Review of compliance

Amocura Limited Haddon Court Nursing Home	
Region:	Yorkshire & Humberside
Location address:	High Street Beighton Sheffield South Yorkshire S20 1HE
Type of service:	Care home service with nursing
Date of Publication:	November 2012
Overview of the service:	Haddon Court is a nursing home registered for up to 83 people situated within Beighton Village, approximately five miles from the city centre of Sheffield. The home is within easy access of the local community, which has a selection of shops and churches. Haddon Court is a large purpose built three-storey care home. It provides nursing and personal care for older

	people who have a physical disability, nursing needs or have dementia.

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

Our current overall judgement

Haddon Court Nursing 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 10 July 2012, 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

People told us what it was like to live at this home and described how they were treated by staff and their involvement in making choices about their care. They also told us about the quality and choice of food and drink available. This was because this inspection was part of a themed inspection programme to assess whether older people living in care homes are treated with dignity and respect and whether their nutritional needs are met.

The inspection team was led by a CQC inspector, joined by a professional professional and an 'expert by experience' (a person who has experience of using services and who can provide that perspective).

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the SOFI and whilst walking around the floors of the home we saw lots of examples where people moved about the home independently. For example, some people used their rooms as they wanted and some spent time in the communal areas.

We saw that staff had a caring approach to people and people were treated with dignity and respect. Staff were polite towards people and behaved in an appropriate manner towards them.

People told us the manager or staff did ask if they were happy with the care provided and any changes they made involving their care, before they were introduced. They told us it

was their choice how they spent their time.

People we spoke with said they didn't like the meals provided. Some comments included, "it's edible but I don't always like it too much" and "I'm never hungry and have plenty to drink. I put up with the food. Sometimes it's ok, but most times it is ...". They told us they got a choice of menu, but it wasn't very good. They told us food was available between meals if they wanted it, but it was usually biscuits. We asked if anyone asked them what they liked to eat and they either said no or they didn't know.

The lunch time period was a poor meal time experience for some people. For example, one person who remained in their wheelchair for their meal, had their hoist sling velcroed around them, which kept going into their meal and some people were not offered alternatives, when they didn't eat their meal. There was no choice of sweet and people were not offered an alternative, if they didn't want the dessert on offer. People were not asked if they'd had enough to eat nor offered more. The trolley on which dirty crockery, cutlery and waste was placed, was sited next to a dining table where people were sitting, which wasn't very pleasant for those individuals.

People felt they could talk to the manager if they had any concerns or were worried about anything.

People we spoke with said it depended on the time of day as to whether there were sufficient staff to help them and sometimes staff were off sick so staff had to rush things and had no time to talk with them.

People we spoke with felt staff had the skills to look after them properly. They told us staff were always away training.

What we found about the standards we reviewed and how well Haddon Court Nursing 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

The provider was meeting this standard.

People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

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

People were not protected from the risks of inadequate nutrition and dehydration. This was because not all people had a choice of suitable food and drink to meet their needs or were supported to eat their meal in an appropriate way.

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

human rights

The provider was meeting this standard.

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.

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

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

There were not enough qualified, skilled and experienced staff to meet people's needs.

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

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

People were not protected from the risks of unsafe or inappropriate care and treatment.

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
During the SOFI and walking around the floors of the home we saw lots of examples where people moved about the home independently. For example, some people used their rooms as they wanted and some spent time in the communal areas.

We saw that staff had a caring approach to people and people were treated with dignity and respect. Staff were polite towards people and behaved in an appropriate manner towards them.

We saw that information was displayed about activities taking place and how people could make a complaint if they needed to.

We spoke with four people about how they felt they were treated by staff, how they were involved in discussions about their care and how they were able to influence the way the service was run.

One person told us that when they moved into the home arrangements for their care was explained to them, others couldn't remember or weren't sure.

They told us the manager or staff did ask if they were happy with the care provided and

discussed any changes they made involving their care, before they were introduced.

They told us it was their choice how they spent their time. Examples included, playing dominoes, bingo, shopping, a dentist visit, watching TV, going on trips or family taking them out. Some people felt there wasn't enough to do and would like entertainers.

One person told us they could never get to their call bell as it was never in reach. We saw that the majority of call bells were placed within reach of people for them to use.

People had single rooms with their personal things around them. Their rooms were able to be locked and they had a lockable space in their rooms to keep items safe, but people told us keys were not provided. We spoke to the manager who said keys were available if people requested them and she would address this with people.

Other evidence
Is people's privacy and dignity respected?

We asked the manager how they made sure staff respected the privacy and dignity of people using the service. They told us through observations, walking around, knowing people and making sure staff were aware of care plans. They said some staff had undertaken dignity training to provide them with the knowledge of what was expected when caring for people with dignity.

The manager told us they had two dignity champions and dignity was an agenda item at the staff meeting and one of the dignity champions completed a dignity audit each month.

We asked the manager if people were provided with a locked facility in their room. They said not everyone had a locked facility, but their was no reason why they couldn't be provided with one. Not being offered a locked facility can compromise people's ability to keep their confidential items, private.

We looked at six care files. The care plans paid particular attention to various aspects of care that demonstrated respect for people, including, what a person liked to be called and their likes/dislikes. Entries in the care plans reflected what each individual's wishes would be.

During interviews with six members of staff it was apparent that the staff took care to ensure people were treated with dignity. They all mentioned ensuring the doors were closed and offering towels/clothing to people to ensure they were covered up as much as possible during personal care. They also mentioned knocking on the person's door before entering.

Are people involved in making decisions about their care?

We asked the manager and deputy about how they made sure that options for care and treatment were explained to people and the risks and benefits outlined to them. They explained this would be done through their initial assessment and then at the yearly review. Where changes were made as part of the monthly review then this would be discussed with the person. They explained people were made aware of facilities at the home and about how they could get involved with making decisions about their care in

the service user guide that was provided on admission and was in their room after admission.

They explained the assessment and care plan would highlight any person's diverse needs, but currently the cultural make up of the home was white British.

They explained involving people in making decisions about their care was done with people through monthly discussions between the person and the activities co-ordinator that they would oversee. For those lacking capacity a comment would be made about their perceived wellbeing.

They stated the home had two activity co-ordinators and care staff would also do activities.

We looked at six care files. People's views and preferences about their care were sought at the point of admission to the care home and documented in the care plans. The information provided in the care plans was thorough, clear and put into practice by staff.

There was evidence in each person's notes of a discussion with the person and their family around whether they would like active medical interventions such as being resuscitated in the event of a sudden collapse and artificial nutrition and hydration.

We found care plans included reference to people's preferences and choices, for example, food and drink preferences. We saw that these preferences were adhered to during our observations.

We spoke with six staff. They told us people were consulted and provided with opportunities to spend their days how they wished, although resources and a lack of staff time limited this. One member of staff commented "Residents have a say but resources are few. Most residents stay in their room and have the TV put on for them". We observed that this did happen as we saw people in their rooms with their TV on.

One member of staff pointed out that there had recently been a 'chair aerobics' course at the neighbouring community centre which several people enjoyed. An ex member of staff also contacted us and they also told us about the chair aerobics and that activities were provided when funding was available.

Our judgement
The provider was meeting this standard.

People's privacy, dignity and independence were respected. Their views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

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

The provider is non-compliant with Outcome 05: Meeting nutritional needs. 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 said they didn't like the meals provided. Some comments included, "it's edible but I don't always like it too much" and "I'm never hungry and have plenty to drink. I put up with the food. Sometimes it's ok, but most times it is ...". They told us they got a choice of menu, but it wasn't very good. They told us food was available between meals if they wanted it, but it was usually biscuits. We asked if anyone asked them what they liked to eat and they either said no or they didn't know.

We spoke with one visitor who told us they take food in for their relative as the food served there is not very good.

We observed the lunch time period at the service to assess people's experiences of a meal time. We saw that people were offered tea or coffee to drink and provided with their meal they had chosen the day previously. Only one person was offered a different choice when they didn't eat their meal. There was no choice of sweet and people were not offered an alternative, if they didn't want the dessert on offer. People were not asked if they'd had enough to eat nor offered more.

The trolley on which dirty crockery, cutlery and waste was placed, was sited next to a dining table where people were sitting, which wasn't very nice for those individuals.

We saw staff supporting people to eat their meals, where they were unable to do this themselves. We saw that staff spent time with them encouraging them to eat. We saw that people were not rushed when being helped with their meal.

Other evidence
Are people given a choice of suitable food and drink to meet nutritional needs?

We asked the manager how they made sure choices of food and drink met people's nutritional needs. She explained that having a choice of suitable food and drink and balancing this with the food and drink being suitable to meet people's nutritional needs can be difficult. She said they start from the premise that menus include appropriate levels of nutrition and link this to choices that people like.

The manager explained the menus were due to be reviewed as a new menu had been put in place and some people were not happy with some of the choices. She explained there was always two choices at meal times, with choices being decided the day before. She said menu boards were provided in the dining room to remind people of the choices that had been available.

They said if people lacked capacity to make choices, discussions would be held with their family and others who may know the person.

The manager stated a budget was in place for food, which enabled sufficient food and drink to be provided for people.

We spoke with six members of staff. Care staff told us each person had a nutritional chart and input/output chart to record their daily intake of food and fluids and that 'MUST' assessment screening tools were completed for each person and updated on a regular basis. They told us people were weighed monthly and if assessed as high risk, were weighed on a weekly basis and referred to the dietician. Staff told us how they would identify people at risk of poor nutrition or dehydration.

Staff told us a choice of food was available and this was discussed with people the day before. Staff told us people were offered a choice of where to eat their meals, but encouraged them to dine in the communal dining area. Staff commented that they felt there was insufficient choice on the menus, with little flexibility for provision of alternative foods should a person not want the food on offer. This was especially so after the kitchen had closed. In contrast, the kitchen staff seemed to think they were doing a good job in meeting the needs of people using the service.

We looked at six care files and found examples of the service meeting and assessing people's nutritional needs, which matched what staff had told us and with what we saw.

Are people's religious or cultural backgrounds respected?

We discussed the cultural makeup of the home and we found all people who used the service were from a similar background, however, the manager said they would meet the diverse needs of people from different cultures and backgrounds through the assessment and care planning process.

We spoke with six staff who all confirmed there was no-one who had special dietary requirements for religious or cultural reasons.

Are people supported to eat and drink sufficient amounts to meet their needs?

We observed the lunch time period at the service to assess people's experiences of a meal time. On the top floor we saw that people were not encouraged to go to the dining room for their meals. The two people in the dining room eating their meal both needed assistance with their meal, which two staff in the room did not provide.

On the middle floor, we saw that one person who remained in their wheelchair for their meal, had their hoist sling velcroed around them. This meant the sling loop kept going into the meal, which made it a poor meal time experience for the person and did not promote good infection control.

We observed that a proportion of the people had to wait a long time for their meal to be served to them and between courses. This was because all care staff were sitting with those individuals needing a lot of support.

The manager told us they identified the level of support each person needed to help them eat and drink through their admission assessment and monthly reviews. They explained they had a nutritional screening tool to identify people at risk of poor hydration and nutrition. They told us they had good relationships and access to health care professionals when they needed it.

We spoke with six staff who explained to us how people were supported to eat and drink sufficient amounts for their needs. All care staff had an awareness of the importance of maintaining adequate nutrition and hydration in people and ways to improve this. For example, through individual likes/dislikes, offering alternatives and offering the meal again later.

We looked in six care files and found examples of the service meeting and assessing people's nutritional needs as described by staff and what we saw.

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

People were not protected from the risks of inadequate nutrition and dehydration. This was because not all people had a choice of suitable food and drink to meet their needs or were supported to eat their meal in an appropriate way.

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
We spoke with four people living at the service. They all felt they could talk to the manager with any concerns that they had or if they were worried about anything.

We saw that people interacted freely with staff and people told us staff treated them in a kind way. They felt their money and belongings were safe at the home.

We saw that staff used an appropriate manner when communicating with people, respecting their needs and wishes.

Other evidence
Are steps taken to prevent abuse?

We spoke with the manager about the steps they took to prevent abuse. The manager made sure that staff could identify potential abuse by providing safeguarding training. They had a safeguarding policy that included whistleblowing. They knew this worked because staff did report allegations of abuse.

We spoke with six members of staff. Staff were aware of the various signs of abuse and the various forms it could take. All were keen to emphasise that abuse was not a recognised problem at this particular care home. They told us there was a policy in place to report any witnessed abuse to their line manager. One member of staff said they would write a report to head office if necessary.

Do people know how to raise concerns?

The manager told us they made sure she heard what people who lived at the home wanted to tell them about raising concerns through overseeing the comments obtained by the activities co-ordinator monthly and being available to speak with people and stakeholders during her daily walk arounds.

Are Deprivation of Liberty Safeguards used appropriately?

In discussions with the manager we asked how they made sure where people were deprived of their liberty, this was done appropriately. The manager told us they were aware of systems and processes in place if restrictions needed to be made, but currently, they had no-one whose liberty was being deprived that needed authorisation. The manager told us that staff had attended Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS) training, but not all staff had attended this.

We spoke with six members of staff who were all aware of the MCA and DOLs, however, some of their knowledge was limited. In general, most staff were able to confirm that every person assumes capacity unless otherwise proven. They told us families would be invited to be involved in the decision-making processes for those who lacked capacity and for those with no family then an Independent Mental Capacity Advocate (IMCA) would be sought.

We saw information about DOLs was displayed at the service.

Our judgement
The provider was meeting this standard.

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.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is non-compliant with Outcome 13: Staffing. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
Everyone we spoke with said it depended on the time of day as to whether there were sufficient staff to help them and sometimes staff were off sick so they had to rush things and had no time to talk to them.

Everyone we spoke with felt staff had the skills to look after them properly. They told us they were always away training.

Other evidence
Are there sufficient numbers of staff?

We saw on the top floor that people were left unsupervised in the main lounge area for periods of time, which meant they were unable to obtain assistance in a discreet way.

On duty today on the middle floor was one nurse and four carers to help 9 people eat their meal and assist a further 16 people with their meal. Staff said usually there were five care staff. Staff told us six of those people remained in their rooms and two staff were assigned to help them, leaving usually three care staff and a nurse to help people in the dining room. One person during our observation was sat at the dining table 45 minutes before a member of staff came to help them with their meal. Others people were kept waiting, for example, between their main meal and sweet, because staff were busy with those people that needed full assistance. On the top floor six people needed assistance with eating and there was one nurse and two staff to carry out those duties and assist a further ten people with their meal.

The manager told us they identified how many staff they needed on each shift through assessing the level of care needed for each person. She stated there was a dependency assessment that was evaluated monthly in the plan of care.

We looked at staff rotas. In the main, staff rotas confirmed the shift patterns described by the manager, though routinely there were only two members of care staff and a nurse on duty on the top floor on the afternoon shift, not three members of care staff as stated.

We spoke with six members of staff. Kitchen staff told us staffing had been a problem because of sickness levels, but this had now been rectified. There was concern raised by the majority of care staff that there were insufficient numbers of staff, notably in the mornings to provide care for people using the service and to ensure adequate nutrition and hydration. This resulted in what two members of staff termed a 'conveyor belt' culture, having to rush to complete essential tasks meaning less time to talk and spend time with each individual. They said their concerns were continuously raised with the manager, but with limited outcomes.

Do staff have the appropriate skills, knowledge and experience?

We spoke with six members of staff. They had a good understanding of the needs of people who used the service. All the staff we spoke with were aware of the importance of adequate nutrition and hydration. Staff told us about the likes and dislikes of people who used the service in relation to food and drink and they were given regular updates regarding changes to people's needs. Staff were able to tell us about people who required special diets. All staff we spoke with told us they had completed training on maintaining people's privacy and dignity, nutrition, mental health and safeguarding and dementia.

The manager told us that they monitored staff performance in meeting people's dignity and nutritional needs through informal observations and any concerns would be addressed in supervision and the staff member offered assistance. If people had specific needs, for example, parenteral (intravenous administration of nutrients) feeding, they would arrange for staff to have training so that they could safely meet that person's needs. They stated training was also in place for maintaining people's privacy, dignity and independence and rights, safeguarding, caring for people with dementia and food hygiene.

The manager told us the basic food hygiene provided for kitchen staff needed updating, to ensure people's knowledge remained up to date. Specific training was sourced for safeguarding, caring for people with dementia and food hygiene from an external training company.

A senior manager provided the training schedule for August 2012 – July 2013 and this included, health and safety, challenging behaviour, equality and diversity, dementia, fire awareness, falls prevention, safeguarding, nutrition, dignity and independence, infection control and pressure care. We saw no food hygiene training planned, which was needed for staff in the kitchen as only two of the five staff had certification for food hygiene. The senior manager stated that would be sourced externally.

The day after the inspection the training statistics were provided. This identified the

majority of staff had not received training in dementia, DoLS and MCA and equality and diversity.

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

There were not enough qualified, skilled and experienced staff to meet people's needs.

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 minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with four people using the service. Only one person knew what their care plan was and said their family took care of it.

Other evidence
Are accurate records of appropriate information kept?

We spoke with the manager about how they assured themselves accurate records were kept of appropriate information. They said people were involved and consulted about their care plans on admission and at their yearly review and when there were any changes. She said nursing staff did evaluations and kept her informed. She stated care staff get to know any changes on handover, from the nurse.

We looked at six care files. A 'MUST' nutritional screening tool was completed, with monthly updates. Where risks had been identified the action to be taken was clearly documented. The care plans also took into consideration the needs, choices and preferences of people.

Are records stored securely?

Discussions with the manager identified care files and daily records were stored in the nurse's office. On the top floor, we found the main care files were kept in the office for

safekeeping, but providing easy access for staff. However, people's 'My Care' charts were left unattended in the main lounge, which means that unauthorised people could gain access to them if no staff were visible. Confidential care records should be securely kept, so that only authorised people can access them.

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

People were not protected from the risks of unsafe or inappropriate care and treatment.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People were not protected from the risks of inadequate nutrition and dehydration. This was because not all people had a choice of suitable food and drink to meet their needs or were supported to eat their meal in an appropriate way.	
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People were not protected from the risks of inadequate nutrition and dehydration. This was because not all people had a choice of suitable food and drink to meet their needs or were supported to eat their meal in an appropriate way.	

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: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People were not protected from the risks of inadequate nutrition and dehydration. This was because not all people had a choice of suitable food and drink to meet their needs or were supported to eat their meal in an appropriate way.	
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: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. There were not enough qualified, skilled and experienced staff to meet people's needs.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. There were not enough qualified, skilled and experienced staff to meet people's needs.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008	Outcome 13: Staffing

	(Regulated Activities) Regulations 2010	
	How the regulation is not being met: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. There were not enough qualified, skilled and experienced staff to meet people's needs.	
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: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People were not protected from the risks of unsafe or inappropriate care and treatment.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard. People were not protected from the risks of unsafe or inappropriate care and treatment.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider was not meeting this standard.	

	We judged this had a minor impact on people using the service and action was needed for this essential standard. People were not protected from the risks of unsafe or inappropriate care and treatment.

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

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