Review of compliance

Chesterfield Royal Hospital NHS Foundation Trust Chesterfield Royal Hospital	
Region:	East Midlands
Location address:	Chesterfield Road Calow Chesterfield Derbyshire S44 5BL
Type of service:	Acute services with overnight beds
Date of Publication:	October 2012
Overview of the service:	Chesterfield Royal Hospital NHS Foundation Trust provides a range of acute services at Chesterfield Royal Hospital including a 24 hour accident and emergency service. The hospital serves the local population of Chesterfield and north Derbyshire.

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

Our current overall judgement

Chesterfield Royal Hospital 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 11 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

We were supported on this review by an expert-by-experience who has personal experience of using or caring for someone who uses this type of care service.

What people told us

People told us what it was like to be a patient in Chesterfield Royal Hospital. They described how they were treated by staff and their involvement in making choices about their care. They also told us about the quality and choice of food and drink available. This was because this inspection was part of a themed inspection programme to assess whether older people in hospitals were treated with dignity and respect and whether their nutritional needs were met.

The inspection team was led by a Care Quality Commission (CQC) inspector joined by an "expert by experience" (people who have experience of using services and who can provide that perspective), and a practising professional. We visited two wards, both designated as primarily caring for older people receiving medical care and treatment. The provider delivered the regulated activities 'Treatment of disease, disorder or injury' and 'Diagnostic and screening procedures' on these two wards. Each ward had 31 patients on the day of our visit. We spoke with 16 patients, three relatives, and eight staff across a range of roles.

Most patients told us they felt staff respected their privacy and dignity. We observed positive and respectful interactions between staff and patients on both wards we visited. However, we also saw examples of patients' privacy, dignity and independence not being upheld or maintained.

Patients had mixed views about the food provided. Some patients were satisfied while

others wanted more variety or wanted meals to meet their specific needs. We saw that patients had a choice of meals and the food provided looked appetising. We found that patients did not always have enough support to ensure they had adequate nutrition and fluids.

Patients told us they felt safe and felt able to report any concerns to staff. We saw that staff carried out assessments to determine if patients were at risk of falling and took action to reduce this risk.

Most patients told us that staff were very good but some patients had mixed experiences and told us some staff were not as helpful as others. For example, one patient said, "It's a difference between shifts, on one nothing's too much trouble, next shift it's 'in a minute' ". We saw that although both wards were very busy on the day of our visit and staff were continually occupied, most patients said their needs were met.

We found that patients had access to their nursing care records, though none of the patients we spoke with had looked at them. We saw that nursing care records were not always accurate or fully completed and often lacked detail.

What we found about the standards we reviewed and how well Chesterfield Royal Hospital was meeting them

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

The provider was not meeting this standard.

People's individual needs, preferences and decisions were not always at the centre of assessment, planning and delivery of care. This meant that people's privacy, dignity and independence were not always respected.

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

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

The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration. The systems in place were not used consistently or effectively to ensure that people had appropriate support to eat and drink sufficient amounts to meet their needs.

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

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

The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the

possibility of abuse and prevent abuse from happening.

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

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet the needs of people using the service.

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

The provider was not meeting this essential standard.

People's nursing records were not accurately or fully completed and were not kept up to date. This meant that people were not protected against the risks of unsafe or inappropriate care and treatment because of a lack of proper information about them.

We judged that this had a minor impact on people using the service and action was 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. We will check to make sure that this action has been taken.

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

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
Most of the patients and visiting relatives we spoke with felt that staff respected their privacy and dignity. Patients said that staff asked them what they liked to be called when they arrived on the ward, and staff then referred to them by their preferred name.

Patients mostly felt that staff spoke to them appropriately and took their views into account. However, one patient said that some staff shouted over patients across the ward to other staff, which they felt was not respectful. Another patient said that that some staff were, "Impatient, don't have the right attitude".

Patients who were able to express their views said they felt involved in decisions about their care and treatment. One patient told us that staff had explained the options, and they had been given sufficient information to help them to make decisions. One patient who was due to be discharged home told us they were involved in planning their discharge, and they were happy with the arrangements in place.

We saw positive and respectful interactions between staff and patients on both wards. For example, we saw staff providing kind and sensitive assistance to a patient who was confused. We saw that staff always used curtains around the bed when assisting with

personal care.

However, we also observed examples where patients' privacy, dignity and independence were not respected. For example, the first patient we spoke with on one ward did not have a nurse call button within easy reach. When we asked the patient how they would call for assistance, a member of staff came over, gave the patient the nurse call button and explained how to use it. We saw that seven out of 31 patients on the same ward did not have a nurse call bell within easy reach. This meant that patients may experience delays in receiving assistance.

Visiting relatives whose family member was receiving end of life care told us that staff had involved them in decisions about the patient's care and treatment. The relatives expressed concern that the patient was being cared for in a six bedded bay, which was very noisy at times. They felt that the environment did not provide sufficient privacy. Staff had not discussed the option of moving the patient to a single room.

We saw that all patients were accommodated in single sex bays or single rooms; not all rooms had en-suite facilities. We saw that some communal toilets and bathing facilities had a sign to show that these were for male or female patients, but some of the facilities did not have a sign. The provider may find it useful to note that although staff knew which facilities to direct patients to, patients may not be aware without a sign in place.

The bedside lockers were adequate for storing patients' belongings. However, the lockers did not have a lockable drawer to enable patients to secure any valuables or personal items.

Other evidence
Were people's privacy and dignity respected?

Staff told us that issues relating to patient privacy and dignity and promoting independence were discussed at staff meetings and handovers. The wards we visited did not have a 'lead' member of staff responsible for promoting dignity and privacy matters. This role could help to ensure a focus on promoting privacy and dignity, and provide a source of information for patients, visitors and staff.

We looked at the nursing care records for eight patients. Four records included the patient's preferred name, four did not. Patients who were able to give their views told us that staff did refer to them by their preferred name. The patient's preferred name should be recorded to ensure all staff are aware. This is particularly important for patients whose communication abilities may be limited. For example, a person with dementia who has always used a nickname may only respond to this. The person may not be able to tell staff about this, but staff could seek this information from the person's relatives.

We saw from the nursing records that staff made regular checks of each patient throughout the day to ensure their comfort, including a 'modesty check'. This meant that staff checked patients were appropriately dressed and covered to ensure their dignity.

The nursing care plans we looked at did not include details of how each patient wanted their privacy and dignity to be respected. For example, the care plans lacked detail of

patients' normal routines regarding their personal hygiene. It is particularly important for these details to be obtained and recorded for patients who may be unable to express their needs and preferences.

Were people involved in making decisions about their care and treatment?

We saw that the information guides about the wards and services provided were available to patients and visitors.

Staff told us that they discussed a patient's care and treatment needs with their family or carers where they were unable to discuss this with the patient. We saw evidence of this in three of the records we looked at. However, we found that a 'Do not attempt cardiopulmonary resuscitation' form had not been fully completed for one patient and did not note if the decision had been discussed with the patient or their representatives.

Our judgement
The provider was not meeting this standard.

People's individual needs, preferences and decisions were not always at the centre of assessment, planning and delivery of care. This meant that people's privacy, dignity and independence were not always respected.

We judged that this had a minor impact on people using the service and action was 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

The provider is non-compliant with Outcome 05: Meeting nutritional needs. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Patients told us they chose meals from a menu each day and there was a suitable variety to choose from. Patients we spoke with had mixed views about the food provided. Some told us it was good enough, such as, "Adequate, a reasonable choice, portions are adequate", "I'm not going to get fat here, but when you aren't doing anything it is ample", "The meals are generally good, you can't fault them". Others thought the food could be better, "The meals don't tempt you to eat when you are unwell as the food is bland and not appetising".

One patient told us they had pureed food and felt that the portions were too big as they were unable to eat more than a few spoonfuls. They said that staff, "Can't understand I can't take it, they keep bringing it". We observed at lunchtime that this patient was served a large portion and refused their meal after trying a small amount. We saw that the patient was quite frustrated by being given portions they could not eat.

Other evidence
Were people given a choice of suitable food and drink to meet nutritional needs?

We saw that the menus gave a variety of hot and cold meals for patients to choose from. The menus included choices for patients who required specific diets, for example, patients who had diabetes. We observed lunchtime on the wards we visited. We saw that the meals were individually served from a trolley and looked appetising.

We saw that patients were offered hot and cold drinks throughout the day. We saw patients' water jugs being replenished to ensure they always had fresh water available.

Staff told us that snack boxes were always available for patients who needed food between regular mealtimes.

Were people's religious or cultural backgrounds respected?

The care records we saw did not include details of the patient's likes and dislikes regarding food and drink. Patients' preferred routines were not recorded and the care plans lacked detail of the individual assistance required with eating and drinking. It is particularly important for these details to be obtained and recorded for patients who are unable to express their needs and preferences.

We did not identify any patients with nutritional needs related to their religious background. Staff told us that meals could be ordered to meet specific religious requirements if necessary.

Were people supported to eat and drink sufficient amounts for their needs?

On both of the wards we saw that the nurses, health care assistants and catering staff all helped to give out the meals at lunchtime. The courses were served separately so that patients could finish their main meal before they received their dessert. We saw that patients were given time to eat their meals and that the lunchtime was 'protected'. This meant that no unnecessary visitors were allowed on the ward at lunchtime to minimise interruption to patients. We observed that on one ward patients who required assistance were served first. This meant that patients who could eat without assistance were left waiting up to 30 minutes for their meals.

Discussion with staff and observation showed that several patients required assistance, prompting and supervision with eating and drinking. We saw that one patient was provided with adapted cutlery to support their independence. We did not see any patients who required staff assistance being given the opportunity to wash their hands prior to and after their meal.

We saw that various signs were available on both wards to help staff identify patients' dietary needs, such as thickened fluids, low fibre diet, or if they required assistance with eating and drinking. However, the signs were not well used; only one person had a sign in place above their bed. Staff had sometimes written a patient's dietary needs on the wipe board above their bed. Although there were systems in place to identify patients' needing support, these were not used consistently or effectively.

We observed staff assisting and encouraging some patients to eat their lunch. However, we saw that some patients did not receive appropriate support and encouragement. For example, staff woke one patient when they took the patient's lunch to them. The patient went back to sleep and the meal remained in front of them until they woke up. By this time the meal was cold. We saw another patient whose recorded dietary intake was poor and the board above their bed stated "assist and supervise and chart all intake". This patient only ate a small amount of lunch but we did not see staff encouraging them to eat more or trying to establish why they had eaten so little. The patient's daily food intake chart was not completed before we left the ward later in the afternoon. If staff were not aware of the patient's limited food intake they may not take appropriate action to ensure the patient had adequate nutrition.

We saw from patients records that they were promptly referred for specialist advice as required. For example, patients were seen by a speech and language therapist where difficulties in swallowing were identified.

We saw that patients were assessed on admission using the Malnutrition Universal Screening Tool (MUST). This helped identify patients who were malnourished or were at risk of poor nutrition. We found that most of the MUST assessments seen had been reviewed each week since the patient's admission.

The care plans we saw did not always reflect the MUST assessment and were not always updated to show the patient's changing needs. For example, one patient's medical records showed that they were 'nil by mouth' on admission but subsequently were able to start having pureed food and thickened fluids. Their care plan did not include this information.

We saw that patients identified as being at risk of poor nutrition had food intake charts for staff to complete. None of the food intake charts we saw had been fully completed. For example, there was a note on one patient's food intake chart that it should be 'strict and concise'. We found no entries at all on three days in one week. This meant that staff could not accurately monitor what the patient had eaten and so take appropriate action to ensure the patient had adequate nutrition.

We found that although patients were provided with drinks during the day, their fluid intake was not accurately recorded. For example, one patient had a fluid intake chart for the day of our visit. We observed the patient having drinks during the day but nothing had been recorded on the chart when we left the ward in the afternoon. For two other patients, we saw that fluid intake charts for previous days had no entries, conflicting with other records that indicated the patients had taken fluids. We saw that many of the drinks cleared away by domestic staff during the morning were half or more full. We were told that patients, "Quite often don't drink, they don't know they are there". This could lead to inaccurate recording of patients' fluid intake and put patients at risk of dehydration.

Our judgement
The provider was not meeting this standard.

People were not protected from the risks of inadequate nutrition and dehydration. The systems in place were not used consistently or effectively to ensure that people had appropriate support to eat and drink sufficient amounts to meet their needs.

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

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Patients we spoke with told us they felt safe and able to report any concerns they may have to staff or the person in charge. Relatives we spoke with also felt able to report any concerns to staff.

We saw staff ensuring safety where patients had been assessed as at risk of falling. For example, by using bed rails, or by having the bed lowered to the floor with a mattress on the floor beside the bed in case the patient rolled out.

Other evidence
Were steps taken to prevent abuse?

Staff told us that they received training about safeguarding vulnerable adults as part of their induction. Staff also received refresher training each year to ensure they understood their responsibilities regarding the prevention of abuse.

The information we held about the provider prior to our visit showed there was a low risk that they were not compliant with this outcome. The information indicated that the provider reported incidents as required, and the speed of reporting was good when compared with similar trusts.

We found that the provider managed allegations of abuse appropriately by following agreed multi-agency procedures. There was a patient safety team based in the hospital who dealt with all adverse incidents, including any allegations of abuse or neglect. We

saw that investigations of incidents were carried out and the results analysed. We saw action plans from recent investigations giving details of action to be taken to reduce the risk of re-occurrence. There was a safeguarding adults group who met regularly and whose membership included Derbyshire County Council Adult Care services staff. This group discussed all allegations of abuse involving the Trust and looked at what lessons could be learned.

Did people know how to raise concerns?

Patients and visitors told us they knew how to raise concerns. The provider may find it useful to note that we did not see any information displayed on the wards we visited about abuse and how to report it.

Staff we spoke with knew what would constitute abuse and knew the procedures to follow to report any suspicion or allegation of abuse.

Were Deprivation of Liberty Safeguards used appropriately?

The staff member in charge on each ward told us there were no current Deprivation of Liberty Safeguards (DoLS) authorisations in place. Staff understood when DoLS should be considered. We saw evidence that assessments of patients' mental capacity to make decisions had taken place, and also assessments of decisions taken in patients' best interests.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The patients we spoke with on one ward were all positive about the way they were treated by staff. They told us that staff were, "Very good, helpful", and one patient said that the care of more vulnerable patients was, "First class".

Patients we spoke with on the other ward had more mixed views. One patient said, "They do a good job in difficult circumstances, very grateful". Other patients told us, "Staff don't always explain", "If you want someone in a hurry they don't come", and "It's a difference between shifts, on one nothing's too much trouble, next shift it's 'in a minute' ". We saw that agency staff were providing cover for permanent staff on this ward on the day of our visit. Agency staff may not be as familiar with patients' needs and ward routines as permanent staff. This means that patients may feel they do not receive consistent care.

We observed that both wards were very busy during our visit. We saw that staff were constantly occupied with checking on patients and meeting their needs. Most patients told us their needs were met by staff. Two patients said there were times when they had to wait for assistance. One of these patients said they had asked a member of staff for a fan as they felt uncomfortably hot but, "She's not got round to it".

Other evidence
Were there sufficient numbers of staff on duty?

We saw that there were eight staff on duty for the morning shift on one of the wards we

visited, and seven staff on the other ward. Each ward had a mix of qualified nurses and health care assistants with support from domestic staff. This meant the staff had a range of qualifications, skills and experience to meet the needs of patients.

We had mixed comments from the staff we spoke with when we asked them if there were enough staff on duty to ensure patients' needs were met. Staff on one ward felt there were usually sufficient staff on duty. Staff on the other ward told us that staffing was reduced from eight to seven for the morning shifts at weekends. They said that this was because the ward was not considered to be as busy at weekends. However, staff felt that patients' needs were the same at weekends and so the staff complement should be the same as during the week.

Staff on both wards told us they did not have a housekeeper at weekends. They felt it would benefit patients to have a housekeeper every day as the housekeepers provided valuable assistance with breakfast and lunchtime.

Staff on both wards told us that extra staff were provided where people were assessed as needing one to one support to maintain their welfare and safety. The ward matron or senior person on call was able to authorise this support.

We discussed the staffing situation with the provider. They told us that there was a review of staffing in progress. The staffing review had already highlighted the need for additional staff on night shifts and this had been put in place.

Did staff have the appropriate skills, knowledge and experience?

Staff we spoke with were knowledgeable about the individual needs of patients. Staff told us they had annual training updates to ensure they had relevant skills and current knowledge to meet patients' needs.

Our judgement
The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet the needs of people using the service.

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
One patient told us, "I've not looked at care records, I don't know where they are, they take it (indicating the notes at the end of the bed) every morning". Another patient said, "Visitors have looked at notes for me". Other patients we spoke with did not provide any feedback related to this outcome.

Other evidence
Were accurate records of appropriate information kept?

We looked at the nursing records for four patients on each ward. We found that the nursing records had conflicting and limited information about patients' needs. Care plans were brief and did not detail all the care, treatment and support that patients were receiving. Staff had completed regular detailed progress reports regarding patients' care, treatment and welfare. However, these did not correspond with the risk assessments and care plans in place which were not always accurate. For example, one patient's care plan stated that they were nil by mouth and had an intravenous infusion running. However, this conflicted with other records which showed that the patient was no longer nil by mouth and required assistance with eating and drinking. The patient's care plan had not been updated since 25 May 2012 to show the changes in the patient's needs.

Another example was a patient who was assessed as being at very high risk of

developing pressure ulcers. However, their care plan simply stated, "To check pressure areas daily". The patient was being nursed in bed. The care plan had not been updated to reflect this, and did not have details of the pressure relieving equipment in use and how often the patient was to be assisted to change their position.

We saw that charts used to record patients' food and fluid intake were not fully or accurately completed. The food charts we saw were often not dated so it was not clear which was the current chart. We saw that entries made in the records of hourly checks and care provided did not correspond with entries in the fluid intake charts. For example, two patients' hourly checks and 'essential care' records indicated that they had taken fluids during the day, but none of the fluids were recorded on the fluid intake chart. We observed another patient having drinks during the day but nothing had been recorded on the chart when we left the ward in the afternoon.

Were records stored securely?

Patients' medical records were stored in trolleys opposite the nurses desk on each ward. This meant that they were easily accessible to staff and were always within sight of staff. Nursing care records, including charts for staff to complete, were kept at the end of each patient's bed. We saw that electronic boards with patients' details displayed were out of sight of patients and visitors to ensure confidentiality.

Our judgement
The provider was not meeting this essential standard.

People's nursing records were not accurately or fully completed and were not kept up to date. This meant that people were not protected against the risks of unsafe or inappropriate care and treatment because of a lack of proper information about them.

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

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
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People's individual needs, preferences and decisions were not always at the centre of assessment, planning and delivery of care. This meant that people's privacy, dignity and independence were not always respected.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were not protected from the risks of inadequate nutrition and dehydration. The systems in place were not used consistently or effectively to ensure that people had appropriate support to eat and drink sufficient amounts to meet their needs.	
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 nursing records were not accurately or fully completed and were not kept up to date. This meant that people were not	

	protected against the risks of unsafe or inappropriate care and treatment because of a lack of proper information about them.

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

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