make them feel they are a nuisance".

One relative told us that they didn't feel as though the staff welcomed the involvement of family members, and said that staff "think they know best".

We saw staff talking kindly to people, and they always knocked before entering people's bedrooms. However, we saw staff entering bedrooms and filling in charts without talking to the person in the room. Care records showed that staff did not always have a good understanding of the importance of respecting people's wishes and choices. For example, one person's daily records stated "(name of person) won't allow us to do it, even today I had to just do it without her consent knowing that if it got worse we are going to get blamed". The issue of providing care without consent is a serious one, and we have referred this to the Wye Valley NHS Trust under its procedures for the protection of vulnerable adults.

Other evidence

Other records by several members of staff, including registered nurses and the registered manager, contained comments such as "has been awful towards staff this morning"; "shouting out a lot this morning in an aggressive way for silly things", and "not easy to know if she is in pain since she screams all the time anyway". These comments do not show that people are treated with consideration and respect.

Our judgement
The home does not ensure that people's privacy and dignity are respected and promoted.

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
At our previous review of the home in July 2011 we had concerns about the management of people's care needs. The purpose of our visit was to ensure that people were receiving care which met their needs.

We saw that most people were spending the day in their own bedrooms, rather than in the communal lounges. It was not possible to see from the care plans whether or not this was their choice, and many of the people were not able to tell us their wishes, due to their frailty. One relative told us that they were concerned that their family member was becoming isolated because they had to spend all day every day in their bedroom.

Most people's bedroom doors were open, so we were able to see that some people did not have their call bells within reach. In two bedrooms, the call bells were on the floor under the bed. This meant that people might not have been able to call for help when they needed it.

We saw that staff were kind and caring in their approach to people, but that they were extremely busy. Staff told us that they did not have time to spend chatting with people, and one staff member said "there's a lot to get through so we just have to keep going till it's done".

We saw that some people were sitting on pressure relieving cushions and that there were pressure relieving mattresses on their beds. These help to reduce the risk of pressure area damage. It is important that people have regular changes of position if

they are at risk of developing pressure sores. Staff should assist people to change position if they are unable to do this for themselves. The home was using charts to show when people had been assisted to change their position. We saw that these charts had not always been completed and therefore there was no evidence to show that people's position had been changed as required.

Although some people had been assessed as being at high risk of pressure area damage, there were not always written instructions for staff about how to reduce the risk. The registered manager told us that the home was using agency staff, so it is particularly important that written information is available so that all staff provide consistent care which meets people's individual needs.

We saw a person lying in bed in their room. The person appeared frail and the care records showed that they were at risk of dehydration and malnourishment. Records showed that the person had not had their bowels open for nine days. The Medication Administration Record (MAR) chart showed that they had been prescribed some laxatives to be given when required. The records did not explain clearly how many laxatives had been given (please see the section on medication: Outcome 9 for more detail). There was no record that the person's GP had been informed, although the GP had visited the home that morning. The registered manager could not recall what the GP had been told, and had not recorded any action to be taken. We subsequently contacted the GP, who assured us that they would follow this up.

Some people at the home had wounds which needed dressings to be done by the nurses. The records did not always explain which dressings should be used or how often the dressings should be changed. One person's care records showed that the most recent dressing had been carried out ten days ago, but the records stated "continue to redress every three days". There were no records to show if any further dressings had been done. We asked the nurse on duty about the dressings, and she told us ""I think it's healed". There was no evidence in the records about the wound having healed. This means that people could be at risk of not having their wounds managed safely due to a lack of accurate information.

Other evidence
The care plans were being recorded on a computerised system, and there were also printed care plans. However, we found that some of the printed care records did not always contain the same information as the computerised care records. We asked some of the care staff whether they would look at the printed care plans or the computerised care plans, and they gave us varying answers. This means that staff may have inconsistent knowledge of people's care needs.

The care plans did not always provide consistent information. For example, one person's care plan stated that they were unable to weight bear, and needed the assistance of one care worker when mobilising. Staff told us that the person was unable to bear their own weight and needed two staff when mobilising. We asked the registered manager about this, and she told us that the person sometimes needed hoisting. There was no information about the use of a hoist in the care plan, and no information about the need for two members of staff to assist the person. Therefore if a member of staff had followed the care plan, they could have put the person at risk of injury.

Records showed that one person's mental capacity had been assessed in December 2010. The care plan stated "I am at low risk as I have been deemed to have mental capacity. I am at high risk as it has been deemed I have limited mental capacity". Therefore there was a risk that staff might not know how able the person was to make decisions.

Our judgement
The home does not provide a safe standard of care to meet people's assessed needs.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are major concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We walked round the home and could see people in their bedrooms, as the bedroom doors were open. We noticed that there were drinks available in each bedroom, but that some people were not able to reach their drinks. One person had a drink on their bedside table, but the table had been pushed against the wall and was out of their reach. A relative told us that drinks were routinely out of reach and that their family member was "always thirsty".

We saw that one person was lying in bed. The charts in their bedroom indicated that staff should be monitoring their fluid intake. The fluid intake chart for the previous 24 hours showed that the total intake had been 300ml. One day during the previous week, the only record of fluid intake was the one word "sips", and there was not a single day over the previous week where the records showed a fluid intake of more than 1050 ml. There was no care plan in place about the person's hydration needs, although other records showed that they were at risk of constipation and pressure sores. A low fluid intake increases the likelihood of constipation and of pressure area damage. We asked the registered manager how much fluid she would want the person to be taking over 24 hours. She told us "about 1000ml". The Royal College of Nursing (RCN) states "daily intake of fluids should not be less than 1.6 litres per day." (Water for Health, 2007).

The registered manager told us that the daily charts were checked by the shift leader every day, and signed to confirm that the checks had been done. She said that if people were not eating or drinking enough, she would implement two hourly fluids, and would document refusals and offer other drinks. There was no evidence that this was being done. The registered manager said that the nurses were checking people's daily

food and fluid intake. She told us that they did not total up the fluid intake but "have a look and see". It is important that staff and health professionals such as GPs can easily see how much fluid is being taken, and therefore a 24 hour total would provide this information. There was no evidence to indicate that any action had been taken to ensure that people received an adequate amount to drink.

Other evidence
Some people living at the home appeared to be very thin. We checked the weight charts for three people. One person's chart showed that they had been weighed only four times since January 2011, in spite of having a Body Mass Index (BMI) of 15, which indicates a high risk of malnutrition. The person's food intake chart showed that they were eating very little at most mealtimes, but there was no evidence that snacks had been offered between meals.

Another person appeared underweight. The records showed that the person had lost weight and stated that the person was "severely underweight". Records showed that the person had been weighed only three times since the beginning of the year.

We were so concerned about the risks to these two people that we have made referrals to the Wye Valley NHS Trust under its procedures for the protection of vulnerable adults.

Our judgement
People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.

Outcome 08:
Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
At our previous review of the home in July 2011 we had concerns about infection control. The registered manager sent us an action plan and told us what measures were being taken to make the required improvements. We checked several communal bathrooms and toilets. We found that they were generally clean and that equipment, such as commodes and bath hoists, was also clean. The corridors and communal lounges were clean and tidy.

Staff were seen to be wearing gloves and aprons when providing personal care, and we saw that they changed their gloves and aprons when they left each person's bedroom.

There were hand washing facilities available throughout the home, and the toilets and bathrooms contained liquid hand wash and paper towels. The use of liquid hand wash and paper towels helps to reduce the risk of cross-contamination.

Other evidence
There were a few minor shortfalls in the way the staff managed some aspects of infection control, but generally standards had improved to the extent that we considered that the home was compliant with this Regulation.

Our judgement
The home manages infection control safely.

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 major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
At our previous review of the home in July 2011 we had concerns about the management of medication. The registered manager assured us that the required improvements had been made.

We checked the medication records and found that there were still concerns, which indicated that medication was not being managed safely. The people who live at Newstead House rely on the staff to ensure that they receive their medication as prescribed. It is extremely important that records are accurate, so that staff know if a medicine has been given.

We saw that one person was prescribed a sleeping tablet to be taken at night when required. The Medication Administration Record (MAR) chart had been signed to show that it had been given at 21:00 on the day of the inspection visit, although the time when we checked the chart was only 14:15. Therefore the record was inaccurate.

One person had been prescribed a laxative with a variable dose of between one to five sachets to be given each day when required. The MAR chart showed that it had been given on most days, but it was not possible to see how many sachets had been given at each administration as this had not been recorded. The care records for this person showed that they had not had their bowels open for nine days, but there was no way of knowing how many laxatives they had been given.

Other evidence
We audited some medication to ensure that the home was maintaining accurate records of the stocks of medication. We checked paracetamol tablets which had been prescribed for one person. The MAR chart showed that 430 tablets had been carried forward from the previous month. The MAR chart showed that 15 tablets had been administered, therefore there should have been 415 tablets left. We checked the actual number of tablets and found that there were 373 tablets. The registered manager was unable to explain what had happened to the missing 42 tablets.

We were not able to audit some of the medication, as the staff had not recorded how much had been carried forward from the previous month. Some boxes were not labelled with the date of opening, so it was not always possible to know if the amount left in the box tallied with the recordings on the MAR charts.

The home was using codes to explain why medication had not been given. There was a code O which was described as meaning "other". This code had been used on many occasions, but there was nothing to explain what "other" meant, so it was not possible to know why the medication had not been given.

When we checked the MAR charts to see if people had received their lunchtime medication, we found that there were gaps on four charts, where the medication had not been recorded. When we checked the medication containers, it appeared that the medication had been given. Therefore the records were not accurate.

Some people had been prescribed medication, such as painkillers or sedatives, to be given as required. There was no information for staff to tell them when the medication should be given. For example, one person's daily records included the information "(name of person) was aggressive and agitated at bedtime, needed to have 2mg diazepam to calm down" and "shouted out all shift. Diazepam given with no effect". Diazepam is a medication which is often used for anxiety. There was no written information to tell staff about any other calming measures that could be used to prevent the person being given medication unnecessarily.

Our judgement
Medication is not managed safely at the home.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with Outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We did not discuss this Outcome with people living at the home.

Other evidence
At our previous review of the home in July 2011 we had concerns about some of the specialist equipment at the home. The registered manager told us that the required servicing of this equipment had been carried out, and that a schedule of servicing was in place. This meant that servicing would be carried out at the required intervals. Therefore the home has made the required improvements.

Our judgement
The home ensures that equipment is properly maintained.

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

There are major concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Newstead House is divided into three units: one which provides care for people who generally do not have nursing needs, and two which provide care for people with nursing needs. On the day of our visit, the registered manager told us that there were 32 people living at the home who had nursing needs. There was only one registered nurse on duty. Although there was a team of care staff to support the nurse on duty, the nurse had responsibility for the nursing care of these people, including the administration of medication, wound dressings and any other nursing needs.

We visited the garden wing of the home, where twelve people with nursing needs live. There were two care staff on duty, and they told us that ten of the twelve people living in that part of the home needed two staff to provide personal care. This meant that when they were busy assisting someone, there were no staff available for anyone else who needed help. They said that, if they need the support of a nurse, they were able to ask, but that having only one nurse on duty meant that sometimes "we have to wait quite a long time if she's busy upstairs".

We saw the effect that the low staff numbers were having on people when we went into the garden wing during the afternoon. We wanted to give a document to a staff member. We walked around the garden wing for five minutes but were unable to find any staff. We heard someone calling out from their bedroom, asking for help. We knocked and went into the bedroom. The person told us that they urgently needed to use the toilet and had been calling for several minutes. We told them that we would try to find staff to help them, and eventually found that both staff members were in one

bedroom providing care for another person. Therefore people were at risk of not having their needs met promptly.

Other evidence
We did not check the training records for staff at this visit, but some of the examples of poor practice throughout this report indicate that training had not been effective. We met with the new chief executive of Somerset Redstone Trust, which owns Newstead House, and he told us that staff training was one of his priorities.

Our judgement
There are not enough staff on duty at all times to meet people's needs in a timely manner.

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 major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
When we visited the home in July 2011 as part of a review of compliance, we found evidence of some shortfalls in the standards at the home. The registered manager sent us an action plan with details of the ways in which the required improvements would be put into place.

When we returned to the home in September 2011, we found that, although there were improvements in some areas, overall standards at the home had deteriorated since our visit in July. This did not give us any confidence in the quality assurance systems within Somerset Redstone Trust.

Throughout this report, we have identified areas of concern which should have been identified and managed by Somerset Redstone Trust. We have reported on risks which should have been assessed and managed. For example, we found that one person did not have a risk assessment in place for the use of bed rails even though there had been an incident, which was recorded thus: "found on routine check to have slid through cot side up to her waist both feet on the floor". The use of bed rails should be governed by a written risk assessment, and we would expect this to be updated after any incident, to ensure people's safety.

We also have concerns that the Trust does not have any clinical leadership for the nurses it employs. The chief executive told us that the registered manager does not receive clinical supervision. The Nursing and Midwifery Council (NMC) states that "clinical supervision allows a registered nurse to receive professional supervision in the

workplace by a skilled supervisor. It allows nurses and midwives to develop their skills and knowledge and helps them to improve care" and "Clinical supervision should be available to registered nurses throughout their careers so they can constantly evaluate and improve their contribution to the care of people."

Other evidence
Under normal circumstances, we would have begun to take enforcement action against the home. However, there have been significant changes in the senior management of Somerset Redstone Trust. We have met the new chief executive since our visit, and he has assured us that they are beginning to address the shortfalls as a matter of urgency. We have been working closely with the Wye Valley NHS Trust to ensure that people living at the home are safe.

We have decided to allow the new chief executive time to make the improvements which are necessary, and we have asked him to provide us with evidence of progress on a regular basis. We will continue to monitor the home, and will visit again to check that the service is compliant with Regulations.

Our judgement
The home does not provide safe quality care and support, because the systems for monitoring the quality of the service are not effective.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The home does not ensure that people's privacy and dignity are respected and promoted.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The home does not ensure that people's privacy and dignity are respected and promoted.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The home does not ensure that people's privacy and dignity are respected and promoted.	
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 does not provide a safe standard of care to meet people's assessed needs.	
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: The home does not provide a safe standard of care to meet people's assessed needs.	
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: The home does not provide a safe standard of care to meet people's assessed needs.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.	
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met:	

	People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Medication is not managed safely at the home.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Medication is not managed safely at the home.	
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: Medication is not managed safely at the home.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There are not enough staff on duty at all times to meet people's needs in a timely manner.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met:	

	There are not enough staff on duty at all times to meet people's needs in a timely manner.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There are not enough staff on duty at all times to meet people's needs in a timely manner.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The home does not provide safe quality care and support, because the systems for monitoring the quality of the service are not effective.	
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: The home does not provide safe quality care and support, because the systems for monitoring the quality of the service are not effective.	
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: The home does not provide safe quality care and support, because the systems for monitoring the quality of the service are not effective.	

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 7 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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