Review of compliance

Disabilities Trust Gregory Court	
Region:	East Midlands
Location address:	Noel Street Hyson Green Nottingham Nottinghamshire NG7 6AJ
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	Gregory Court offers accommodation for persons who require personal care for up to 10 adults.

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

Our current overall judgement

Gregory Court 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 because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 October 2011, 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

People told us that they were able to make lifestyle choices. Those who were more independent were able to access their community and told us they were treated with respect. One person said "I am happy as I can go out when I want." Some people using the service said they were not always spoken to in a dignified way. One said "Some staff can be patronising and treat me like a two year old."

People told us that they were able to access health care services in the community. People were not always receiving the care they needed and staff did not always know about their care needs because these were not well recorded. One person said "A couple of staff don't clean me at night and I'm sore through the night. When they clean me it's better if I sit down but they don't all do that."

People told us that they liked the food. One person said "The meals are excellent." Another said "I've no complaints with the food; I have tea and coffee facilities in my room. If you want a sandwich or anything for supper you can ask for it and its there for you."

People generally felt safe at the service. One said "They always keep you safe." Another person also said they always felt safe with the staff. One described staff as "Kind."

People who used the service and their visitors told us that there were not enough staff

provided to meet people's personal care needs. One person said "They are short staffed." Another said" It gets a bit hectic at times with the understaffing."

One person who used the service said they thought staff were appropriately trained. They said "They have all the skills they need for their job." Another said that staff did not know how to communicate with them properly.

One person told us "There is a resident's meeting once every month." Another said "I fire my views off at the meetings and minutes come from them so we know what's what." They knew who their key worker was and said "If I want to chat, we get that chat." A further person said "Most of the time things get dealt with."

What we found about the standards we reviewed and how well Gregory Court 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 were able to make choices about their lifestyle and access the community. People were not always treated with dignity. Delays in reviewing people's care and their lack of involvement meant that care plans did not accurately reflect peoples choices or hopes for their future.

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

Gaps in care planning, risk assessments and identification of care needs meant that people may experience unsafe or ineffective care.

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

People had access to meals that were suitable and available at times when they needed them.

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

Failures to identify and report safeguarding issues. Also failures to identify and act upon issues of challenging behaviour appropriately, meant people were potentially at risk.

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

Delays in maintenance had a negative impact on people's care and environment.

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

People did not always receive the care they needed because staffing levels were not sufficient.

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

Gaps in staff training and supervision meant that people may not be receiving care from competent staff.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Poor quality assurance and lack of management support meant that people were not receiving safe and appropriate care and services.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take 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 moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
One person who used the service showed us a copy of their care plan. This was kept in their bedroom. They told us "I got to say what I wanted and helped to write it." Also that their daily choices and aspirations had also been recorded. They said they could come and go as they pleased both around the home and in their local community. Also that staff ensured their dignity and privacy.

Most people who were able to go out independently said there were no restrictions on their lifestyle choices. One said "If I want to go out I will go out; to the supermarket or into town. It's our choice and we do it. I enjoy doing my puzzles and there are no restrictions on us at all as far as I can see." Another person told us "I can go into town and stuff like that, nothing stops us." One person said "I am happy as I can go out when I want."

One person told us that their ability to maintain some independence with their personal hygiene had been prevented because a piece of equipment they used to clean themselves had been broken for some time. They told us this had impacted on their ability to maintain their dignity. They said "It's so humiliating that the staff have to wash me." Another person said that the staff did not always treat them with respect. They said "Some staff can be patronising and treat me like a two year old."

Other evidence
We spoke to two people who used the service, then checked their care plans. We saw that these did include most of their needs and also their interests and aspirations. They had signed the care plans to show that they had read and understood them, also to show they had been involved in writing them.

We saw that care plans had been written up to 18 months ago. They had been reviewed at yearly intervals but the content had not been updated. We saw that one person's care plan stated that staff gave them their medication. This person told us they were managing their tablets themselves. They also told us that their aspirations had changed since the care plan was written.

There was no record that people had been involved in reviews of their care plans. Some of the care plans were up to three years old. One persons care plan was written in 2009. This recorded that they would like a review sooner than every six months. Their care plan reviews showed there had been an 11 month gap between 2010 and 2011 where no review had been recorded.

The new manager showed us newer care (support) plans that people themselves had written. The aim was to incorporate these into the main care files to make these more accessible for people living at the home.

Our judgement
People were able to make choices about their lifestyle and access the community. People were not always treated with dignity. Delays in reviewing people's care and their lack of involvement meant that care plans did not accurately reflect peoples choices or hopes for their future.

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
Those people who were able to go out into the community independently told us that they had good access to outdoor activities. One person who used the service told us "I am going to a pottery course for eight weeks." They also said they went to the local supermarket and bank.

One person who used the service told us that the staff took them to the GP practice for appointments and that they got to see the dentist and optician. We saw that people's care files recorded visits by occupational therapists, speech and language therapists as well as liaison with specialists such as psychologists. We found that although people attended appointments, care was not always proactively delivered. One person told us that they wanted to be able to make their own drinks and get out of the home using an electric wheelchair. They told us that they had not been referred to an occupational therapist for an assessment to see if there were any aids that could be provided to help them regain some independence.

Care plans did not provide sufficient detail about people's health needs. For example, one person was identified at risk of sore skin, but there was no assessment of their skin condition and identification of pressure sore risk. This person told us they got sore at times when staff did not properly dry them. They said "A couple of staff don't clean me at night and I'm sore through the night. When they clean me it's better if I sit down but they don't all do that." Another person was incontinent but there was no continence assessment in their care plan, there were no specific instructions for staff on what equipment to use. A further person told us they could be occasionally incontinent if they

were not assisted to the toilet in time. This person's care plan did not identify this as a care need.

Other evidence
Care plans did not detail any screening programmes that the people might need such as breast screening. One person was taking an anti-coagulant (blood thinning) medication. The possible side effects of this were not written down in a plan of care. As a result, care workers were unsure about what side effects to look out for. One persons care review undertaken with their social worker raised concerns about the person's weight gain and asked for their weight to be checked. There was nothing in the person's care plan to ask staff to check the person's weight regularly. One care worker told us they checked everyone's weight every three months but they could not locate the records.

Care plans were written in a person centred way but did not provide staff with clear plans for how each person would spend their week. They did not state what staff support they might need at different times of the week to enable them to fulfil their social needs and undertake activities within their community. Some care plans contained the names of the person's key worker/s. These people were no longer on the staffing rota as they had left the home.

People's care records were disjointed and information was difficult to follow. One effect of this was that two care workers told us that they did not know how to get hold of people's social workers; they told us there was no information like that available to them. Daily ongoing care records completed by care workers did not provide a clear picture of what social activities or trips out people were taking. They did not indicate any personal one to one time between the person and their key workers to establish any ongoing concerns or needs. Records were mainly focused around tasks that had been completed for people, such as assistance to wash and dress and whether they had eaten. They did not correspond well to the care needs outlined in the person's care plan. These records were held separately.

One care worker told us that the communication book had been removed from use. They told us that they had previously used the information in that when handing over care information to the next staff on shift. They said that the current sheets used for handing over information were not effective. They said "There was a change in medication that we didn't know about." Another care worker told us "The care files have been changed and we don't know where to get information from now."

People's risk assessments had been reviewed in June 2011 and were signed by them. One person's risk assessment stated that they could not go out independently following an accident they had when out and about. This had only occurred on one occasion. This person told us that they would like the chance to go out independently again. There was no evidence that their safety to do this had been re-assessed so that they could regain some independence.

We saw that incidents of verbal aggression toward staff had been recorded on 'ABC' behaviour monitoring charts. We saw there was nothing in these people's care plans to direct staff as to how they should deal with this. There was also nothing recorded in the people's risk assessments.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 24 October 2011.

Our judgement
Gaps in care planning, risk assessments and identification of care needs meant that people may experience unsafe or ineffective care.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
One person who used the service told us "The meals are excellent." Another said "I've no complaints with the food; I have tea and coffee facilities in my room. If you want a sandwich or anything for supper you can ask for it and its there for you." A visitor also said "They are good meals." They told us that there was always plenty of food.

Other evidence
We checked food stocks and spoke to the cook. They had a good understanding of the individual dietary needs of people and plenty of food supplies were available. The cook told us that he shopped locally weekly. He was monitoring people's food intake and recording their meal choices each day.
People's individual food choices were stated in their plans of care.

Our judgement
People had access to meals that were suitable and available at times when they needed them.

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

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People had information about equality and rights in their care plans. They also had information about how to complain and also information telling them about abuse and who they could talk to.

One person who used the service told us that the staff were very good. They also said "They always keep you safe." Another person also said they always felt safe with the staff. One described staff as "Kind."

Other evidence
Forms known as 'ABC charts' were completed by staff when there had been incidents of both verbal and physical challenging behaviour exhibited by people who lived at the home. The new manager told us they were not always made aware when these had been completed by care workers. There was no formal and regular monitoring of these records. Incidents had not been updated into people's care plans or risk assessments. This meant there were no instructions for staff about how they should deal with incidents and how they could prevent recurrence.

Two care workers told us that they did not have support meetings following incidents where they had been subjected to verbal abuse by people who used the service. One care worker told us that because issues were never fully resolved "it makes me feel uncomfortable working with that person again; I am always watching what I am saying."

Staff at the home had notified us about one safeguarding incident during 2011. We found documentation and were also told by care workers about a further two potential safeguarding issues that had taken place since August 2011. These had not been referred to the local authority and we had not been notified. One care worker told us they had reported this abuse to the new manager. They said "When we report abuse nothing is done." We asked the new manager to report them.

Care workers told us they had received safeguarding training. One said "I have done the safeguarding training four months ago with Nottingham City Council." They knew where the safeguarding and whistle blowing procedures were kept. Another care worker said that in addition to the safeguarding training they had also had training on managing challenging behaviour.

Our judgement
Failures to identify and report safeguarding issues. Also failures to identify and act upon issues of challenging behaviour appropriately, meant people were potentially at risk.

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
While we were visiting some maintenance issues were brought to our attention. One person told us that a piece of equipment in their bathroom had been broken for some time. Another person told us the tap in their bathroom was noisy. One person who used the service said that in their opinion "They have cut back budgets to keep the place going."

Other evidence
We had been notified before our visit that the heating had been broken for some time. We saw that this had been repaired. The heating provided was very hot. A care worker told us that medication was being stored in people's bedrooms. They knew this had to be stored below a certain temperature. They told us that the heating was too high and that this meant that medications were being stored at temperatures that were too high. They said they had brought this to the attention of management but this had not been resolved. The home was very hot while we were there.
One care worker told us that some tiles had come off a shower and were lying on the floor.

The new manager was aware of the heating problems and had reported this. They had acquired the services of a gardener who was carrying out garden maintenance on the day we visited. A health and safety committee had been set up and the first meeting was due to take place. One person who used the service told us they would be chairing the meeting to ensure that people's views were put forward.

Our judgement

Delays in maintenance had a negative impact on people's care and environment.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are major concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People who used the service, their visitors and care workers all told us that there were not enough staff provided to meet people's personal care needs. One person said "They are short staffed." Another said" It gets a bit hectic at times with the understaffing. There are those people that need two people to deal with them and those that need one. I only need one person so I get left a bit." One further person said "The staffing is a joke. I've had a shower at 12 o' clock because they are late. There used to be three now there are two staff." One person said "A couple of staff rush me to bed. I tell them to come back later. They are always in a hurry, always rushing." They also said "They went round and asked what time I wanted to get up. I'm left in bed until 12 and I'm an early riser. They know that because I told them."

People also told us that low staffing levels had impacted on their ability to go out into their community. One person told us "One person wanted to go to the goose fair but there was no staff to take them, they ended up not going." Another said that "There are not enough staff. Some days there is only two on and I'm lying there until nearly 12. My sister is waiting for me in town. When I get up late I miss her and she is my life. I've got a life as well as anyone else." One person's care plan detailed any restrictions there may be on their lifestyle choices. This stated 'I need two staff members to hoist me into bed so I have to go before 9.30pm as only 1 member of staff is on after this time.'

A visitor told us "The cleaner had to take them to an out patients appointment as there were no care staff." They also said "(named the person) is supposed to get so many hours a week funded for activities, but they don't get any." Also "Sometimes there's no

cook here."

One person who used the service told us that there was continuity of staff providing care to them. They said "the staff are stable enough."

Other evidence
Care workers expressed concerns about the lack of available staff to meet people's needs. One care worker told us that one person who lived at the home sat in front of the television all day every day. They said "We couldn't even take them for a haircut because there was not enough staff; we had to buy some clippers so we could do it. They liked to go to the cinema and we used to take them every week but now we can't take them." They also told us "There's never enough of an overlap of staff to enable people to do everyday things." A further care worker said "It's not nice for people to be told they can't have any activities. I have really seen changes to service users. They are really affected by this." Another said "Three people yesterday missed breakfast because there was not enough staff."

One care worker told us that they were under constant pressure to perform but were often dealing with understaffing and being moved between catering, administration and care duties. They told us that this impacted on the staff as they were getting tired. They said "the company tries not to book agency staff but there has been a lot of sickness." They also said "I don't like working under pressure and feeling worried about what can go wrong." Another care worker told us "Tenants can't go out because there is not enough staff. Medication is forgotten so they get it late and they are missing appointments." A further care worker also expressed concerns, saying "We are all worried that something is going to go wrong because it is affecting both us and the service users."

One care worker told us that they had problems completing paperwork as they were always being asked to perform care duties because of understaffing. They said "You can't update paperwork when you are covering the floor."

Care workers told us that usual staffing levels were three care workers plus manager in the morning and two care workers in the afternoon. We checked the staffing rotas for the period 8 August 2011 to 12 October 2011. We saw that during one week in August four morning shifts were only covered by two care workers. On a second week in August three morning shifts were covered by two. During September and October this situation improved but there were still up to two days on some weeks where two care workers were working the morning shift.

We checked care plans for people who used the service. These showed that two care workers would need to be available at all times because some people needed two people to assist them. We saw there was no third care worker on any evening shift on the staffing rota.This meant there was no extra staff provided during the evenings to take people out.

In view of the major concerns identified in this outcome area the Care Quality Commission served a Warning Notice on the Registered Provider on 24 October 2011.

Our judgement
People did not always receive the care they needed because staffing levels were not

sufficient.

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
One person who used the service said they thought staff were appropriately trained. They said "They have all the skills they need for their job." Another said that staff did not know how to communicate with them properly.

Other evidence
Care workers were receiving regular programmes of training in mandatory subjects such as moving and handling, basic food hygiene and first aid. We saw a learning and development planner on the wall in the manager's office. This showed all the mandatory training that care workers had received and that which was planned. The new manager told us that they had nominated a member of staff to act as a lead for infection control. They were going to attend specific training to increase their knowledge of this subject. One care worker said "We've got person centered training tomorrow. I've never done that before."

At least one of the people living in the home suffered from epilepsy. Two care workers told us they had never received training on epilepsy. Information sheets for epilepsy and cerebral palsy were seen in one care file. Two care workers were unsure about the care someone needed who was taking an anticoagulant (blood thinning) tablet. One care worker showed us patient information sheets for medications that people were taking.

One care worker told us they hadn't had much support from management. Another said "I have only had one supervision since I first started; the new manager picked up on that and has done one." The new manager told us that she was aware that staff had not

been receiving regular supervision and had provided every staff member with one supervision session in June 2011. They had not had any further supervision and there were no dates for when these would take place

Our judgement
Gaps in staff training and supervision meant that people may not be receiving care from competent staff.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
One person told us "There is a resident's meeting once every month." Another said "I fire my views off at the meetings and minutes come from them so we know what's what." They knew who their key worker was and said "If I want to chat, we get that chat." A further person said "Most of the time things get dealt with."

The new manager told us that general satisfaction questionnaires had not been sent out. They were able to confirm that resident's meetings were held regularly and that a person who used the service had chaired a recent meeting.

People told us they felt a sense of frustration at the lack of progress on acting upon their requests and in communicating with them. One person said they had reported a piece of faulty equipment to the manager "Some time ago." The fact this equipment was not working was impacting on their dignity. The new manager told us that she had asked an Occupational Therapist to visit about this. The person needing it was unaware of this. Three people told us that they had been informed a year go that there was uncertainty about the future of the home. They were worried about this but it was their perception that they had not been given any further information by Disabilities Trust.

Other evidence
The registered manager for this service had left during 2011. A temporary new manager had been in place since May 2011. This person had started to make some improvements to the service such as starting staff supervisions. They had also started to update care plans. In addition, they were able to show us monthly and quarterly

audits that had been completed. These focused on care files, personnel records, medication and nutrition among other areas of the service.

The supplying chemist and primary care trust had also completed audits of medication systems since June 2011.

We saw that audits of care records had not been detailed enough to ensure they accurately reflected people's needs and were updated.

We found that the systems for staff supervisions had not been effective in ensuring that staff felt supported. Also that they received support meetings following incidents where they had received verbal abuse by people living at the service.

Appropriate systems for the management of petty cash had not been in place whilst the new manager was taking annual leave. This has resulted in the service running out of money to buy food for the people living there. Two care workers told us that staff had used their own personal money to buy food and were then reimbursed.

We had found that there had been staffing shortages that meant that the assistant manager had been covering care duties as well as administration of the service. Care workers had also told us that the new manager was not around very often. We checked the manager's rotas between 29 August 2011 and 16 October 2011. This showed that the new manager worked Monday to Friday every week. We saw that they had actually worked at the home for 11 out of a potential 35 days within that total time period. We checked the availability of the assistant manager. This person was on both the care rota and manager's rota. This showed that they had worked 19 out of 35 possible management days. Other days they had covered care or kitchen duties. This meant there was insufficient management support for the home.

The new manager told us that he post was temporary. We have not been notified about any arrangements to provide a permanent registered manager for this service.

Our judgement
Poor quality assurance and lack of management support meant that people were not receiving safe and appropriate care and services.

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 were not always treated with dignity. Delays in reviewing people's care and their lack of involvement meant that care plans did not accurately reflect peoples choices or hopes for their future.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Failures to identify and report safeguarding issues. Also failures to identify and act upon issues of challenging behaviour appropriately, meant people were potentially at risk.	
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: Delays in maintenance had a negative impact on people's care and environment.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008	Outcome 14: Supporting staff

	(Regulated Activities) Regulations 2010	
	How the regulation is not being met: Gaps in staff training and supervision meant that people may not be receiving care from competent staff.	
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: Poor quality assurance and lack of management support meant that people were not receiving safe and appropriate care and services.	

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

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

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

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

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA