Review of compliance

P H Blackman Limited Thrapston Dental Practice	
Region:	East Midlands
Location address:	3-5 Chancery Lane Thrapston Kettering Northamptonshire NN14 4JL
Type of service:	Dental service
Date of Publication:	May 2012
Overview of the service:	Thrapston Dental Practice provides private dental treatment. It is located in the centre of the small town of Thrapston in Northamptonshire. Further information is available from the dental practice's statement of purpose.

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

Our current overall judgement

Thrapston Dental Practice 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 5 April 2012, talked to staff and talked to people who use services.

What people told us

We spoke with a number of people using the service who told us the dentist was kind and explained things well.

One person said he came here on recommendation many years ago after a bad experience elsewhere; he was very pleased with the service and would "travel 500 miles to see this dentist"

Another said the dentist was always gentle and applied "something soothing" on her gums before injecting local anaesthetic, which helped her cope with her needle phobia.

Although people had positive experiences of care and treatments, we found some concerns, especially in relation to infection control and medicines management.

What we found about the standards we reviewed and how well Thrapston Dental Practice 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 use the service were given appropriate information and support regarding their care and treatment

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

People received appropriate treatment in line with their individual dental plans, but suitable arrangements were not in place to ensure all treatment was provided safely in a foreseeable medical emergency.

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

People using the service and staff were not protected from the risk of infection as the cleaning of the treatment room did not meet HTM 01-05 Essential Quality Requirements, and the provider could not demonstrate that the dental instruments in daily use were sterile.

There were inadequate systems in place to manage and monitor the prevention and control of infection.

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

People were not protected against the risks associated with the unsafe use and management of medicines because the provider could not demonstrate that the medicines were stored at the correct temperature, and the emergency drugs were out of date; therefore the provider did not have in place appropriate arrangements to manage medicines.

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

People using and working in the service were not always protected from the risks of unsafe premises as there were no fire notices or fire practices and there was free access to the dental practice via another business

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

Staff were not appropriately supported to enable them to deliver safe care and treatment to people using the service.

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

People using the service were not protected from the risks of inappropriate or unsafe care and treatment, due to a lack of effective systems to monitor the quality of the service and identify, assess and manage risks.

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

People's care records were not all held securely as paper records were held on open shelves and there was access by another business to the records storage area.

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. 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 compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with five patients attending the surgery for treatment on the day of our visit. One person told us he came here on recommendation many years ago after a bad experience elsewhere; he was very pleased with the service and would "travel 500 miles to see this dentist"

We spoke with two people who had received various treatments from the dentist. They told us the dentist put them at ease and had explained everything. One other person said the dentist was always gentle and applied "something soothing" on her gums before injecting local anaesthetic, which helped her cope with her needle phobia.

Other evidence
The front door to the premises displayed the name of the dentist, the opening hours and a number to call in case of a dental emergency.

The dental nurse greeted the patients in a friendly way and the waiting area was large, well-lit and comfortable. There was no information displayed about the people who worked at the dental practice, or their roles. However, there was information available about oral health. The price list was displayed in the waiting room and at the reception desk. People were given appropriate information, for example one patient was given

written and verbal information for the care of her mouth after treatment.

One person had waited for half an hour before the receptionist advised her that due to the previous patient's emergency treatment they had run over time. Arrangements were immediately made for her to return later that day, as she lived locally. We observed follow up appointments had been made to accommodate people at their convenience.

The dentist explained that he discussed treatment options with patients and let them decide what treatment they wanted. He made a note of the treatment the patient chose on computerised patient files, and this was the method for recording consent. He told us that when a patient had limited capacity, he spoke to them first to gauge their understanding and then involved their carer in the discussion. He did not demonstrate knowledge the Mental Capacity Act 2005, and how this related to his practice.

Our judgement
People who use the service were given appropriate information and support regarding their care and treatment

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People's needs were assessed and treatment was planned and delivered in line with their individual dental plans.

Other evidence
We saw that people were assessed and received treatment that met their individual needs. Two young people had been referred to the appropriate orthodontist at the right time; the treatment had been completed successfully. This meant that they could start their adult life with cosmetically attractive teeth.

One person was given an emergency appointment and had been treated as a dental emergency that morning; another person's appointment was moved to accommodate this. This showed that the dental practice had administrative arrangements in place to deal with dental emergencies.

The emergency medication was not checked or maintained in good order to ensure people received safe and effective treatment in the event of a medical emergency. We have reported on this in Outcome 9, Management of Medicines

Our judgement
People received appropriate treatment in line with their individual dental plans, but suitable arrangements were not in place to ensure all treatment was provided safely in a foreseeable medical emergency.

Outcome 08:
Cleanliness and infection control

What the outcome says

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
We spoke with people using the services but their feedback did not relate to this outcome

Other evidence
There was a record of the dates that the treatment room had been cleaned; this showed that the room was cleaned approximately every three days. Compliance with decontamination guidance published by the department of health (HTM 01-05 Essential Quality Requirements) specify that cupboard doors, the floor and other surfaces should be cleaned daily and there should be a local protocol clearly outlining surface and room cleaning schedules. There were no schedules describing the nurse's responsibilities with regard to cleaning the treatment room. There had been no formal assessment of the nurse in completing cleaning tasks. This meant the competence of people in reducing the risk of infection was not assessed. There were no audits on infection control, which meant that risks to people of acquiring infections were not monitored or managed.

After instruments had been sterilised they were transferred unwrapped into the treatment room into a drawer. The instruments were removed from the drawer as needed, placed on a disposable tray near the dentist before each person arrived for treatment. There was no record or monitoring of when the items were placed into the drawer. The Essential Quality Requirements of HTM 01-05 state that instruments should be used within one session unless they are wrapped for storage. As there was no record of when the instruments had been placed into the drawer before they were used, this was not monitored and put people at risk of acquiring infections from non-sterile instruments.

Compliance with HTM 01-05 Essential Quality Requirements means that there must be an effective quality assurance system, including at least, quarterly audit of decontamination processes. The provider had not assessed the service against the government's guidance on decontamination of dental instruments (HTM01-05 audit tool) or had any audits showing the effectiveness of their decontamination processes. This meant the service could not be sure that all procedures were being followed properly and that people were protected from infection.

The dental nurse showed us how the waste amalgam and old x-ray fluids were stored. She showed evidence of regular collections from a waste control company who collected the waste on a regular basis. The dentist showed how sharps, lead x-ray foils and excess or expired drugs were disposed of in the correct sharps disposal boxes. This meant that the staff were disposing of hazardous waste safely. There was a poster on what to do if someone had a needle stick injury. This is where a needle accidentally pricks someone on the skin, after it has been used on someone else. The dental nurse was able to demonstrate the correct procedure.

Our judgement
People using the service and staff were not protected from the risk of infection as the cleaning of the treatment room did not meet HTM 01-05 Essential Quality Requirements, and the provider could not demonstrate that the dental instruments in daily use were sterile.

There were inadequate systems in place to manage and monitor the prevention and control of infection.

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

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a major impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with people using the services but their feedback did not relate to this standard

Other evidence
The medicines at the dental practice were not being managed in accordance with national guidelines.

We looked at the storage of drugs for injection within the practice. They were stored in a refrigerator within the decontamination room. The refrigerator was in open view of anyone walking along the corridor and did not have a locking mechanism attached to it. This meant that the medicines were not kept safely.

We saw that the emergency drug for diabetic hypoglycaemic attacks (low blood sugar), was stored in the fridge. The drug manufacturer's guidelines state it should be stored within a certain temperature range. The drugs refrigerator did not have a thermometer to determine if the drugs were being stored at the correct temperature. In addition there was no system for recording the refrigerator temperature to ensure the integrity of the drugs within it. This put people at risk of receiving medication that was less effective because it had not been stored at the correct temperature.

There was an unsealed emergency medical bag which contained drugs, the bag did not have any tamper evident packaging. However, some of the drugs were up to five years

out of date. The Resuscitation Council (UK) publish Medical Emergencies and Resuscitation (July 2006) which are the standards for clinical practice and training for dental practitioners and the regulations for medicines management state that medicines required for resuscitation or other medical emergencies are accessible in tamper evident packaging that allows them to be administered as quickly as possible. The Resuscitation Council (UK) publish Medical Emergencies and Resuscitation (July 2006) which are the standards for clinical practice and training for dental practitioners. The dentist explained that they had a contract with a company to inform them when drugs were out of date, and send them replacements as the drugs expired. Although there was evidence that one medicine had been recently replaced, this system was not effective as several drugs were many years out of date . There were no records of the emergency drugs having been checked. The Resuscitation Council (UK) 2012 recommends that dentists carry out weekly checks of the emergency drugs.

We found therefore that people would potentially receive drugs that were out of date in an emergency. The staff at the dental practice did not have the correct drugs to give safe treatment in emergencies such as anaphylactic shock (caused by allergies), asthma attacks, respiratory or cardiac emergencies.

Our judgement
People were not protected against the risks associated with the unsafe use and management of medicines because the provider could not demonstrate that the medicines were stored at the correct temperature, and the emergency drugs were out of date; therefore the provider did not have in place appropriate arrangements to manage medicines.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard

Other evidence
The doors to the reception area opened inwards with ease, and there was a ramp leading from the reception to the treatment room, allowing wheelchair access. There was a visitors' toilet which was spacious enough to allow wheelchair access.

We saw a certificate showing that the premises had been inspected for fire regulations, and there was a weekly record of the fire alarm test. However, there were no written fire procedures available for people using the service, nor evidence of any fire drills having been carried out. This meant that patients and staff might not know what to do in the case of a fire, putting them at unnecessary risk.

The premises were shared by a business on the first floor. There was a staircase in the waiting room that led to the first floor. At the top of the stairs was a door that could only be opened from the first floor to allow emergency exit for the people on the first floor in the event of a fire. As the people on the first floor could access the dental practice at any time, there was not adequate security to the premises.

Our judgement
People using and working in the service were not always protected from the risks of unsafe premises as there were no fire notices or fire practices and there was free access to the dental practice via another business

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 14: Supporting staff. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard

Other evidence
There were inadequate arrangements in place to ensure staff were appropriately trained in order to protect people from risks to their health, welfare and safety:

The dentist had evidence of up to date training in carrying out x-rays in line with Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). However, the dentist said he had not received any training in safeguarding in the last few years. The Resuscitation Council UK guidance states Cardiopulmonary resuscitation (CPR) skills should be updated annually, however the dentist had not had Cardiopulmonary resuscitation (CPR) training since 2010. The General Dental Council recommend training for dentists in legal and ethical issues every five year cycle of training; the dentist said that he had not had post graduate training in consent, which is regarded as both an ethical and legal issue.

The dental nurses were responsible for their own training to maintain their dental nurse qualifications. The dental nurses were on a five year rolling programme for training and there was evidence to suggest that staff had completed some of the verifiable training which all appeared to be through electronic learning. The staff training files were disorganised, which made it difficult to identify the current level of training and professional development for staff. There were no records of mandatory training required such as infection control, safeguarding adults and children, CPR and fire safety, and no record to show training and development staff had attended and when it

needed updating. The Resuscitation Council UK guidance is that Cardiopulmonary resuscitation (CPR) skills should be updated annually, however the dental nurses and the receptionist had not had Cardiopulmonary resuscitation (CPR) training since 2010.

There was a first aid box available to staff in the cleaning room, but there were no staff with up to date first aid training. This put patients at risk of harm if they required first aid. There was no evidence of anyone having up to date training in The control of substances hazardous to health (COSHH). This meant that the staff and patients could be at risk of unsafe use of any cleaning materials.

The dental nurses could not recall the last time there had been a staff meeting; there were no records of any staff meetings, formal, informal or planned for the future. The staff team did not hold meetings to discuss any adverse events, complaints or comments, nor actions taken following any of these.

Our judgement
Staff were not appropriately supported to enable them to deliver safe care and treatment to people using the service.

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
We spoke to people using the services but their feedback did not relate to this standard

Other evidence
We saw evidence that the instrument cleaning equipment was well maintained, and had regular checks from the manufacturers. However, there were no in-house schedules for the servicing and maintenance of equipment, relying solely on the manufacturers to supply the service.
There was no evidence that the emergency equipment and drugs had been monitored weekly in accordance with the Resuscitation Council (UK) 2012 recommendations. This was confirmed by finding items and medicines with expiry dates that were many years in the past, and that no arrangements were in place to ensure the cardiac defibrillator was in working order. We saw the emergency equipment contained children's and adult pocket masks and oral airways. The oral airways were in sealed plastic bags which displayed sterilisation expiry dates of 1995. This meant that patients and staff were at risk of inadequate care in the event of a medical emergency.
We found there were inadequate arrangements for dealing with emergencies: Contrary to guidance from the General Dental Council (GDC) there were no evidence or records of the staff practising for an emergency, and staff did not have up to date first aid or emergency resuscitation training.

There was a record of all the x-rays that had been performed, together with a grading of the quality of the x-ray. The record showed that nearly all of the x-rays were of a good

grade. The patients' records recorded that people had received x-rays, but not the reason for having them. There were no audits for the monitoring of the quality of the patient records, and no monitoring of patient consent.

There were undated risk assessments for blood contamination, Legionella, latex gloves and cleaning products. The dentist said that these were completed many years ago, which meant risks to people's safety and welfare were not being properly assessed and minimised. There was no evidence that the provider took account of or analysed adverse events or incidents so as to improve practice.

People's views were sought through a survey in 2011 and a comments box in the reception area. The staff said that they hardly had any comments made. Although the survey findings were largely positive, there was no evidence that the findings of the survey had been analysed, which would have shown that there were concerns about timekeeping. The poor time keeping had not beenaddressed. There was no provision for people to make a complaint, and the complaints procedure was not displayed.

Our judgement
People using the service were not protected from the risks of inappropriate or unsafe care and treatment, due to a lack of effective systems to monitor the quality of the service and identify, assess and manage risks.

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 minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard

Other evidence
Patients' records were stored in two ways at the practice: all pre 1995 records were held in paper format and post 1995 on the computer system. Electronic notes were held on computers which were on the receptionist's desk and in the treatment room. There was a password to access the medical records section of these notes, so that these were held securely.

We found that current paper documents were still stored in the paper records. These were stored on open shelves in the reception area behind the desk. The dentist agreed that in the event that the receptionist was distracted, anyone could access the patients' notes. The premises were shared by a business on the first floor, and there was direct access between the two businesses. This meant patients' personal information could be accessed by people entering the practice from the shared business, and there were no procedures in place to prevent this or keep the records securely.

Our judgement
People's care records were not all held securely as paper records were held on open shelves and there was access by another business to the records storage area.

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
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: People received appropriate treatment in line with their individual dental plans, but suitable arrangements were not in place to ensure all treatment was provided safely in a foreseeable medical emergency.	
Surgical 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: People received appropriate treatment in line with their individual dental plans, but suitable arrangements were not in place to ensure all treatment was provided safely in a foreseeable medical emergency.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People received appropriate treatment in line with their individual dental plans, but suitable arrangements were not in place to ensure all treatment was provided safely in a foreseeable medical emergency.	
Diagnostic and screening procedures	Regulation 15	Outcome 10: Safety

	HSCA 2008 (Regulated Activities) Regulations 2010	and suitability of premises
	How the regulation is not being met: People using and working in the service were not always protected from the risks of unsafe premises as there were no fire notices or fire practices and there was free access to the dental practice via another business	
Surgical procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People using and working in the service were not always protected from the risks of unsafe premises as there were no fire notices or fire practices and there was free access to the dental practice via another business	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: People using and working in the service were not always protected from the risks of unsafe premises as there were no fire notices or fire practices and there was free access to the dental practice via another business	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff were not appropriately supported to enable them to deliver safe care and treatment to people using the service.	
Surgical procedures	Regulation 23 HSCA 2008	Outcome 14: Supporting staff

	(Regulated Activities) Regulations 2010	
	How the regulation is not being met: Staff were not appropriately supported to enable them to deliver safe care and treatment to people using the service.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff were not appropriately supported to enable them to deliver safe care and treatment to people using the service.	
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: People using the service were not protected from the risks of inappropriate or unsafe care and treatment, due to a lack of effective systems to monitor the quality of the service and identify, assess and manage risks.	
Surgical 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: People using the service were not protected from the risks of inappropriate or unsafe care and treatment, due to a lack of effective systems to monitor the quality of the service and identify, assess and manage risks.	
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: People using the service were not protected from the risks of inappropriate or unsafe care and treatment, due to a lack of effective systems to monitor the quality of the service and identify, assess and manage risks.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People's care records were not all held securely as paper records were held on open shelves and there was access by another business to the records storage area.	
Surgical procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People's care records were not all held securely as paper records were held on open shelves and there was access by another business to the records storage area.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People's care records were not all held securely as paper records were held on open shelves and there was access by another business to the records storage area.	

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 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

Document purpose	Review of compliance report
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