### GCH (St Katharine's) Limited
#### St Katharine's House

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<th>Region:</th>
<th>South East</th>
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| **Location address:**   | Ormond Road
|                         | Wantage    |
|                         | Oxfordshire|
|                         | OX12 8EA   |
| **Type of service:**    | Care home service with nursing |
| **Date of Publication:**| September 2011 |

**Overview of the service:**

St Katharine's House is a large home set in spacious grounds in the town of Wantage in Oxfordshire. It can accommodate 76 people who require nursing or personal care support. The home has an active Christian community and continues to have links with the local Convent, St Mary's. They have a new unit for people with a primary need of support for dementia or similar disorders.
Our current overall judgement
St Katharine’s House was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review
We carried out this review 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 05 - Meeting nutritional needs
Outcome 09 - Management of medicines
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review
We reviewed all the information we hold about this provider, checked the provider’s records, 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
Some of the people we spoke to were concerned that they were no longer involved in the future planning for the service. They were also concerned as they thought that no one listened to their views. They told us that they received the support that they needed for personal care. However, they stated that they were not receiving the assistance to maintain their interests and social lives that they had enjoyed.

They told us that the food was not as good as it used to be. They felt there was a lack of choice at mealtimes. People told us that they thought the home was kept clean and tidy and they were generally happy with the environment. They did state that they were not confident about the lack of fire safety practices in the home.

People living in the home thought that there were less staff working there than previously. However, they were complimentary about staff and used words such as ‘super’ and ‘remain pleasant and cheerful’.

What we found about the standards we reviewed and how well St
Katharine's House was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who lived in the home did not feel that their opinions were always sought or respected in regard to how the service was provided. People, we spoke to, did not feel that their views and experiences were taken into account about how services were developed. Previous regular meetings for residents, to discuss issues regarding the home, were no longer in place. Some people were not clear about the costs of living in the home as stated in their Permanent Resident Occupancy Agreement.

Overall, we found that improvements were needed for this essential standard.

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

Individual care plans did not always have accurate and detailed information for staff to provide the necessary care. Changes in care needs were not always reflected and updated in care plans; therefore people were at risk of not receiving the care they needed. The people living in the home had access to a range of activities. However, these were not always tailored to individual’s needs or interests, particularly for those with dementia or similar mental health conditions.

Overall, we found that improvements were needed for this essential standard.

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

Dietary needs for people living in the home were assessed and recorded during their initial assessment, prior to admission to the home. People were able to make choices for their main meals and snacks were made available throughout the day. However, the monitoring of some people’s dietary intake was not always undertaken, where this had been assessed as a requirement. Significant changes in some people’s weight did not appear to have been identified, explored and addressed.

Overall, we found that improvements were needed for this essential standard.

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

Some, but not all, areas of the home were clean. However, the home was failing to protect people, who live in the home, against the risks associated with poor standards of hygiene. This was because of dirty and stained carpeting, dirty sluice areas and cracked toilet pans and washing clothes in areas where food was being prepared. Chemicals, for use in the laundry, were freely accessible and not stored safely and securely.

Overall, we found that improvements were needed for this essential standard.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way
Medicines were administered by either a qualified nurse or staff who had undertaken training in medicines management. There were different systems in place, in different units within the home, for the administration and management of pain relief. Some people living in the home managed their own medication. However, the home did not have processes for monitoring people’s ability to manage, and continue to manage, their own medication safely. The facilities for storing controlled medications were not secure.

Overall, we found that improvements were needed for this essential standard.

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

The home provided a range of rooms and facilities for people living there to use. This included access to a chapel, library and large garden. However, the garden did not provide a safe and secure area for people living in the home who may be confused. Some of the carpeting and flooring had holes and tears. Security arrangements in place did not always stop unauthorised persons entering the home unchallenged. Equipment was stored haphazardly and inappropriately around the home posing a risk to entering or leaving the building in an emergency.

Overall, we found that improvements were needed for this essential standard.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

The home has a range of equipment in use to assist staff in supporting and helping people living in the home. Equipment, we saw in bathrooms had been checked for its safety. However some of the bathrooms did not have sufficient handrails for people to use these independently.

Overall, we found that the home was meeting this essential standard, but to maintain this improvements need to be made.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The home did not have effective recruitment processes in place to ensure that the appropriate pre-employment safety checks were carried out, before an offer of employment was made.

Overall, we found that improvements were needed for this essential standard.

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

There was insufficient information to determine whether the home had enough staff with the right knowledge, skills and experience to support the needs of people living in the home. There was a lack of workforce planning to determine how the needs of people would be met by sufficient numbers of care staff.

Overall, we found that improvements were needed for this essential standard.
Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Care staff working in the home did not feel supported through training and individual supervision to remain knowledgeable and competent in their roles. Many staff had not attended basic training or training updates. Staff did not feel involved in the development of the home and the services it provided. It was not clear as to whether new staff undertook an induction programme when first employed in the home.

Overall, we found that improvements were needed for this essential standard.

**Actions we have asked the service to take**

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

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

**Other information**

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

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

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<td>There are moderate concerns with Outcome 01: Respecting and involving people who use services</td>
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<th>Our findings</th>
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<td><strong>What people who use the service experienced and told us</strong></td>
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<td>Some of the people we spoke to were concerned that they no longer were involved in the future planning of the home, kept informed of changes or that anyone listened to their views. One person stated that they were not listened to by staff in regard to the extra support they requested when they were unwell. Another person said that the care staff treated them with respect and listened to what they say. Another person stated that they had moved bedrooms six times and there ‘was talk’ of her moving again even though she was happy with her room.</td>
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<td>People, we spoke to, told us that the previous regular residents committee meetings run and held by the people living in the home had stopped. They told us that this was because the people living in the home felt they were unsupported by the provider. People, we spoke to, also expressed their concern that they were not able to choose where to sit at tables in the main dining room.</td>
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<td>Some people living in the home had previously told the Commission that it had not been made clear to them, if and what, they were required to pay for in the home. The concerns were around choosing or having to pay additional costs for bedroom furniture.</td>
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<td><strong>Other evidence</strong></td>
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St Katharine's was a Christian community place of residence which had undergone changes since the change of ownership in 2009. There had been an increase in the level of support and care needed by some of the people who lived there. This increase was particularly for people, more recently admitted to the home, with higher dependency needs, than people already living in the home. A significant number of people, more physically active and independent, had chosen to leave the home in the last year to live elsewhere.

**Our judgement**

People who lived in the home did not feel that their opinions were always sought or respected in regard to how the service was provided. People, we spoke to, did not feel that their views and experiences were taken into account about how services were developed. Previous regular meetings for residents, to discuss issues regarding the home, were no longer in place. Some people were not clear about the costs of living in the home as stated in their Permanent Resident Occupancy Agreement.

Overall, we found that improvements were needed for this essential standard.
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 moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
Most of the people who we spoke to stated that they received the support that they required for their personal care needs. One person did not think they obtained the extra personal care support they needed. People, we spoke to, described how changes in the activities provided have been dramatic. Where they had previously had lectures and serious music they now had activities such as hat making and sing-a-long. They told us that less people living in the home were interested in these activities and remained in their rooms and did not participate.

Other evidence
We reviewed care planning records for six people living in the home. We sampled documents from across the different areas of the home to assess the quality of the information provided to staff to be able to support and meet individual's needs.

All the records, that were reviewed, showed that information about health, personal and nursing care needs were obtained prior to admission to the home. People or their relatives or advocates were asked about their life choices such as daily routines, likes, dislikes and interests. Some records had information about people's wishes for care and support at the end of their life. Other people's records recorded choices for their care after their death.

Consent to planned care and to have photographs taken, for use in the home, had been obtained. Records contained documents for identifying and recording the dependency needs of people. These included, for example, the assessment of nutritional needs, the
potential and likelihood of falls and any risks to the individual from staff supporting and helping people to move.

However, the quality of the information in the care records was variable and some care plans had not been recently reviewed. An example of this was where a monthly review had been planned following a falls assessment for one person. The assessment had been last carried out over two months previously. The review of the care plan had not taken place and changes had not been made to the guidance to staff of how they needed to support them safely. In another persons records a gap of over six months had been left between a reassessment of nutritional needs and the management of their pain.

Where individual's needs had changed, this was not always reflected in the planned care for them. An example of this was where a person had been treated for an injury and subsequently underwent surgery in hospital. This had not been recorded in the care plan records. There was no reference to the support needed for personal care or for treatment such as pain relief. For another person, there was no assessment process, or consent recorded, regarding the decision to move them from the residential part of the home to the nursing or dementia unit.

During our visit we spoke to staff about the provision and support given to the people to maintain their interests, chosen activities, involvement in the local community or attend social events. Staff told us that 40 hours of staff time to run activities were provided in the home during the week. These hours were divided amongst three members of staff to organise and provide activities. Another member of staff to provide additional support for activities was in the process of being recruited. Activities were not provided at weekends as staff said, that the people living in the home often had visitors. Games and craft activities were left in the activity room. These may get used if care staff had the time, but staff told us this was not often.

A review of individual care plan records showed that there was not a planned process of support for people to participate in activities. In particular, there was nothing recorded to provide stimulation or relevant activity for people who did not receive visitors, were confined to their beds or remained in their room, were confused or had dementia.

The activities team of staff met once a week to discuss people's interests or issues but these meetings were not recorded. None of the co-ordinators had received activity training for people who have dementia. We were given an estimated figure, by staff that around 40 of the current 58 people living in the home participated in activities. Examples of activities, currently being run, included a weekly round of the sweets trolley, an in house shop for sweets and treats and a clothes shop where people could sell and buy clothes.

The activities co-ordinators had access to a car that was given to the home by a previous resident. It was used infrequently and was not suitable for people who use wheelchairs. The car could accommodate three passengers and a driver.

Our judgement
Individual care plans did not always have accurate and detailed information for staff to provide the necessary care. Changes in care needs were not always reflected and updated in care plans; therefore people were at risk of not receiving the care they
needed. The people living in the home had access to a range of activities. However, these were not always tailored to individual's needs or interests, particularly for those with dementia or similar mental health conditions.

Overall, we found that improvements were needed for this essential standard.
Outcome 05:
Meeting nutritional needs

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
There are moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The people we spoke to stated that the food was not as good as it used to be. Comments included that sandwiches were provided more often, than previously, for the evening meal instead of hot food. People told us that they could not change their mind for meals at mealtimes and had to have what they had chosen the day before. One person stated that the meals were not balanced and too heavy and stodgy and did not meet her dietary needs.

Other evidence
We looked at the information in the sampled care plans to see how individual's nutrition and fluid needs were assessed and monitored. Dietary needs and personal choices were identified in the initial assessment carried out prior to the person's admission to the home.

Weight, nutritional risk assessments and planned monitoring records were put in place. However, in some of the records there were gaps in the monitoring and recording of people's weight. For one person, the nutritional assessment said that staff should monitor the person's weight twice weekly. However, this was being recorded once a month. Another two records, that were reviewed, showed that a significant change had occurred in people's weight for both individuals but this had not been identified or acted upon by staff.

We looked at the plan for the lunchtime meal being served in the main dining room of the residential area of the home. We also observed how the meal was provided. People sat at tables in accordance to the table seating plan that was on display on the wall of
the dining room. Menus and the person’s choices for their meals had been left on the
tables for people to read. People had been given a choice of two main meals which
they had requested the day before. There was only one dessert on the menu. None of
the people we observed requested a change to the meal they were served. People
were not rushed to eat their meals and some found the size of the portions too big and
left them unfinished. None of the staff, we spoke to, could give information of how the
menu plans were developed or what involvement the people who lived in the home had
in the process.

Snacks and drinks were provided between meals from the kitchenette areas on each
floor of the different units of the home. When we reviewed this, on a tour of the home,
we could see very little food stored in readiness should it be required. We were told by
kitchen staff that sandwiches were placed in the fridges around the home in the evening
should people want extra food during the night. Fresh fruit was available during the day
on every table in the main dining rooms. Cake and biscuits were provided during the
morning and afternoon.

**Our judgement**
Dietary needs for people living in the home were assessed and recorded during their
initial assessment, prior to admission to the home. People were able to make choices
for their main meals and snacks were made available throughout the day. However, the
monitoring of some peoples dietary intake was not always undertaken, where this had
been assessed as a requirement. Significant changes in some people’s weight did not
appear to have been identified, explored and addressed.

Overall, we found that improvements were needed for this essential standard.
Outcome 08: Cleanliness and infection control

What the outcome says
Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

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**What people who use the service experienced and told us**
One person told us that her room gets cleaned once a fortnight but was kept to a very satisfactory standard. Others stated that they felt the home was clean.

**Other evidence**
We reviewed the environment of the home including a sample of bedrooms, bathrooms, toilets and shared communal areas. We also looked at the laundry areas, sluices and some storage facilities. The majority of the areas in the home, but not all, appeared clean. However, one bedroom had an odorous smell.

Throughout the home much of the flooring including carpeting in corridors was dirty and stained. Bathrooms and toilets were mostly clean. However, two of the toilets were observed to have cracked bases and one had staining on the floor.

Liquid soap and paper towels were provided in bathrooms, toilets or where people need to wash their hands. Hand hygiene information was on display in some of these areas. Plastic aprons, available to staff, were stored in the sluices.

Sluices were positioned around the home. The majority had both sluice sinks for emptying commode pans and an electronic sterilizer. However, one sluice did not have a door to secure it and only had a sluice sink. Most of the sluice rooms we reviewed had stained and soiled sinks. Some of the sluice rooms were untidy and appeared not to be clean.

We looked at some of the facilities for soiled linen. The home had a 'red bag' system for soiled or contaminated linen. They also had large industrial washing machines. The
The laundry area in the home had separate areas for handling dirty or clean linen and was kept clean and tidy. However, some of the clean linen stored in the linen cupboards in other parts of the home had been placed on the floor.

Some of the kitchenette areas had domestic washing machines that were in use. We saw personal washing was being carried out by some people living in the home. This was in areas where food was stored and prepared for others.

We saw large containers of chemicals for use in the laundry being stored in one of the drying rooms. The door to the room was not lockable and the room was left unattended when the staff were not present in the evenings and weekends. Information about Control of Substances Hazardous to Health Regulations 1988 was on display in various parts of the home, including the laundry.

Our judgement
Some, but not all, areas of the home were clean. However, the home was failing to protect people, who live in the home, against the risks associated with poor standards of hygiene. This was because of dirty and stained carpeting, dirty sluice areas and cracked toilet pans and washing clothes in areas where food was being prepared. Chemicals, for use in the laundry, were freely accessible and not stored safely and securely.

Overall, we found that improvements were needed for this essential standard.
Outcome 09: Management of medicines

What the outcome says
This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement
There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Some people living in the home manage their own medicines. People, we spoke to, told us that they had no concerns about the support they had for their medicines.

Other evidence
We looked at the information, recorded in the sampled care plans, for people’s medication needs or treatment. Information about their medication treatment and support was recorded in the initial assessment of their needs before they commenced living in the home. Some people had the support for medication identified in their plan of care, some did not. Some of the people living in the home managed their medication themselves. However, there was no information about how people’s ability to continue managing their own medication was assessed or monitored.

We looked at some of the information and the processes in place for staff to monitor and provide support for pain management. Some parts of the home were using pain management monitoring document tools and providing pain relief when required. Other records showed that staff were not using these to support the treatment provided to people.

We looked at the system in place for administering medication to people living in the home. In the nursing wing, the nurse on duty was responsible for providing the medication administration to the 25 people living on the two floors of this part of the home. In the residential wing, there was usually one carer on duty who was trained in...
medication management to administer medication across three floors. Assistance for the people living on the top floor was rarely required as most people took and looked after their own medication.

The ground and first floor of the residential part of the home had separate medication trolleys secured safely. The home provided routinely prescribed medication in a monitored dosage system. A local pharmacy was responsible for dispensing these and pharmacists visited regularly to check the administration and storage in the home.

One person in the residential wing was receiving medication that needed safe storage in accordance to requirements for controlled drugs. There was only one cupboard used for the storage of controlled drugs. The cupboard was situated on the ground floor and we found it not secured safely.

**Our judgement**

Medicines were administered by either a qualified nurse or staff who had undertaken training in medicines management. There were different systems in place, in different units within the home, for the administration and management of pain relief. Some people living in the home managed their own medication. However, the home did not have processes for monitoring people's ability to manage, and continue to manage, their own medication safely. The facilities for storing controlled medications were not secure.

Overall, we found that improvements were needed for this essential standard.
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

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<td>The people, we spoke to, were generally happy about the environment. One person stated they liked their room as they got the sun in the morning and not the evening. Another person stated that they wouldn't mind a bigger room as she had lots of furniture. She also added that she lived above the kitchen and was woken at 7am by the extractor fan being turned on.</td>
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<td>Two people, we spoke to, were concerned about fire safety and said that there had not been a fire practice since October 2010. They were worried because staff on duty were mostly new and they said that some did not appear to know what they were doing. One person told us that a false alarm occurred recently but staff did not follow the usual fire practice 'rules'. So she went back into the building because she wanted to, rather than because staff told her it was safe to do so.</td>
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<td><strong>Other evidence</strong></td>
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<td>During the visit we looked at the facilities and some of the information for safe working practices in the home. We looked at some of the security measures in place and the availability and practicalities of some of the outside spaces that people living in the home could use.</td>
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<td>Several of the communal areas were not used as they were being altered to be used for other purposes. A dedicated art room was in the process of being dismantled during the day of the visit to the home. None of the staff could offer information about whether this was being reinstated in another part of the building. A library area had been transferred downstairs to the ground floor of the residential unit. This was to provide a dining and</td>
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sitting area on the first floor in the separate unit for people with dementia. People living in the home had access to a large chapel in the building. This was accessible to those who used a wheelchair.

Throughout the home there was a mixture of carpeting or linoleum on the floors of the bedrooms and in corridors. There were tears and holes in the carpets that could be hazardous to people walking across them.

Some of the homes equipment, such as hoists, had been left in the corridors, blocking doors and access. Some people who used personal aids, such as walking frames or wheelchairs, had left them in front of fire doors. Rooms that had been previously used as quiet sitting rooms were being used for storage and had equipment, furniture and some people's personal possessions in them, making them inaccessible. Some storage cupboards were untidy and disorganised.

The majority of bedrooms in the home were for single use and people shared bathroom facilities. The 25 bedrooms in the new nursing wing had en-suite facilities. Each floor of the home had a mixture of bathrooms or bathrooms with toilets. Some of the toilets in the older part of the building were not suitable for people with limited mobility and were inaccessible for a wheelchair user. The home did have assisted baths or hoists in the majority of the bathrooms reviewed. Some of the shower units in parts of the home had raised bases but no handrails for people to use unsupported.

The home has a call bell system that appeared to be linked to all bedrooms on each floor. We observed that some people were sitting too far away from the bell cords to be able to summon assistance without getting up. For some people this was problem as they needed assistance from staff to enable them to move. Some of the occupied rooms did not have call bell cords.

We looked at the arrangements for fire safety in the home. We observed that a number of bedroom doors were propped or wedged open with cushions, material or chairs. Some of the fire doors in the corridors did not shut or fit properly. Staff were not able to provide any information in regard to any fire practice drills having taken place since October 2010.

We looked at the security in place to protect people living in the home. Close circuit television had been installed and camera's observed some of the doors to the outside and corridors within the home. However, we were able to enter the home freely. There was a key code system in place for access to the new dementia unit on the first floor of the residential wing.

There were large gardens with level pathways that surrounded the home. However, the home did not have a secure area to the gardens where people with dementia or confusion could use independently.

Our judgement
The home provided a range of rooms and facilities for people living there to use. This included access to a chapel, library and large garden. However, the garden did not provide a safe and secure area for people living in the home who may be confused. Some of the carpeting and flooring had holes and tears. Security arrangements in place did not always stop unauthorised persons entering the home unchallenged. Equipment
was stored haphazardly and inappropriately around the home posing a risk to entering or leaving the building in an emergency.

Overall, we found that improvements were needed for this essential standard.
Outcome 11:
Safety, availability and suitability of equipment

What the outcome says
This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement
There are minor concerns with Outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
We did not speak to people about this essential standard.

Other evidence
We looked at the aids and equipment in use around the home. We also looked at care records and spoke to staff about some of the moving and handling practices in the home.

The bathroom and other hoists had been checked for safety within the last six months. The majority appeared to be in reasonable working order. A bath seat in one of the bathrooms in the nursing wing had a broken cover on one 'arm' leaving sharp edges uncovered. The need for specific equipment to help people to move, such as hoists was identified by staff.

Many of the toilets, bathrooms and shower areas, particularly in the residential area of the home, did not have sufficient hand or safety rails for people to use them independently. There was no information to show that these areas had been risk assessed to ensure that they provided the necessary support that people needed.

People moving into the home could bring some personal items, such as furniture, with them. However, staff could not provide information of how the furniture was assessed to be suitable to meet the persons needs or were not a risk to their safety.
Our judgement

The home has a range of equipment in use to assist staff in supporting and helping people living in the home. Equipment, we saw in bathrooms had been checked for its safety. However some of the bathrooms did not have sufficient handrails for people to use these independently.

Overall, we found that the home was meeting this essential standard, but to maintain this improvements need to be made.
Outcome 12: 
Requirements relating to 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement
There are moderate concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We did not speak to people about this essential standard.

Other evidence
The local social services and the provider both had said that there were some concerns about the recruitment practices carried out in the home. The concerns were that several months previously, staff had been employed to work in the home, without the appropriate pre-employment checks being carried out before confirming their appointment.

We looked at the records for four staff to see what information was obtained and what the recruitment process was. Each record included an application form, health declaration, reference requests and proof of identity. Two records showed that the necessary information, including a formal interview process had been carried out. Two of the records we looked at did not include this information.

In one file we found that there was a gap in information for work history that had not been identified and checked. In the file of another person, there was no reference from the last employer. Both of these members of staff had been employed in the home in the last six months.

Our judgement
The home did not have effective recruitment processes in place to ensure that the appropriate pre-employment safety checks were carried out, before an offer of
employment was made.

Overall, we found that improvements were needed for this essential standard.
Outcome 13:
Staffing

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One person we spoke to, said that they felt the home was not run so well, as they had lost so many staff. They said that this included the bursar, the warden and the deputy. They also said that staff in the kitchen had been reduced as had care staff. We were told that staff were super, even though they have to work in straitened circumstances, were always very busy but remained pleasant and cheerful. Comments from other people supported the view that there appeared to be less staff. People told us that sometimes they had to wait longer for assistance, than previously, as there was fewer staff. Another comment was that a member of staff from an agency, who worked at nights, couldn't speak or understand English. This made the person feel quite unsafe.

Other evidence
We looked at staff rotas and spoke with staff working in the home. We also reviewed information we had received from other health and social professionals who had been in contact with or visited the home.

We were provided with the duty rotas for the current week and two previous weeks. The homes system for planning staffing was divided into three main areas, nursing, residential and the dementia unit. Looking at the information recorded there were gaps in the planned rota that showed that 16 shifts one week and 27 for another week were required to be covered in the nursing wing. We were informed that was accommodated by a mixture of bank staff or agency staff. Some of the records showed that for some shifts none of the staff would be actually those permanently employed by the home. The records were confusing and some of the alterations and amendments had not been
updated and may not have reflected the actual staff on duty.

When we spoke to staff they told us that they were moved around the home to work where required. There were two permanently employed registered nurses in the nursing unit with one nurse on duty each shift. The gaps in cover for registered nurses were met by bank staff and nurses supplied by a staffing agency.

Care staff working in the residential unit, provided the support that people required on the ground floor and the second floor of the home. However, the support necessary for those living on the second floor was minimal. In the dementia unit the planned rota showed that one carer supported the eight residents living there. Some staff worked very long shifts from morning to when night staff came on duty. On the day of our visit we were told that they were minus one carer on duty for the morning in the nursing unit which has slightly delayed providing support to people. We observed that one resident was still sitting in her night clothes at 11 am.

The home has a team of seven domestic staff who work 170 hours during the week. Two members of staff provide 10 hours of domestic assistance on a Saturday and Sunday. There were two members of staff employed specifically in the laundry for 57 hours between them, during the week.

**Our judgement**

There was insufficient information to determine whether the home had enough staff with the right knowledge, skills and experience to support the needs of people living in the home. There was a lack of workforce planning to determine how the needs of people would be met by sufficient numbers of care staff.

Overall, we found that improvements were needed for this essential standard.
Outcome 14: Supporting staff

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to people about this essential standard.

Other evidence
We looked at the records for recruitment and employment for four staff. We also reviewed information for the supervision of staff and spoke to staff during the visit to the home.

The recruitment and employment records did not show that the staff had had undergone an induction programme when they first stated working in the home. Some of the records held copies of certificates of training that staff had attained. This included training in dementia care and a National Vocational Qualification in care. There was no evidence in the record we reviewed that the learning and development needs of staff had been assessed.

Care staff told us that some colleagues were trained to provide medication administration which was reviewed regularly. Others told us that they had, had training for caring for people with dementia. The training records supported this. However, there were significant gaps in the training provided to staff for health and safety and food hygiene training which were not recorded as having been undertaken.

Most of the staff had had fire safety, moving and handling, safeguarding and infection control training. However, some of the staff had not undertaken moving and handling refresher training for nearly two years. The training information also showed that staff had not had training for meeting people’s nutritional needs, managing incontinence or in
the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Staff had not received individual supervision that had been planned. Staff we spoke to commented that, they thought that there was a lack of communication from the provider and their views were not sought about how the service was run. Other staff we spoke to told us that they were not aware of what the planned changes were to develop the home.

**Our judgement**
Care staff working in the home did not feel supported through training and individual supervision to remain knowledgeable and competent in their roles. Many staff had not attended basic training or training updates. Staff did not feel involved in the development of the home and the services it provided. It was not clear as to whether new staff undertook an induction programme when first employed in the home.

Overall, we found that improvements were needed for this essential standard.
Improvement actions

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 11: Safety, availability and suitability of equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Why we have concerns:</strong></td>
</tr>
<tr>
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| Treatment of disease, disorder or injury                           | Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010           | Outcome 11: Safety, availability and suitability of equipment           |
|                                                                  |                                                                           | **Why we have concerns:**                                               |
|                                                                  |                                                                           | The home has a range of equipment in use to assist staff in supporting and helping people living in the home. Equipment, we saw in bathrooms had been checked for its safety. However some of the bathrooms did not have sufficient handrails for people to use these independently. |

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

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

The provider’s report should be sent within 14 days of this report being received.

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

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

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<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 01: Respecting and involving people who use services</td>
</tr>
<tr>
<td></td>
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<td>How the regulation is not being met: People who lived in the home did not feel that their opinions were always sought or respected in regard to how the service was provided. People, we spoke to, did not feel that their views and experiences were taken into account about how services were developed. Previous regular meetings for residents, to discuss issues regarding the home, were no longer in place. Some people were not clear about the costs of living in the home as stated in their Permanent Resident Occupancy Agreement.</td>
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<td>Outcome 04: Care and welfare of people who use services</td>
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<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td>Individual care plans did not always have accurate and detailed information for staff to provide the necessary care. Changes in care needs were not always reflected and updated in care plans; therefore people were at risk of not receiving the care they needed. The people living in the home had access to a range of activities. However, these were not always tailored to individual's needs or interests, particularly for those with dementia or similar mental health conditions.</td>
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<tr>
<th>Accommodation for persons who require nursing or personal care</th>
<th>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</th>
<th>Outcome 05: Meeting nutritional needs</th>
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<tbody>
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<td>Dietary needs for people living in the home were assessed and recorded during their initial assessment, prior to admission to the home. People were able to make choices for their main meals and snacks were made available throughout the day. However, the monitoring of some peoples dietary intake was not always undertaken, where this had been assessed as a requirement. Significant changes in some people's weight did not appear to have been identified, explored and addressed.</td>
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<td>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 08: Cleanliness and infection control</td>
</tr>
<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td>Some, but not all, areas of the home were clean. However, the home was failing to protect people, who live in the home, against the risks associated with poor standards of hygiene. This was because of dirty and stained carpeting, dirty sluice areas and cracked toilet pans and washing clothes in areas where food was being prepared. Chemicals, for use in the laundry, were freely accessible and not stored safely and securely.</td>
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</tbody>
</table>
| Accommodation for persons who require nursing or personal care | Regulation 13  
HSCA 2008  
(Regulated Activities)  
Regulations 2010 | Outcome 09: Management of medicines |
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<td><strong>How the regulation is not being met:</strong></td>
<td>Medicines were administered by either a qualified nurse or staff who had undertaken training in medicines management. There were different systems in place, in different units within the home, for the administration and management of pain relief. Some people living in the home managed their own medication. However, the home did not have processes for monitoring people’s ability to manage, and continue to manage, their own medication safely. The facilities for storing controlled medications were not secure.</td>
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| Accommodation for persons who require nursing or personal care | Regulation 15  
HSCA 2008  
(Regulated Activities)  
Regulations 2010 | Outcome 10: Safety and suitability of premises |
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<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td>The home provided a range of rooms and facilities for people living there to use. This included access to a chapel, library and large</td>
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</table>
garden. However, the garden did not provide a safe and secure area for people living in the home who may be confused. Some of the carpeting and flooring had holes and tears. Security arrangements in place did not always stop unauthorised persons entering the home unchallenged. Equipment was stored haphazardly and inappropriately around the home posing a risk to entering or leaving the building in an emergency.

<table>
<thead>
<tr>
<th>Accommodation for persons who require nursing or personal care</th>
<th>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010</th>
<th>Outcome 12: Requirements relating to workers</th>
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<tr>
<td><strong>How the regulation is not being met:</strong></td>
<td>The home does not have effective recruitment processes in place to ensure that the appropriate pre-employment safety checks are carried out, before an offer of employment was made.</td>
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<p>| Accommodation for persons who require nursing or personal care | Regulation 22 | Outcome 13: Staffing |</p>
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<thead>
<tr>
<th>Requirement</th>
<th>Regulation</th>
<th>Outcome</th>
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</tr>
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<tr>
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<td>Outcome 14: Supporting staff</td>
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<td>Regulations 2010</td>
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The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

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

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

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

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

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

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

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
### Information for the reader

<table>
<thead>
<tr>
<th>Document purpose</th>
<th>Review of compliance report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Audience</td>
<td>The general public</td>
</tr>
<tr>
<td>Further copies from</td>
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### Care Quality Commission

<table>
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<tr>
<th>Website</th>
<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
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<tr>
<td>Email address</td>
<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
</tr>
<tr>
<td>Postal address</td>
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