Review of compliance

Four Seasons (Bamford) Limited Holbeche House Care Home	
Region:	West Midlands
Location address:	Wolverhampton Road Wall Heath Kingswinford West Midlands DY6 7DA
Type of service:	Care home service with nursing
Date of Publication:	July 2012
Overview of the service:	The home can provide accommodation for up to 49 people who require nursing care.

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

Our current overall judgement

Holbeche House Care 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 9 May 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out this review to check on the care and welfare of people using the service. The home had a nursing unit and a separate dementia care unit. The manager told us there were 20 people in the nursing unit and 24 people in the dementia care unit on the day of the visit. We spoke to seven people, two relatives, six staff, the manager, the regional manager and seven health and social care professionals.

Records showed that people and their relatives were not involved in making care and treatment decisions. One person said, "If I had the choice, I probably would like to be involved."

Staff were able to describe basic care needs for people. However, we found that staff did not take timely action to seek expert advice for people's healthcare needs.

We saw that arrangements in place did not ensure that people and their finances were appropriately safeguarded.

We saw that staff were not approaching people who were anxious when they were wandering in the dementia care unit. Staff made some positive interactions with people when giving them drinks and their meals. This meant that staff were not proactively engaging with people to reassure them and relieve their anxiety.

We found that there were minimal arrangements to monitor the quality of services being provided at the home. The action plan we saw following an audit did not prioritise or identify immediate actions that were needed to provide appropriate care and keep people

safe. We received inconsistent information and explanations from the regional manager, the manager, and the staff throughout the visit.

We saw that records were inconsistent, inaccurate, and not stored in a systematic manner. People's care records did not provide an overview of people's needs and health conditions. This meant that there is a risk that staff may not be appropriately providing care for people.

What we found about the standards we reviewed and how well Holbeche House Care 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 regulation. We judged that this had a moderate impact on people. The provider needs to ensure that there are arrangements to ensure that there is a promotion of people's independence and their dignity is maintained.

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The provider should ensure that people experience care, treatment, and support that meets their needs and protects their rights.

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The provider did not ensure that people who use the service were protected from the risk of abuse.

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 regulation. We judged that this had a moderate impact on people using the service. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service. The provider did not ensure that people were protected from the risks of unsafe or inappropriate care and treatment.

Actions we have asked the service to take

We have asked the provider to send us a report within 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 moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People's views were not taken seriously and people were not involved in making decisions about their care and treatment.

The manager told us that people were involved in making treatment decisions as they were invited to attend care planning meetings. One relative told us, "They never keep us updated about what is happening." We saw that records for care planning and reviewing did not show that people and their relatives were involved or invited. This meant that people and their relatives were not involved in making decisions. One person said, "I didn't know we could do that."

The manager told us that people could express their opinions and choose what they wanted to do throughout the day. People we spoke to said, "I get up when I want but they force me back into bed" and "I want to watch TV but the staff said I am not allowed to keep it on at lunchtime." This meant that although people might express their views, these were not always taken seriously.

People who use the service were not given appropriate information and support regarding their care or treatment.

We saw that people were not always supported appropriately throughout the day to mobilise around the home, carry out activities, eat, and take their medicines. For example, one person who could not eat their lunch independently was not supported appropriately to eat her meal. This meant that staff did not always support people to carry out different tasks. We saw that staff did not ensure that people's dignity was respected when people were being transferred from their chair to a wheelchair in a hoist.

We saw that visual aids were not used around the home, especially to support people with dementia as they can often forget things. For example, we saw that signage to orientate people was limited to different door colours or numbers. Food menus were not available in a visual format to enable people to associate food items with pictures. This meant that people were not always supported to understand where they were, what they were being asked and make choices.

Other evidence
There was no other evidence.

Our judgement

The provider was not meeting this regulation. We judged that this had a moderate impact on people. The provider needs to ensure that there are arrangements to ensure that there is a promotion of people's independence and their dignity is maintained.

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
People's needs were not always assessed in a timely manner.

We saw that an assessment of people's needs took place prior to them living at the home. One person told us, "They did an assessment to talk about what I was looking for." Records showed that not all people had received an assessment prior to coming to the home, or during their stay at the home. This meant that assessments were not always carried out in a timely manner to ensure that staff can take care of people's needs. Staff we spoke to were able to describe people's basic care needs. However, one person did not have an assessment or a care plan in place although they had been living at the home for two months. This meant that there was an increased risk that the person would not receive consistent care for their needs.

People's care and treatment was not planned and delivered in line with their individual care needs.

We looked at four people's care records in the nursing unit and two people's care records in the dementia care unit. We saw that although people's care plan stated what people's needs were, it did not detail how staff should meet those needs. We saw that the care plan was not person centred or reviewed regularly. For example, one person with complex health conditions last had their care plan reviewed four months ago. This meant that care records did not provide an overview of people's current health conditions and health needs.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We found that most interactions that staff did have with people were positive. However, the number of interactions between staff and people was minimal and task orientated. One person told us, "Staff have good days and bad days, but I can't knock them for trying." Another person said, "Staff are OK."

We asked the manager whether agency staff were used when staff called in sick or were unable to attend work. The manager told us that no agency staff were used and that the home had some bank staff to cover some shifts. This would ensure that people are looked after by staff who know and understand their needs. One staff told us, "If someone calls in sick they ring around for other carers, if not we get agency staff."

The manager told us that the home had two activity coordinators. The activities coordinator we spoke to told us that they helped people to eat their meals. We saw that the activities coordinator spoke to people in the dementia unit to ask them what plants they would like to grow in the garden. We saw that one person from the nursing unit was taken to a local shopping centre on the day of the visit. One person said, "We don't do much, we can watch TV." We saw that people did not have any other activities throughout the day. This meant that people did not have the opportunity to be involved in a wide range of meaningful activities at the home to meet their individual needs and preferences. This is particularly important for people with dementia to be able to stimulate their mind and engage in appropriate activities, which can alleviate anxiety.

We found that people with pressure sores were not given appropriate and consistent care to aid the healing. One person had displayed symptoms of having a pressure sore of a serious nature and it took the home over one month to get the tissue viability nurse to assess the wound. The tissue viability nurse we spoke to confirmed that this was a grade three pressure sore. This was not reported to us, as it should have been. We could not tell from the records when the pressure sore occurred and what treatment or care had been given. This meant that people's records did not provide an overview of the care and treatment they might have received.

We looked at this person's turn charts, which told us how often their position was changed to relieve pressure in the area where the sore was identified and to prevent any other pressure sores. Records showed that the person's position was only changed during the night. We spoke to staff who told us that the tissue viability nurse had told them they did not have to keep records for this person when they were sitting out in a chair. We contacted the tissue viability nurse who told us that the person was not able to sit in the lounge on a chair because staff said there were no pressure relieving cushions. This meant that people did not receive appropriate care in line with health conditions that should be delivered promptly. We have alerted the local authority about this for it to be investigated.

We saw that people were given pre-prepared plates of food at lunchtime. One person said, "I don't like carrots, but they don't ask they just put it all in." We saw that people were not offered a choice of drinks throughout the day. We saw that drinks were given to people without engaging with them. In the dementia care unit, we saw that people were given drinks in small cups. We raised this with the manager as this was not providing people with an individual and person centred approach. The manager told us that this is because some people cannot drink in large cups as they may pose a risk to

themselves or others. This meant that a personalised and individual approach was not adapted to ensure people received a choice that met their needs and preferences.

The staff rota showed that on some days there was only one nurse at night between the nursing unit and the dementia care unit. One person said, "Staff do not always come when you want, they say give me a quarter of an hour." We saw that night staff did not always offer people drinks during the night. Night staff we spoke to confirmed that drinks were not offered that night. We saw that records showed that drinks were not given between 9:00pm and 8.30am in the morning. This meant that staff did not always provide timely care for people during the night.

Care and treatment was not planned and delivered in a way that ensured people's safety and welfare.

A visitor advised us of their concerns about their relative who appeared very poorly. It was not clear if this person had been assessed by a doctor. It was also not clear how closely staff were monitoring them to respond to any deterioration in their condition. We requested that a doctor's review was requested, following which the person was admitted to hospital. We saw that there were other instances when healthcare professionals were not contacted in a timely manner. For example, one person's care records stated that they were at high risk of malnutrition and should be weighed weekly. However, records showed that the person was not weighed for two months or referred to a dietician, as they should have been. This meant that the home did not ensure that people received expert advice about their healthcare needs.

Staff we spoke to were unaware of having the need to carry out certain care related tasks like, weighing people. We saw that some people had never been weighed and some people were not weighed regularly. For example, there was one person who had not been weighed since admission as staff told us the person could not sit on scales. However, we were told that the person could sit on a chair. The deputy manager confirmed that people who were bed bound were not weighed using different alternatives. This meant that there were inconsistent arrangements for measuring and monitoring people's weight.

Records showed that appropriate risk assessments were not carried out for all aspects of care and that the risk assessments that were in place were not amended appropriately. For example, we saw that one person's falls risk assessment stated 'no changes' although they had a fall that month.

We saw people were transferred from their chair to the wheelchair in an unsafe manner. We saw that some wheelchairs only had one footrest instead of two. Staff told us, "there was only one footrest on the wheelchair." People who were transferred using this wheelchair did not have a risk assessment in place to identify associated risks and detail why this risk was taken. This meant that unsafe practices were used, as two footrests are needed on a wheelchair to protect a person from injury such as fractured ankles.

We looked at the management of medicines and balances. We found that medicine had been signed as administered although it was still in the dosette box. We found that balances were not always correct and that medicines were not carried over. This meant there was an increased risk that medicines were not being administered as prescribed.

We saw that the morning medicines round in the dementia unit took place very quickly and most of the medicines administration records (MAR) stated that people had refused their medicines. It is particularly important to explain and encourage people to take their medicines as prescribed.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The provider should ensure that people experience care, treatment, and support that meets their needs and protects their rights.

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 non-compliant with Outcome 07: Safeguarding people who use services from abuse. 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
People who use the service were not protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We found that one person had assaulted another person. However, there were no detailed records to state what had happened and what actions staff took. The home has a duty to report such incidents to us and the local authority, which had not been done. We raised this with the manager who told us that staff had not made her aware of this incident. This meant that arrangements for incidents to be reported were not consistent and robust. We alerted the local authority about this incident and we are awaiting the outcome of the investigation.

During the visit, we found that there were four different safeguarding concerns, which the register manager had not identified or reported. We alerted the local authority of these safeguarding concerns and are waiting to hear back to review the outcome of the investigations.

The manager told us that some staff had received training on Deprivation of Liberty Safeguards (DoLS) by an external professional. However, staff we spoke to were unaware of what the Mental Capacity Act (MCA) and DoLS meant. This is particularly important as DoLS applications had been made for people using the service. This meant that staff were unaware of their responsibilities under the act to know when to

act in people's best interests.

We found that some people had bedrails to minimise the risk of them falling. The manager told us that consent is obtained from people or their relatives to ensure that people understand the risks of using bedrails. When we asked to see the consent forms, we were told that this had not yet been carried out. This meant that people were not asked for their consent and made aware of risks associated with bedrails.

Staff we spoke to knew what abuse was and were able to tell us what they would do in the event of an allegation of abuse. However, we found that staff had not appropriately escalated incidents relating to safeguarding. This meant that staff were not reporting safeguarding incidents to management or the local authority.

The home looks after small amounts of personal money for people. We looked at two people's money records and balances. We found that money balances were correct. We saw that there was an electronic record and a paper record of all credit and debit payments. However, we found that a majority of debit transactions were not identical in both records. We found that some debits were not accompanied with receipts. The manager informed us that the records had been audited following an incident related to people's finance. However, missing receipts and discrepancies in records had not been identified. The registered provider had not taken action to ensure systems were in place to manage and record people's money appropriately. This meant that there was an ongoing risk of people's finances not being safeguarded appropriately.

Records showed that suitable checks were carried out to ensure that only suitable staff who can work with vulnerable adults were recruited.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The provider did not ensure that people who use the service were protected from the risk of abuse.

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
People who use the service, their representatives, and staff were not asked for their views about their care and treatment.

The manager told us that surveys were carried out six monthly and the last one was carried out in 2011. We asked to look at the results and the analysis and were informed that the previous survey was carried out in 2010. This meant that people's views were not sought through a questionnaire on a regular basis for improvements to be made in the home.

The manager told us that 'resident meetings' were not regular and that an open door policy was encouraged. We asked to see the minutes for meetings held and these were typed up on the day of our visit and given to us. The minutes did not show that people and their relatives were asked for their input. People and their relatives were told about money being invested into the home, new paperwork being introduced and the manager having an open door policy. There were no records to show discussion and seeking input from people and their relatives. This meant that people and their relatives were not asked for their views to make positive changes in the home.

The manager told us that normally staff meetings were held six monthly, but they were held monthly at the moment. We were only able to see minutes for one staff meeting in April 2012. The minutes showed that there was a discussion around staff roles, supervision, training, and issues relating to night staff. This meant that management

and the staff were able to discuss how to make improvements in working practices.

We saw records for six staff who had supervision. We found that supervision records were not personalised as all the completed records had the same actions for all different staff. One staff we spoke to said, "It is a bit touch and go to be honest." This meant that staff did not have regular and consistent opportunities to raise concerns, discuss training needs, and get feedback on their performance. The registered manager should have created robust arrangements for staff supervision and used this as an opportunity to improve staff attitude, aspects of care, and interactions with people.

Decisions about care and treatment were not made by the appropriate staff at the appropriate level.

We found that there were unclear lines of responsibilities and reporting of issues, incidents, and concerns. For example, we saw that one incident was not appropriately escalated to the nurse; another incident was not appropriately escalated to the manager. We found that there were two instances when medical advice was not sought in a timely manner. The registered manager failed to have an overview of such incidents to make changes that would ensure people received professional advice when needed. Staff we spoke to were unclear of reporting lines and responsibilities. This was particularly important are staff are relied upon to complete electronic records to report incidents.

The provider did not take account of complaints to improve the service.

The manager informed us that no complaints had been received and if they do receive complaints these were resolved immediately. One relative told us, "We have complained so many times but nothing has happened." During the visit, we saw that staff were dismissive and not proactive at listening to a relative's concerns and complaints about a person's care at the home. This meant that people were not encouraged to make a complaint and that these concerns were not taken seriously. The manager told us that verbal and informal complaints were not recorded. This meant that the home were unable to audit trends and patterns to make improvements, where possible.

The systems in place were not effective to enable learning from incidents and implementation of appropriate changes.

The manager told us that staff record accidents electronically. The manager described the system, which enabled her to analyse the accidents and escalate this to the regional manager. We were unable to see the full system as the computer system was not working. We asked the manager whether the electronic system had been replaced with another system temporarily. The manager told us there was nothing else in place. The system relied on staff completing records in an accurate and timely manner. We were unable to see what actions were taken to minimise risks for people. This meant that systems were not in place to ensure management and staff have a constant overview of risk associated with people.

We saw an action plan for shortfalls in the service after the manager had audited different aspects of the home. We saw that there was no prioritisation for the actions

although there were issues that required addressing immediately. This meant that arrangements were not in place to ensure that people's safety, welfare, and rights were protected by making immediate improvements and changes.

The manager was unable to give us information about when the last PCT pharmacy inspection was carried out and whether there were any recommendations. We were also unable to see the results of this audit as the manager informed us that she never received a report. We asked the manager to chase this up to ensure she maintains an overview of such recommendations and reports.

Our visit identified failures in the home that had not been identified and addressed by the registered manager or registered provider. This meant that both local and national systems were not effective at picking up issues within the home that needed to be changed and improved immediately.

We found that many of the issues raised during this visit were raised in a previous inspection in 2011. Although there has been a change in provider during this time, the manager had been in post for two years. The registered manager would therefore have been aware of the recommendations from the previous inspection. We found that improvements had not been made in relation to care, safeguarding, and supporting staff. This meant that previous recommendations were not taken seriously and actions were not taken to ensure that people's needs are being met appropriately.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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
People's personal records including medical records were not accurate and fit for purpose.

We saw that care plans and risk assessments were not regularly updated or reviewed accurately. For example, one person who had developed a pressure sore did not have their risk assessment amended appropriately to reflect this information. This meant that people's care records were not accurate and reflective of their current needs.

We saw that people's care plans were not person centred. The information in care plans did not detail how and when care should be delivered. The care plans were basic and lacked information about individual's preferences and needs. This meant that staff did not have specific information about people. We found that care records and risk assessments were not updated for all people. This meant that there was a risk that staff may not be aware of changes to people's health and care needs.

We saw that there were records for people's social activities and personal care needs. These records were not available for all people we pathway tracked. This meant that there were inconsistencies in documentation for each person. The records showed that people did not take part in any activities during the weekend. We raised this with the manager who told us that people did take part in activities but this was not recorded by staff. One person's fluid chart was only available for two days. We saw that one

person's personal hygiene records showed that they were only washed three times in one month. This meant that people's records were not fit for purpose or reliable.

Records could not be located promptly when needed.

We found that records were not systematically stored or located when needed. For example, one person's weight charts were not in their care file. This information was later found on a plain piece of paper. The regional manager informed us that the home had run out of weight charts. This meant that provisions were not in place to ensure consistent paperwork is used to record people's information and this was not stored in a central place.

We found that some records that we requested to see were unavailable due to the computer system not working. The manager told us this problem had existed for a long time but it had become inaccessible for four days. There was no failsafe system to ensure that valuable information about people's care and safety was recorded and available for staff when needed. This meant that there is a risk that important information relating to people's care and health may not be recorded centrally for staff to access this promptly.

We spoke to the primary care trust (PCT) pharmacist who supplies the home with supplementary drinks for people who need extra nutritional support. They told us that they had requested weight records for people on several occasions, but had never received them from the home. This meant that relevant care records for people were not available for other health professionals when requested.

We were unable to find records relating to one person's health conditions to show what had happened and how staff managed the condition. We raised this with the staff and manager and were told that the records might have been archived. This meant that records for current health needs were not available to review, monitor, and evaluate the effectiveness of care provided.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service. The provider did not ensure that people were protected from the risks of unsafe or inappropriate care and treatment.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider needs to ensure that there are arrangements to ensure that there is a promotion of people's independence and their dignity is maintained.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider needs to ensure that there are arrangements to ensure that there is a promotion of people's independence and their dignity is maintained.	
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: The provider needs to ensure that there are arrangements to ensure that there is a promotion of people's independence and their dignity is maintained.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA	Outcome 04: Care and

	2008 (Regulated Activities) Regulations 2010	welfare of people who use services
	How the regulation is not being met: The provider should ensure that people experience care, treatment, and support that meets their needs and protects their rights.	
Diagnostic and screening procedures	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: The provider should ensure that people experience care, treatment, and support that meets their needs and protects their rights.	
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: The provider should ensure that people experience care, treatment, and support that meets their needs and protects their rights.	
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: The provider did not ensure that people who use the service were protected from the risk of abuse.	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The provider did not ensure that people who use the service were protected from the risk of abuse.	

Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The provider did not ensure that people who use the service were protected from the risk of abuse.	
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 to regularly assess and monitor the quality of service that people receive.	
Diagnostic and screening procedures	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 to regularly assess and monitor the quality of service that people receive.	
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 to regularly assess and monitor the quality of service that people receive.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met:	

	The provider did not ensure that people were protected from the risks of unsafe or inappropriate care and treatment.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider did not ensure that people were protected from the risks of unsafe or inappropriate care and treatment.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider did not ensure that people were protected from the risks of unsafe or inappropriate care and treatment.	

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

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

The provider's report should be sent to us within 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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