Review of compliance

Mr T & Mrs S Kandiah Remyck House	
Region:	South East
Location address:	5 Eggars Hill Aldershot Hampshire GU11 3NQ
Type of service:	Care home service without nursing
Date of Publication:	September 2011
Overview of the service:	Remyck House is a privately owned care home registered to provide residential care for up to 29 older persons many of whom may have dementia. The home is located in the North Hampshire town of Aldershot with easy access to town centre shops and other communal facilities. The towns of Farnborough and Fleet are within ten minutes drive, Guildford 20 minutes

	drive, as is the M3 motorway giving easy access to London.

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

Our current overall judgement

Remyck 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 Remyck House had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 July 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and reviewed information from stakeholders.

What people told us

Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, during our visit, we used our SOFI (Short Observational Framework for Inspection) tool. We made use of this several times during the visit and spoke to one relative. We were told that their relative living at the home appeared well cared for and enjoyed the food. They said that the home appeared clean when they visited, which was at least once a week. They said the staff were friendly.

What we found about the standards we reviewed and how well Remyck House was meeting them

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

Residents are not protected against the risks of receiving inappropriate or unsafe care or treatment. Proper steps have not been taken to meet the residents' individual needs or to ensure their welfare and safety.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

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

People who use this service are at risk of their nutritional needs not always being assessed and monitored effectively.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

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

Remyck House is failing to protect people who live and work in the home against the risks associated with infection by failing to provide a safe environment. The provider is also not taking into account the Health and Social Care Act 2008 Code of Practice on the prevention and control of infection and related guidance.

Overall, we found that Remyck House was not meeting essential standards and improvements are needed.

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

People are at risk of not receiving their prescribed medication when prescribed or needed. Appropriate arrangements are not in place for the obtaining, recording and safe administration of medication.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People who use this service are not being protected fully by the premises being adequately maintained.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

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

People who use this service are protected from unsafe or inappropriate care by appropriate levels of staffing

Overall, we found that Remyck House is meeting this essential standard.

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

People who use this service are having their needs met by competent staff. The provider must continue to ensure that any poor practice is addressed and managed effectively.

Overall, we found that Remyck House is meeting this essential standard

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

Records of events that affect people are not always being maintained effectively.

Overall, we found that Remyck House was not meeting essential standards and improvements are needed.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

We also spoke to one relative who said they visited at least once a week and their relative appeared clean and tidy.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that care plans and risk assessments were reviewed monthly or whenever required. We found that a new activity co-ordinator was now in post. New lifestyle journals had been introduced at the home and were being completed with the assistance of family members. The action plan stated that staff were much more interactive with the residents due to activities being offered.

The Hampshire Multi-Agency Safeguarding team had held review meetings before our latest visit. As a result, the home had received input from the Hampshire County Council's quality improvement officer, specialist nurse for residential homes and Hampshire County Council's Partnership in Care Training (PaCT) regarding training in care planning and risk assessments. A quality improvement officer from Hampshire County Council had visited in June 2011 and set an action plan for concerns they found. Hampshire County Council were continuing to monitor the action plan in place

for Remyck House at the time of our visit.

Rushmoor Borough Council carried out an environmental health inspection into food and health and safety in May 2011 that raised five concerns which required immediate attention. A follow up inspection was carried out in June 2011 and required the home to action risk assessments for falls and scalding from water. The manager stated during a meeting before our visit that the majority of requirements had been actioned. However, Rushmoor Borough Council was continuing to monitor the action plan in place for Remyck House at the time of our visit.
During our visit, we made use of our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allowed us to spend time watching what was going on at the home and helped us to record how people spent their time, the type of support they got and whether they had positive experiences. We observed that one of the staff was carrying out manicures on a couple of the residents and this was interactive. People appeared to enjoy the attention and time that staff member spent with them. However, we found that there was little interaction between the other staff and the residents. We observed that some of the staff were stood in a group talking to each other and did not interact with the residents. Other staff sat next to the residents and spent their time watching the television.

We observed that one resident spent the whole day sat in a corner of the lounge and had not been assisted to move during the seven hours that we spent at the home. This person indicated that they were uncomfortable as we heard them say several times that their back ached and "I could cry with the pain". We observed on several occasions the staff walking past this person and they did not ask if they could do anything to relieve their pain and discomfort.
All of the five care plans we looked at were difficult to use to find information we needed. They were not always cross-referenced to provide accurate information about the care and treatment of the residents they related to. Two members of staff told us they found the care plans difficult to follow and keep up to date.

Records showed that following a fall, a risk assessment and care plan for one resident had not been reviewed to demonstrate how the identified risk would be managed to protect the resident from further falls.

We found that residents, or those acting on their behalf, were not involved in developing their own care plan and these care plans were not centred on the resident as an individual.

The care record for a resident who had a urine catheter contained no information about the care of the catheter. There was no care plan in place to demonstrate how the staff were caring for this particular need. This put the resident at risk of inadequate and inconsistent care. However, the staff confirmed that they were supporting the resident with the care of their catheter as this person had dementia and was not able to manage this but this was not being recorded. There was also no procedure for recording the frequency of catheter changes as required.

Care records for another resident showed that they had behavioural problems and they needed a psycho-geriatric assessment. A further entry one month later stated 'no change in behaviour. Community Psychiatric Nurse (CPN) not engaged yet.' This demonstrated that proper steps had not been taken to ensure the resident had the input

from the appropriate healthcare specialists they needed.

One care staff member confirmed that, generally,
everyone was woken up and assisted to get ready for the day by the night staff. This process started around 06:00am. There was no reference in any care plan we saw that people had agreed to be woken at this time, or had been asked what time they wanted to get up. Another care staff member confirmed that most people were woken by the night staff at around 06:00am, and they were dressed and in the dining room or lounge having their breakfast by 08:00am. On the day of our visit, we arrived at Remyck House at 09:30am and eight out of the nine residents were sat in the lounge. The staff confirmed they had all had their breakfast.

In view of the major concerns identified in this outcome area, the Care Quality Commission served a Warning Notice on the Registered Provider on 29 July 2011.

Our judgement
Residents are not protected against the risks of receiving inappropriate or unsafe care or treatment. Proper steps have not been taken to meet the residents' individual needs or to ensure their welfare and safety.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

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 moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
Not all the people that used the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

One resident told us they liked their lunch. We spoke to one person who told us their relative enjoyed the food.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that menus had been reviewed and that the manager now had control of ordering and maintaining food levels and petty cash was available if necessary.
We found that soft drinks, tea and coffee were available throughout the day as were biscuits, chocolate, and fruit.

Rushmoor Borough Council carried out an environmental health inspection of the kitchen in May 2011 that raised two concerns that required immediate attention. The manager stated during a meeting before we visited that the majority of requirements had been actioned. However, Rushmoor Borough Council were continuing to monitor the action plan in place for Remyck House at the time of our visit.

During our visit, we observed residents in the lounge had drinks within reach, but there was little interaction from staff to encourage people to drink. Staff told us they asked residents their preferred choice of meal each day, and care plans stated the individuals'

likes and dislikes.
The chef was knowledgeable about residents' preferences and explained how a special plate had been purchased to encourage a resident, who had a small appetite, to eat. We spoke to the resident as they ate their lunch from the plate for the first time. Although they were not aware of the reasons for the plate, they were interested in the foods that had been separated into the three separate sections of the plate. The resident ate all of the food and told us they enjoyed it. Staff said it was very rare for this resident to eat all of their food, so the plate was obviously a success.

We saw a few residents had their lunch in the lounge at the chairs they were sat in. Again, staff interaction to encourage people to eat was limited. We saw that one resident had refused their meal but no encouragement was given to them to eat their meal. Staff said "they often refuse so we heat it up and try again later." The resident was not offered an alternative.

Although records showed residents had been weighed once a month, the staff had failed to take any further action following significant weight loss for one resident. There was no nutritional assessment or care plan in place to demonstrate how the risk of weight loss would be managed.

On our last visit, there was a concern over the levels of food available at the home. During our latest visit, we saw plenty of fresh and frozen food available.

Our judgement
People who use this service are at risk of their nutritional needs not always being assessed and monitored effectively.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

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

There are major concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

We also spoke to one relative who said the home was clean whenever they visited. Two residents said that their rooms were "all right ".

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance had been downloaded and was available for staff to access. The manager stated in their action plan that they had attended PaCT infection control training and was delivering training to staff. They told us that policies and procedures had been reviewed and that the manager completed 'spot checks' of all communal areas and bathrooms.

During our visit, we went into all of the bedrooms and communal areas. We saw several stained sheets and mattresses. We found carpets that were stained and chairs that were dirty when we removed the cushions.

In one bedroom, the mattress was heavily stained. Although there was a plastic cover on the mattress, they were both heavily stained. Staff told us the resident was continent. We saw the resident's care plan that stated the resident 'manages their own continence needs.'

In an unoccupied room, the bed was made but the sheet was stained, so too was the mattress. The staff confirmed that the room was all set up ready for any new admission. We found a comb in the en-suite bathroom cabinet of one bedroom that was full of hair and dirt. In the same bedroom, the mattress was heavily stained with a thin bottom sheet over it.

The manager told us they carried out room checks but did not pull back the bedding. On the day of our visit, a consultant who had been employed by the provider was carrying out risk assessments. They went with the manager around the home and removed stained bedding. The manager told us they had requested new bedding from the provider but only a quarter of what was requested had been supplied.

We asked the manager how they took account of the Code of Practice. They did not answer us.

Our judgement
Remyck House is failing to protect people who live and work in the home against the risks associated with infection by failing to provide a safe environment. The provider is also not taking into account the Health and Social Care Act 2008 Code of Practice on the prevention and control of infection and related guidance.

Overall, we found that Remyck House was not meeting essential standards and improvements are needed.

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
Not all the people that used the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that medication was being 'booked' into the home using the Medication Administration Record (MAR) sheet. It also said that the manager and deputy manager were carrying out audits. The action plan stated that medication was being stored appropriately and drugs were being returned monthly to the pharmacy using the correct procedure. We were also told that the medication book was being checked after each administration. The manager stated that MAR sheets were being signed in accordance with requirements and guidelines. They also told us that errors were being eliminated due to constant monitoring. The action plan stated that only senior staff now administered medication. They also told us that all staff had received pharmacy medication training.

During our visit, we looked at the Medication Administration Record (MAR) sheets and the amount of medicines held at the home. We found that there were extra tablets that could not be accounted for.

The MAR sheet for one resident showed they had been prescribed Paracetamol 1-2

tablets 4 times a day as required. The MAR sheet showed that this person was receiving this 4 times a day. The senior care worker we spoke to confirmed that the resident needed the medication to control her pain. The MAR sheet showed that the resident had not received any pain control from 30 June 2011 up to 8 July 2011. The senior care worker confirmed to us that the reason that this person had not received their pain control was because the home had run out of this person's Paracetamol. We noted that this person started to receive their Paracetamol again once it was received into the home on the 8 July 2011.

Another resident was prescribed medication to be administered one sachet daily. The MAR sheet showed that this person had not received this medication at all. The senior carer stated that this person was not on this medicine. We found there were 20 sachets in the medicine trolley that had been dispensed for this person. The manager said that this should have been administered but did not know why this person had not received this medicine.

We found that 12 sachets of medication for another resident that had been dispensed had not been recorded on their MAR chart and this person had not been receiving their prescribed medicine. The manager told us that she was not sure why this had not been written on the MAR chart and thought that this person did need to have this medicine. There was no record to indicate that this medicine had been discontinued.

We found that another resident was also prescribed Paracetamol to be administered one to two tablets four times a day as required. The staff were failing to record the variable dosages that this person was receiving. We found that on the 4 July 2011 the record showed that 30 Paracetamol tablets were carried forward. On 12 July 2011, 100 Paracetamol tablets were received. The MAR record showed that this person had received 34 tablets which meant that there should have been 96 tablets remaining. However there were only 88 tablets left in stock. The manager could not account for the missing tablets.

We found the same resident was prescribed tablets to be given for two months. The MAR record did not contain the date that this medicine had started and we asked the manager how the staff would determine that they had completed the two month course. The manager said that she did not know and would need to look into this.

Another resident was also prescribed Paracetamol, two tablets to be given four times a day. We found that the record showed that 98 tablets were received. This person's MAR sheet showed that they had been administered 90 Paracetamol tablets, which meant that there should have been eight tablets remaining. However, there were 20 tablets left in stock. The manager said that she did not know why there were extra tablets and agreed there were serious discrepancies in the MAR records.

One resident that had been admitted for respite care was receiving four types of medicines according to his MAR sheet at the time of our visit. There was no record of what medicines and how many tablets this person had brought into the home. The manager stated that staff had failed to record the amount of medicines received on their admission. We found that the medicines cupboard contained four lots of medicines that included 70 tablets for this resident. The manager confirmed that these tablets had

not been recorded as received by staff as required.

This put people at risk of not receiving their prescribed medication and appropriate pain control as and when needed.

The manager told us that she was carrying out an internal audit of medicines at the home; however none of the shortfalls we found had been identified through this audit.

In view of the major concerns identified in this outcome area, the Care Quality Commission served a Warning Notice on the Registered Provider on 29 July 2011.

Our judgement
People are at risk of not receiving their prescribed medication when prescribed or needed. Appropriate arrangements are not in place for the obtaining, recording and safe administration of medication.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that water temperatures were being maintained weekly.

During our visit, we looked around the communal areas and almost every occupied and most unoccupied bedrooms. We found the window pane surround near the sill in one of the unoccupied bedrooms was rotten and cracks were letting in a draught. We found the headboard was not secured to a single bed in another occupied bedroom. There was only one bathroom on the ground floor that was equipped to assist residents in and out of the bath. Staff confirmed that all of the 10 residents who were living at Remyck House on the day of our visit needed assistance.

We found that a wall in the dining room had paint peeling and flaking off. We were told by the manager and two staff that this was an ongoing issue caused from a leak in the shower room directly above on the first floor. The wall had been painted several times but the cause of the damage had not been resolved.

There was a notice on one of the two ground floor toilets that stated 'not to be used until further notice' and the door was locked. Staff opened the door and the toilet was being

used as storage for cleaning equipment. The staff told us that all residents used the one toilet on the ground floor unless they used the lift to gain access to the three toilets available on the first floor.

We asked the manager if the thermostatic valve had been fitted to the hot water supply, and the manager confirmed it had. Staff told us the provider was slow to respond to reports of faults. We saw records in the kitchen that showed faults with the dishwasher and cooker had taken several weeks to put right.

Rushmoor Borough Council carried out an environmental health inspection into food and health and safety in May 2011 that raised seven concerns that required immediate attention and three with timescales that varied from two weeks to three months. A follow up inspection was carried out in June 2011 and required the home to action risk assessments for burns from hot surfaces, implement measures to control Legionella, review the layout and practices in the laundry room and to ensure pipework under wash hand basins were boxed in. The manager stated during a meeting before our visit that the majority of requirements had been actioned. However, Rushmoor Borough Council were continuing to monitor the action plan in place for Remyck House at the time of our visit.

Our judgement
People who use this service are not being protected fully by the premises being adequately maintained.

Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

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
Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

We also spoke to one relative who said the staff were friendly and there seemed to be sufficient numbers available.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that the rota had been changed to ensure all shifts were covered by a senior care worker for the dispensing of medication. Since commencing employment in December 2010, we found that the manager had introduced a deputy manager, and had employed 3 new staff and a part time cleaner.

During our visit, the manager told us they determined staffing levels by looking at residents' individual need and risks. We looked at the rota that showed three staff on duty for every shift. However, there was no reference to who was the senior staff member on duty. The manager told us that all staff had job descriptions stating their role and responsibility.

At the time of our visit, the home employed domestic, catering staff and one activities co-ordinator.

Our judgement
People who use this service are protected from unsafe or inappropriate care by appropriate levels of staffing

Overall, we found that Remyck House is 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

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that the manager had put together a training matrix.
They told us that staff were receiving regular support and supervision.

During our visit, we saw records that staff had been receiving regular supervision. The staff we spoke with told us they were receiving regular time with the manager on a one to one basis to discuss work and training needs.

However, we saw staff using their mobile phones for personal calls and staff not engaging with residents. We raised these issues with the manager and asked what they would do to address this. The manager told us the provider had employed a consultant to help them manage staff who do not carry out their responsibilities effectively.

Since our previous visit, the home has received input from the Hampshire County Council's quality improvement officer, specialist nurse for residential homes and Hampshire County Council's Partnership in Care Training (PaCT) regarding training in care planning, safeguarding, medication and supervision. A quality improvement officer from Hampshire County Council visited in June 2011 and set an action plan for

concerns they found. Hampshire County Council were continuing to monitor the action plan in place for Remyck House at the time of our visit.

Our judgement
People who use this service are having their needs met by competent staff. The provider must continue to ensure that any poor practice is addressed and managed effectively.

Overall, we found that Remyck House is meeting this essential standard

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
Not all the people that use the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome. The action plan stated that records such as care plans, MAR charts and audits had been carried out or reviewed and kept up to date.

Since our previous visit, the home had received input from the Hampshire County Council's quality improvement officer and PaCT regarding record keeping. Hampshire County Council were continuing to monitor the action plan in place for Remyck House at the time of our visit.

Rushmoor Borough Council carried out an environmental health inspection into health and safety in May and June 2011 and set requirements that they were monitoring, such as reporting un-witnessed falls under Reporting Injuries, Diseases and Dangerous Occurrences (RIDDOR)

During our visit, we found a record that included inappropriate language. We also saw that some records had not been maintained effectively, such as the care plans.

We saw accident forms had been completed for accidents and that CQC had been notified and so had the Health and Safety Executive.

Our judgement
Records of events that affect people are not always being maintained effectively.

Overall, we found that Remyck House was not meeting essential standards and improvements are needed.

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 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	Why we have concerns: Records of events that affect people are not always being maintained effectively. Overall, we found that Remyck House was not meeting essential standards and improvements are needed.	

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 within 14 days of this report being received.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People who use this service are at risk of their nutritional needs not always being assessed and monitored effectively. Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: Remyck House is failing to protect people who live and work in the home against the risks associated with infection by failing to provide a safe environment. The provider is also not taking into account the Health and Social Care Act 2008 Code of Practice on the prevention and control of infection and related guidance. Overall, we found that Remyck House was not meeting essential standards and improvements are needed.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met:	

	People who use this service are not being protected fully by the premises being adequately maintained. Overall, we found that Remyck House was not meeting this essential standard and improvements are needed.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider's report should be sent to us within 14 days of this report being received.

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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Care Quality Commission

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