Review of compliance

Mr & Mrs R Mahomed Lyndhurst Nursing Home	
Region:	London
Location address:	238 Upton Road South Bexley Kent DA5 1QS
Type of service:	Care home service with nursing
Date of Publication:	September 2012
Overview of the service:	Lyndhurst House is a home providing nursing care for 16 people. It is situated in the London borough of Bexley.

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

Our current overall judgement

Lyndhurst 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 22 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We spoke to two people at the home and some relatives visiting the home on the day of our inspection.

People told us the staff were kind to them and helped them with what they needed, but that some people did not have much to do with their time. Relatives told us they thought people at the home were treated well by the staff but that it would be good to see more staff to help at lunch time.

We also 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. We saw that staff treated people kindly and were patient, however we noted that people spent periods of time with only very limited interaction with others.

What we found about the standards we reviewed and how well Lyndhurst 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 not meeting this standard. We judged this to have a minor impact on people using the service and action was needed for this essential standard.

People's privacy, and dignity were respected but people were not always involved in making decisions about their care and treatment.

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

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

People did not always experience support that met their needs and protected their rights. The home's own policy on activities was not always followed and people were not provided with sufficient opportunities for stimulation and activity.

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

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

People were not always supported to be able to eat and drink independently, and not always given the means to make informed choices about meals.

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

The provider was meeting this standard.

The provider had begun to take reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider was not meeting this standard. We judged that this had a major impact on people using the service. This is being followed up and we will report on any action when it is complete

The provider did not have effective systems in place to reduce the risk of the spread of infection because staff were unaware of the infection control policy and cleaning audits had not been completed.

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

The provider was not meeting this standard. We judged that this had a major impact on people using the service. This is being followed up and we will report on any action when it is complete

People were not cared for by staff who were always supported to deliver care and treatment safely and to an appropriate 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

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

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The provider's Control of Substances Hazardous to Health policy was not followed regarding. There was no effective complaints procedure.

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 that this had a moderate impact on people using the service and action was needed for this essential standard.

People were not always protected from the risks of unsafe or inappropriate care and treatment because records could not be located promptly.

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. 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 non-compliant with Outcome 01: Respecting and involving people who use services. 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 told us they were treated with and kindness respect by staff.

One relative said they felt well informed about their family member's care although some people we spoke with did not recall being consulted about their care plans or given information such as who their GP was.

People who were more mobile said there were not many opportunities for community visits, or even to make use of the home's garden because staff were needed to support people in the garden and they did not always have time to do so.

We observed that staff spoke with people at eye level and always used the person's name. The staff knocked before entering rooms and respected people's dignity.

Other evidence
People were not always able to express their views and be involved in making decisions about their care and treatment. We saw a sample of consent forms for the use of bed rails and to have photographs taken which had been signed by people using the service or their relatives. However the sample of care plans we looked at were not

signed by the person or their family member or representative to show they had been consulted or involved in planning their care.

People were not always supported or provided with opportunities to be involved in the local community. The home had hosted a garden party during August 2012 which was attended by family members and people living at the home. However, the activities programme on display did not include any trips out of the home, and people were not making use of the garden during our visit. We were told by people this was because staff did not always have time to support them to access the garden.

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

People's privacy, and dignity were respected but people were not always involved in making decisions about their care and treatment.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Some people or their relatives told us they did not always have enough to do in the home, but others were quite happy to read or watch television. A person said they went to bed earlier than they would have done previously because there was nothing else to do in the evening.

During our visit we observed people in the lounge with little stimulation for long periods of time.

Other evidence
Care and treatment was planned and delivered in a way that was intended to ensure people's safety. Risk assessments were carried out for areas such as pressure areas, mobility and nutrition. The sample of care plans we looked at demonstrated that risk assessments and care plans were reviewed monthly and we saw that appropriate referrals had been made depending on the outcome of the risk assessment. For example we saw a dietician referral had been noted as a result of weight loss and a change in a nutritional rescreening score.

People's care and treatment reflected relevant guidance. We saw that guidance relating to pressure sore treatment from a specialist nurse had been incorporated in to the care plan for two people.

People's needs were assessed and basic care and treatment was planned and

delivered in line with their individual care plan. People had an assessment of their individual needs and the care plans reflected these needs. For example we saw that someone with a history of breathing problems had a care plan which told staff how to provide support for this problem.

Our inspection on 05 January 2012 found there was a lack of stimulation for people in the home. The provider wrote to us and told us they would consider an increase in the activity co-ordinator's hours, and that staff would be trained to occupy people in a meaningful way and to continue the activities programme within the home. The home's policy on social contact and activities stated that people should be supported to maintain hobbies and interest such as visiting the pub and drawing and staff should be aware of the need for mental stimulation.

When we inspected the service on 22 August 2012 we found that activities were not always planned and delivered in a way that met people's individual needs. We saw an activity programme with one activity a day, for four days of the week. The activity co-ordinator was off on the day of our inspection and there were no planned activities. We looked at a sample of the daily progress notes for half of the people living at the home. We found very few documented activities in these notes. For example, over a two week period in August 2012 one person who lacked mobility and therefore remained in bed had no record of activity participated in, or being offered. The radio in this person's room was not working, and there was no television in their room. When we discussed this with staff they told us they made frequent visits to the person in their room to offer fluids and make sure the person was comfortable but there were no activities offered. We also saw that activities such as listening to music or watching television were recorded for three other people but there was no record of regular additional activities.

We saw from the staff rota that the activity co-ordinator worked at the home for eight hours per week, and there was no cover for holidays or days off. Staff we spoke with said that they interacted with residents whilst giving care but it was the activities co-ordinator who organised additional activities. This meant that people's care and treatment was not always planned and delivered in a way that was intended to ensure people's welfare.

There were not always effective arrangements in place to deal with foreseeable emergencies. We saw from the staff rota that a house keeper was employed by the service five days per week and that a carer covered for this house keeper during periods of leave. However on the day of our visit the house keeper was not working and there was no additional cover arranged. This meant that care staff were taking on cleaning duties in addition to supporting people with care and treatment and this reduced the time available to staff to stimulate people.

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

People did not always experience support that met their needs and protected their rights. The home's own policy on activities was not always followed and people were not provided with sufficient opportunities for stimulation and activity.

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 moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
A person told us the food was "not bad" and they had a choice "up to a point".
We observed the cook offering a person an alternative meal of sandwiches when they did not like their hot meal. However we also observed a person use a tissue box to protect their clothes from food spillages whilst eating, and we saw that this person did not have a plate guard to prevent food from slipping off their plate.

Other evidence
Our inspection of 05 January 2012 found the menu was repetitious and was only available in small print. There was no access to adapted cutlery in order to support people to maintain their independence when eating. The provider wrote to us and told us the home had produced large print menus and purchased adapted cutlery, and the cook would meet with people living in the home to ask about their food choices. At our January 2012 inspection we also found there was a lack of suitable dining room furniture and the provider told us they had purchased dining room chairs.

When we visited on 22 August 2012 we saw that six new dining room chairs were in place in the dining area of the home. However while the provider had addressed the issue regarding dinning room chairs, equipment to assist people to eat and drink independently was not always available. For example we asked staff about the use of adapted cutlery as we observed that one person in the home required the use of a plate guard to support them to eat independently. The staff were unable to confirm if plate guards had been purchased by the provider and none were in use on the day of our visit. Following our inspection the provider submitted information to show that he was now in the process of purchasing plate guards, an action we had asked the provider to

do following our January 2012 inspection.

The cook told us they offered people a choice of a hot meal or sandwiches or an omelette or soup at lunch time, and they met with people who could communicate to discuss their preferences on a daily basis. However, there were no large print or picture menus available on the day of our visit. This meant people were not always provided with a way of choosing suitable and food and drink.

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

People were not always supported to be able to eat and drink independently, and not always given the means to make informed choices about meals.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People or their relatives told us they felt safe in the home.

Other evidence

Our inspection of 05 January 2012 found that not all staff were familiar with the process for reporting safeguarding incidents in the manager's absence and not all staff had completed formal safeguarding training. The provider wrote to us and told us they had booked training in safeguarding and Mental Capacity Act (2005) and that staff were aware of how to report concerns in the absence of the home's manager.

At our inspection on 22 August 2012 staff told us they had received training in safeguarding during 2012. The staff stated they would report suspected abuse to the home manager and if he were away they said they would go to the qualified nurses. The staff told us one qualified nurse was aware of the procedures to report allegations of abuse to the Care Quality Commission (CQC) but we did not see this staff member on the day of our visit.

We saw a sample of Criminal Records Bureau (CRB) checks had been carried out on staff working at the home, to ensure only suitable people were employed at the home.

Our judgement
The provider was meeting this standard.

The provider had begun to take reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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 non-compliant with Outcome 08: Cleanliness and infection control. We have judged that this has a major impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us they found the home clean.

Other evidence
Our inspection of 05 January 2012 found that a housekeeper was not employed seven days a week. We did not see aprons or gloves in the sluice rooms and a single mop was in use for all areas. Our inspection found that the provider was not compliant with the code of practice for Prevention and Control of Infection for example no auditing or monitoring was carried out on cleaning and hygiene. The provider wrote to us and told us they would review the infection control policy and ensure staff were aware of this policy. The provider told us they had purchased additional mops and buckets for the home and appoint a house keeper. They also told us they would complete monthly cleaning audits and a hand hygiene audit.

During our inspection on 22 August 2012 we saw that additional mops had been purchased, and that there were three containers of alcohol gel hand cleanser placed in corridors around the home to reduce the risk of cross infection. There were aprons and gloves available in one downstairs laundry room but not in the upstairs sluice room although the staff we spoke with told us they carried spare clean gloves in their uniform pockets. We observed staff to be washing their hands and replacing aprons after giving care during our visit. This ensured that the risk of cross infection was minimised.

However, the infection control policy for the home stated that soluble bags would be used for soiled laundry. Staff we spoke with told us these bags were not generally in use for soiled laundry, and they were not aware of the infection control policy. We did not see any soluble bags for washing soiled laundry at our visit. Staff also told us they

would clean up a urine spillage with tissues and were unsure which mop to use for cleaning urine spills. The training matrix the manager sent us also showed gaps in the infection control training for staff: for example the house keeper had received no infection control training and three registered nurses and one healthcare assistant had not completed any infection control training. This meant people were not always protected from the risk of the spread of infection.

We saw a sample of cleaning audits from July 2012 but the hand hygiene audits were not available at the time of our visit because staff at the home could not locate the audits in the manager's absence. This meant that appropriate infection control guidance had not been followed at the home to always protect people from the risk of infection.

Our judgement
The provider was not meeting this standard. We judged that this had a major impact on people using the service. This is being followed up and we will report on any action when it is complete

The provider did not have effective systems in place to reduce the risk of the spread of infection because staff were unaware of the infection control policy and cleaning audits had not been completed.

Outcome 14:
Supporting workers

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 non-compliant with Outcome 14: Supporting workers. We have judged that this has a major impact on people who use the service.

Our findings

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

Other evidence
At our inspection on 05 January 2012 staff told us they had not received supervision or appraisal. We also found that no staff were trained in fire safety, medication or use of Control of Substances hazardous to Health (COSHH) materials. We saw that only small numbers of staff had been trained in dementia care and food hygiene. The provider wrote to us and told us that they had booked some staff training on dementia. The provider told us that a staff supervision matrix was now in place and that they had appointed a company to provide training for staff identified through appraisal and supervision.

When we inspected the home on 22 August 2012 not all staff we spoke with could recall the dates of all the training they had received although one staff member showed us their training certificates for training in palliative care, mental capacity and induction.

The manager sent us a copy of the training matrix for the home for 2011-2012. The majority of staff had now received training in palliative care and dementia care. Fourteen of the 19 staff were also trained in health and safety and the use of COSHH. However four registered nurses and two health care assistants had not received any training in moving and handling people and six clinical staff still had not received training in food hygiene.
One staff member showed us a certificate to confirm they had received safeguarding training in June 2012. The manager sent us a copy of the training matrix: 12 of the 19

staff had attended SOVA training within the last year. However there were five registered nurses and three health care assistants who had not received any training in safeguarding. Four clinical staff and the cook had been trained in the Mental Capacity Act (2005) which meant the majority of staff had not received training in this area. This meant that people were not always protected from the risk of abuse because not all staff were trained in how to identify and respond to allegations of abuse or to be aware of people's capacity to consent.
Therefore we found that people were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Staff we spoke with told us supervision ranged between monthly supervision sessions and supervision that took place as required but not at a set frequency. Staff did not recall attending staff meetings. The provider sent us a sample of supervision records for July and August 2012 but it was not possible to know if staff supervision had been sustained on a regular basis since our inspection in January 2012.

Our judgement
The provider was not meeting this standard. We judged that this had a major impact on people using the service. This is being followed up and we will report on any action when it is complete

People were not cared for by staff who were always supported to deliver care and treatment safely and to an appropriate standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
No one we spoke with was aware of the home's complaints policy.

Other evidence
At our inspection of 05 January 2012 we found that staff meetings were not held frequently and that no formal audit of care plans was carried out. The provider wrote to us and said they had implemented a monthly quality assurance programme.

At our inspection on 22 August 2012 we found that the provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. For example, we saw that an area of carpet on the downstairs corridor by the staff office was worn and was a potential trip hazard if not repaired. This hazard had not been identified in the maintenance audit record file. We also saw an entry in a fire door testing record book that since 16 July 2012 the weekly fire alarm test records showed the fire door between rooms four and five had failed to close. There was no record of the action taken to rectify this problem although the fire doors did worked when we tested them on the day of our inspection.

The provider's policy for the Control of Substances Hazardous to Health (COSHH) stated that a COSHH folder containing reports for each substance would be available for all staff to ensure action was taken to store cleaning materials safely. Staff were unable to locate this folder and we saw that the cupboard containing cleaning materials was not locked and located in an outdoor area which was easily accessible. The

provider themselves had noted the cupboard was not lockable in an environmental audit on 31 July 2012 but there was no risk assessment in place to show that the risks to health safety and welfare had been considered by the provider in deciding to leave this cupboard unlocked.

The complaints' policy for the home was only displayed in the staff office. Staff were unable to show us a log of complaints made to the home on the day of our inspection. Therefore it was not possible to see if complaints were managed appropriately and changes made to improve the quality of services provided. However we saw a sample of surveys completed by relatives or people using the service in December 2011, and the provider showed us some recordings of meetings with relatives in July 2012 to discuss their family member's care meaning that people were given some opportunity to express their views in relation to the service.

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

The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The provider's Control of Substances Hazardous to Health policy was not followed regarding. There was no effective complaints procedure.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

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

Other evidence
Staff records and other records relevant to the management of the services were not always accurate and could not be located promptly when needed. For example the provider was not able provide records relating to staff training and supervision, and quality assurance during our inspection.

Records were kept securely but could not be located promptly when needed. During our inspection the registered manager was on annual leave and had not made provision for staff to access training and supervision records relating to staff employed at the home. The staff were also unable to access the requested quality assurance documents. The provider did not adhere to our request to supply these documents within 48 hours of his return to work.

The provider sent us a sample of medication audits carried out at the home, but the audits were not dated which meant they were not accurate or fit for purpose.

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

People were not always protected from the risks of unsafe or inappropriate care and treatment because records could not be located promptly.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People's privacy, and dignity were respected but people were not always involved in making decisions about their care and treatment.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People's privacy, and dignity were respected but people were not always involved in making decisions about their care and treatment.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People did not always experience support that met their needs and protected their rights. The home's own policy on activities was not always followed and people were not provided with sufficient opportunities for stimulation and activity.	

Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People did not always experience support that met their needs and protected their rights. The home's own policy on activities was not always followed and people were not provided with sufficient opportunities for stimulation and activity.	
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 were not always supported to be able to eat and drink independently, and not always given the means to make informed choices about meals.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were not always supported to be able to eat and drink independently, and not always given the means to make informed choices about meals.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The provider's Control of Substances Hazardous to Health policy was not followed regarding. There was no effective complaints procedure.	

Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others. The provider's Control of Substances Hazardous to Health policy was not followed regarding. There was no effective complaints procedure.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People were not always protected from the risks of unsafe or inappropriate care and treatment because records could not be located promptly.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People were not always protected from the risks of unsafe or inappropriate care and treatment because records could not be located promptly.	

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.

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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