Review of compliance

Community Health Association of Shaftesbury Castle Hill House	
Region:	South West
Location address:	Bimport Shaftesbury Dorset SP7 8AX
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Castle Hill House provides accommodation and personal care for up to thirty older people, including people with dementia. The home has three floors, connected by passenger lifts. There is an accessible, secure garden. The home is situated near Shaftesbury town centre.

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

Our current overall judgement

Castle Hill House was not meeting one or more essential standards. Improvements are needed.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 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 the home between 9:30 am and 5:00 pm on Thursday 15 September 2011. We spoke with people that live in the home and with relatives who were visiting. We observed how care was given, and spoke with most of the staff that were on duty during the day. A member of staff not on duty contacted us separately.

We saw many positive interactions between staff and people in the home. For example, when people were sitting down, staff lowered themselves to chair height to engage with them. There were a few examples of less positive contacts by staff, such as not sitting alongside people when assisting them to eat. People living in the home presented as comfortable. We saw that people were supported to make choices about meals, drinks and how and where they spent their time. We saw instances of care workers engaging with people by reference to things or events that they knew were significant to them.

A person's regular visitor told us there was "an easy exchange of information" with the home. They also commented that the home appeared to be a very safe place to live. They said they would not agree to their relative being there if they thought otherwise.

Two regular visitors to the home thought there were enough staff to meet people's needs. Care staff we spoke to agreed, although they said they found themselves under pressure of time due to the range of essential care tasks to be accomplished. Staff told us they did not experience regular individual supervision, and they saw a need for more channels of direct communication with their managers.

What we found about the standards we reviewed and how well Castle Hill 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

People and their relatives are involved in the assessment of their care needs and how the home plans to meet them. People living in the home are respected in most staff interactions with them, thereby upholding people's dignityand supporting choice, but some staff do not show respect for people's individuality and perceptions. Overall, we found that Castle Hill House was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

People receive care that promotes wellbeing by taking account of their health and personal needs and preferences. Overall, we found that Castle Hill House was meeting this essential standard.

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

People are being protected from abuse because managers and staff at all levels understand the signs of abuse and how to report concerns. There are effective systems to respond to concerns and ensure people's human rights are being respected and upheld. Overall, we found that Castle Hill House was meeting this essential standard.

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

People live in a clean environment, and there is provision to maintain this by adherence to the published code of practice for infection control in health and adult social care. Overall, we found that Castle Hill House was meeting this essential standard.

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

People experience continuity of personalised care through the provision of appropriate staff in sufficient numbers. Overall, we found that Castle Hill House was meeting this essential standard.

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

People are cared for by staff who are supported to achieve appropriate qualifications and receive ongoing training. However, staff do not consistently receive individual supervision, and have limited opportunities for formal dialogue about their work with management. Therefore the care people receive does not always reflect the training or directions that staff have been given. This is a breach of Regulation 23 (1)(b). Overall, we found that

improvements are needed for this essential 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

People receive care that manages risk, meets people's needs and preferences, and informs the service's plans for further development, because the home and provider have effective systems for obtaining information about the quality of service delivery and people's experience of living in the home. Overall, we found that Castle Hill House was meeting this essential standard.

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

Our findings

What people who use the service experienced and told us
We saw how two staff used a hoist to assist a person to transfer from a wheelchair to an armchair. They maintained conversation with the person throughout, giving reassurance and explaining each detail of the transfer process in advance. They took account of the person's dignity and privacy needs. A person declined an offer of a cushion, which a care worker thought would make them more comfortable. The worker explained they would leave the cushion in reach and return later. When they did so, they respected the person's choice still not to use the cushion.

We saw many positive interactions between staff and people in the home. When people were sitting down, staff lowered themselves to chair height to engage with them. However, we also saw a recently appointed care worker asking a person if they were "all right?" without addressing the person at chair level, or awaiting any response. At a meal table where three people needed direct assistance to eat, the three staff providing the assistance remained standing. This detracted from people's dignity and did not allow the staff to attend fully to individual needs. We observed a staff member who addressed people with terms of endearment rather than by preferred names. We noted use of the terms "feeding" and "feeders' table" rather than "people needing help to eat".

The cook showed us how people's choices from the menu were received from care

staff, so that people's chosen meals were available. Daily choices included a vegetarian option. Alternatives such as salads and omelettes were prepared at short notice, so people were not bound by choices they had made before meal times. The kitchen staff were currently working out with care staff, how best to meet a person's needs for finger foods, so that they could continue to enjoy a satisfying diet. Care staff had access to the kitchen at night, and so could provide snacks to people that wanted them then. Where people needed their food pureed, the various parts of the meal were pureed separately so people retained a sense of a proper meal.

Communal rooms were laid out with chairs around edges rather than grouped to use focal points such as windows, fireplaces or television. One lounge was retained as a quiet room, without a television. People received individual, personalised attention. We observed a care worker managing provision of hot drinks to six people in a lounge over a half hour period. They were assisted to consume a drink of their choice, at a pace they found appropriate.

A person's regular visitor told us there was "an easy exchange of information" with the home. Staff kept to an agreement to inform them of any change in medicines prescribed to their relative.

Other evidence
We highlighted at a previous visit that two of the rooms are for double occupancy, and that this has implications for people's privacy. At this visit we found that two single rooms were being created from a sitting room, in order to replace one of the double rooms. The use of double rooms meant that one person was sharing with another who was now receiving end of life care. There was documentation of how this was being managed, including how people had been included in decision-making. There was no policy of discounting the fees for people sharing rooms.

People's care plans included personal profiles. These showed people's relatives were invited to share information about a person's past experiences and achievements. Staff told us they had a better understanding of the people they worked with as a result. We saw instances of care workers engaging with people by reference to things or events that they knew were significant to them.

Some care plans showed evidence of signed agreement by people's relatives or other advocates. The manager said relatives varied in their willingness or availability to sign care plans, or to accept invitations to attend care plan review meetings. We did not see evidence of recording unsuccessful efforts made to involve people in this way.

There was a quarterly newsletter produced jointly by the home and its sister home in Shaftesbury. This was lively and engaging. It gave a variety of information to people in the home, their supporters and staff, including planned and actual developments in the service, staff training and events and activities.

The team leader for a local district nursing team told us that staff at the home always made good provision for preserving people's privacy and dignity when nurses called to provide treatment.

Our judgement
People and their relatives are involved in the assessment of their care needs and how

the home plans to meet them. People living in the home are respected in most staff interactions with them, thereby upholding people's dignityand supporting choice, but some staff do not show respect for people's individuality and perceptions. Overall, we found that Castle Hill House was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
The home had a large room, 'The Garden Room', as a centre for activity and occupation. This had capacity for up to 18 people, including often one or two people from the community attending for day care. Three members of staff were employed as activities workers. During our visit a number of people spent substantial time in the garden room. We were told that over a week (Monday to Friday), all people had the opportunity to spend time there if they wished. There was encouragement to socialise, with others or individually with staff, through games, crafts, conversation or going into the garden. A programme was displayed in the home to show what activities were planned through the week.

A specialist facilitator came into the home twice a week to provide chair-based exercise sessions. During our visit there was an organised sing-song in the main part of the home, which several people joined in. One person living in the home was wearing an overall and said they enjoyed undertaking cleaning tasks. Staff rotas showed that some staff were delegated to prioritise support to people to engage in activities.

People presented as comfortable in how they were dressed. Spectacles were clean and there were records of provision of mouth care. There was regular availability of hairdressing and foot care.

A person visiting a close relative told us the care that staff provided fitted around the person's needs and level of understanding. The person's familiar routines had been carried on in the home.

Other evidence
Care plans included nutritional assessments for all people, reviewed monthly. People's vulnerability to pressure area damage was also assessed monthly by use of a recognised assessment tool. Where risks were identified, by changes in scores in the assessment tools, there was evidence of responses to reduce the risk. For example, pressure area risks were reduced by use of pressure relieving cushions and mattresses and guidance on safe mobility.

Care workers we spoke with said they were very aware of the content of care plans. They considered their observations contributed to reviews and changes of plans. They were notified of changes through staff handover meetings at the start of working shifts. However, one care assistant told us of the risk of missing vital information if it was not carried forward from one handover meeting to another.

One member of staff was designated each day as responsible for administration of medicines. There was clear guidance on how to administer medicines that were prescribed with a variable dose or to be taken as needed. We saw care workers checking with people about whether they required pain relief, both verbally and by observation.

The home was currently working towards accreditation under the 'Gold Standard Framework' for end of life care. This entailed a nine months' training schedule for staff and collation of evidence of embedding good practice. A person was in receipt of end of life care. An additional member of staff had been brought in to ensure continuity of care. There was collaborative working with visiting district nurses. They had arranged for supply of a controlled drug, for which there was appropriate storage and documentation. The district nursing team leader described the home's liaison with district nurses as "excellent". They referred to the response of staff of the home to the requirements of achieving the Gold Standards Framework, as an indication of high standards of care being achieved.

Care staff kept daily records of the care they gave. These demonstrated care in line with care plan guidance, but were not easy to follow. The service had recognised this and a new format was to be introduced, alongside planned record-keeping training for staff. We found that records of people's involvement in social activities did not fully reflect the things they had actually done. People were allocated a key worker and a key worker record formed part of care records. These could offer an opportunity to reflect on a person's experience of care and their lifestyle in the home, but they were extremely sparse and some had no entries for several months.

Our judgement
People receive care that promotes wellbeing by taking account of their health and personal needs and preferences. Overall, we found that Castle Hill House was meeting 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
Staff demonstrated a patient and respectful approach in their interactions with people. Staff told us they had received training about recognising abuse, and about safeguarding protocols. They were aware of their obligations under the provider's procedure for whistle blowing, which they said they had confidence in.

A visitor commented that the home appeared to be a very safe place to live. They said they would not agree to their relative being there if they thought otherwise. They had seen the physical security of the home increased during the time their relative had lived there, which prevented unauthorised entry.

Other evidence
A recently recruited care worker told us they had received training about abuse awareness, whistle blowing and safeguarding within their induction. Other staff said this training was renewed annually. Additionally, two to four staff per month were attending safeguarding training provided by the local authority. The home's training plan showed all staff will have received this training. Senior staff had attended the local authority safeguarding training for managers in June 2011. There had been no safeguarding alerts made by or about the home over the past year.

A person's care plan showed a mental capacity assessment had been carried out, with evidence of routine review of the outcome. There was a prompt sheet in the plan to remind staff in what circumstances a deprivation of liberties application would have to be made.

Our judgement
People are being protected from abuse because managers and staff at all levels understand the signs of abuse and how to report concerns. There are effective systems to respond to concerns and ensure people's human rights are being respected and upheld. Overall, we found that Castle Hill House was meeting this essential standard.

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
We visited all bathrooms, shared toilets, the sluice room and laundry. Standards of cleaning were high throughout. There was a need for a minor repair to a laundry wall to ensure it could be cleaned properly. Bars of soap, in a bathroom and in the sluice room, were disposed of when we pointed them out.

Some people's rooms had been fitted with vinyl flooring in place of carpet, because of the nature of individual continence difficulties. The manager said the possible loss of homeliness was compensated for by enhancement of people's dignity and comfort.

Visitors to the home were directed to use hand cleaning gel, which was provided in the main entrance. We saw that staff wore protective aprons or gloves as necessary.

Other evidence
The home had consulted the Health Protection Agency (HPA) in January 2011 for advice on management of an infectious condition. The HPA infection control nurse was concerned that understanding of infection control issues generally within the home appeared under-developed at that time.

We met a member of staff who had been given a role to take a lead on infection control management in the home. They had significant experience of working as an infection control lead nurse in the NHS. They had a working knowledge of the 'Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. They described how they were developing systems and audit tools that fit with the Code of Practice, which they were confident would identify shortfalls such as we found. They were to assume a training role for staff. A secondary link member of

staff was to be designated within the home.

The district nursing team leader told us they had never had any concerns about levels of cleanliness in the home.

Two domestic staff were employed on weekdays, and one each day at weekends. They worked to a cleaning schedule, which was monitored. A laundry worker was provided each morning and evening.

Our judgement
People live in a clean environment, and there is provision to maintain this by adherence to the published code of practice for infection control in health and adult social care. Overall, we found that Castle Hill House was meeting this essential 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
We spoke with a group of four care assistants, all of whom considered the staffing rota provided sufficient staff to meet the needs of people in the home. All had experience of being telephoned during time off to be asked to cover additional shifts, usually because of other staff ringing in sick. All four said there was no difficulty refusing extra work if they did not want it, but some of them considered the home should develop more of a bank of relief staff as a first port of call to help in this way. Two other care workers told us the staffing rota was not maintained at full strength when a number of staff were on holiday during July and August 2011. They had experience of staffing falling to four care workers whilst extra cover was sought. This put them under pressure to provide support to people when they required it.

A care worker was concerned that pressure to complete essential tasks meant people could receive less individual attention, or be supervised less in communal areas, than was desirable. When we visited, an additional care worker was provided to give individual attention to the needs of a person nearing end of life. We observed that care staff were continuously occupied in care tasks, but they maintained an individual approach to people and remained alert to changing needs of others.

We met two regular visitors to the home, both of whom considered there to be enough staff to meet people's needs.

Other evidence
We looked at care staff rotas for August and September 2011. The basic provision was

five care workers between 7:15 am and 8:00 pm, usually including at least one supervisors (senior care worker). Short shift times, such as 8:30 am to 11:00 am and 5:30 pm to 8:00 pm, were used to achieve an additional staff member on duty at the busiest times. The activities workers on weekdays in the Garden Room were additional to the care staff rota. There were three care staff at night, between 9:15 pm and 7:30 am. This meant there was in-built time for handovers of information between staff on night and day shifts.

The manager told us that maintaining staff availability during the summer holiday season had necessitated a lot of calls on staff to work additional hours, especially when there were unexpected absences due to staff sickness. The rotas showed adjustments to individual start and finish times, or changes of shift, so there were times when the usual staff numbers were not maintained throughout. The manager told us there was a small 'bank' of relief staff to call on, but they were often not able to help. Staff employed more recently by the home or its sister home were contracted to work in either home, so they could be directed to help cover shortfalls. The manager found this increased the flexibility with which staff could be deployed. She told us she and the deputy matron undertook direct care duties when necessary. They also looked at ways of managing issues related to staff sickness. For example, back to work interviews had been started.

Three members of staff were about to leave, and three potential replacement staff were currently going through the recruitment process.

The district nursing team leader told us their nurses had never made any observations that suggested less than adequate staffing in the home.

Our judgement
People experience continuity of personalised care through the provision of appropriate staff in sufficient numbers. Overall, we found that Castle Hill House was meeting this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
A care worker described how management had identified their particular skills as a result of which they were to move into an activities role. When we spoke with a group of care workers, they told us training was regularly made available. They valued training received about dementia and end of life care, which they considered had resulted in them working in improved ways due to greater understanding. Another care worker said they felt limited in how far they could put such training into practice because of pressures of time to complete essential tasks. They did not feel they had opportunities to share their view formally with management.

Five care workers we spoke with had little experience of individual supervision, and considered they had too little opportunity as a group to meet with management. There were reminders to staff in a number of places of the home's 'open door policy'. This offered a constant opportunity to see the manager or deputy about any issue at the end of a shift. Whilst this was seen as welcome, it was also seen as daunting by some staff as they felt matters might be seen as either too trivial or serious. Care workers told us they saw management as approachable, but they felt that minuted meetings would enable them to be more involved in development of the home.

Other evidence
The service had a full time training co-ordinator. They maintained a training matrix for the home, to ensure staff were able to undertake mandatory refresher training as it became due. There were plans in place for staff who showed on the matrix as out of date for any refresher training. For example, 15 staff were to undertake first aid training with an external provider in October 2011.

There was a common induction for staff appointed to Castle Hill House and the sister home, based on Skills for Care common induction standards. This involved working in both homes, so that staff would be able to provide continuity of care if required to work in either home at any time.

An external trainer was used to deliver training about dementia, working with difficult behaviours, and end of life care. There was also a link with end of life training facilitators from the local hospital. All supervisors had achieved National Vocational Qualification (NVQ) in care, mostly to level 3. Just over half of other care workers had achieved NVQ to level 2 or 3, with others working towards level 2. The activities coordinator in the Garden Room belonged to a cluster group of people in similar roles at other services. This gave them opportunities to develop their role and that of other staff in that part of the home.

There was evidence of annual appraisals of staff. Records of individual supervision of staff showed there had been a reduction since the previous year. 21 staff had received two or three supervision sessions with a more senior member of staff in the current year, but a similar number had only had one supervision, and nine staff had not had an individual supervision meeting at all. Records of supervision meetings did not consistently consider with staff their key worker roles and how their work was impacting on the lives of people in the home. Supervision was not used to identify staff training needs and wishes, or the benefits of training that had been received. The home's training matrix did not include provision for training to supervisors in supervision skills.

Our judgement
People are cared for by staff who are supported to achieve appropriate qualifications and receive ongoing training. However, staff do not consistently receive individual supervision, and have limited opportunities for formal dialogue about their work with management. Therefore the care people receive does not always reflect the training or directions that staff have been given. This is a breach of Regulation 23 (1)(b). Overall, we found that improvements are needed for this essential 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 compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
A person visiting a relative said they had very recently completed a comprehensive questionnaire from the home. They were aware of how to make a formal complaint. They told us they had "no doubts about the openness or efficiency of management to respond to anything".

During our visit there were two false fire alarms triggered by maintenance work in the home. In each instance all staff attended the assembly point and a person took charge of the situation. This demonstrated staff were aware of how to respond to the alarm. Senior staff used the opportunity to establish that staff knew what their next actions would be in the event of it not being a false alarm.

Other evidence
We were shown how an extensive audit of the service's management systems and risk assessments was carried out annually. This was in part informed by a questionnaire survey of stakeholders, which had a different focus each year as well as covering essential aspects of how people experienced the service. Results of a questionnaire survey recently circulated were being collated.

We saw the provider's business plan for the home for the previous and current year, which took account of audit and stakeholder feedback. The service's newsletter recorded that some people that lived in the home, and relatives, had attended the provider's annual general meeting. This had included updating people on the home's work and decisions in relation to the Gold Standard Framework for end of life care.

Incidents and accidents were formally reviewed for outcomes and patterns every six months.

We found that the management processes in the home had recognised and made plans to address issues that had arisen. For example, infection control had been identified as an area for improvement and delegated to an appropriate team member. Supervisors' meetings with management had been started to improve communications within the staff team, although there were few ways of obtaining feedback and ideas directly from care workers. Inconsistencies in record keeping had been recognised, leading to plans for a simplified daily record of care and provision of training in record keeping.

Our judgement
People receive care that manages risk, meets people's needs and preferences, and informs the service's plans for further development, because the home and provider have effective systems for obtaining information about the quality of service delivery and people's experience of living in the home. Overall, we found that Castle Hill House was meeting this essential standard.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People living in the home are respected in most staff interactions with them, thereby upholding people's dignityand supporting choice, but some staff do not show respect for people's individuality and perceptions. Overall, we found that Castle Hill House was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff do not consistently receive individual supervision, and have limited opportunities for formal dialogue about their work with management. Therefore the care people receive does not always reflect the training or directions that staff have been given. This is a breach of Regulation 23 (1)(b). Overall, we found that improvements are needed for this essential standard.	

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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