Review of compliance

Four Seasons Homes No 4 Limited Kingfisher House Care Home	
Region:	East
Location address:	St Fabians Close Newmarket Suffolk CB8 0EJ
Type of service:	Care home service with nursing Care home service without nursing
Date of Publication:	August 2012
Overview of the service:	Kingfisher House Care Home is owned by Four Seasons Homes No 4 Ltd and is registered to accommodate up to 91 people. The service is registered to provide the following regulated activities: 'Accommodation for persons who require nursing or personal care', 'Diagnostic and screening procedures' and 'Treatment of disease, disorder or injury'.

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

Our current overall judgement

Kingfisher House Care Home was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 09 - Management of medicines
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 14 - Supporting workers

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 13 July 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.

What people told us

We spoke with ten people during our visit and observed the care practices, which included an observation of lunch time. The feedback received was mixed. Three people told us that they were waiting to go to bingo. They stated that they played draughts, quizzes and had regular entertainment provided. They said there were regular professional visitors to the home, including a hairdresser. They said staff were "Ok "and they had no concerns. They said their health and personal care needs were met.

We spoke with four relatives who did not raise any concerns. Two people told us they had found it necessary to complain but were satisfied with the way the service responded to it.

We observed lunch and where people required assistance with their meal by staff who did this is a respectful manner? . Seven people in one lounge were observed to be asleep until we interacted with them. One person told us there was nothing to do and they could not communicate with the other residents, some of whom had dementia or required nursing care. They said they would like to get outside. We did not observe anything for people to do. There were no magazines, books or board games.

What we found about the standards we reviewed and how well Kingfisher House Care Home was meeting them

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

The provider was not meeting this standard. We judged this to have a moderate impact on people.

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

The provider was not meeting this standard. We judged this to have a minor impact on people using the service.

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

The provider was not meeting this standard. We judged this to have a moderate impact on people using the service.

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

The provider was meeting this standard. People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

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

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service

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

The provider was meeting this standard. Staff received appropriate professional development.

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 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
We spoke with people throughout the day of our visit and observed their care. One person told us, "It is alright here, things have improved." They said their health care needs were met and there were activities should they want them. A relative said they had complained in the past and their concerns had been dealt with so they were satisfied.

One person told us they were cold. Staff immediately gave them a blanket.

We spoke with three people upstairs who were waiting for staff to take them downstairs for bingo. They told us about the range of activities on offer and said there were books to read. Each of them said they had regular visitors and there were no restrictions on visiting hours. They said their personal care needs were met and they could have a bath or shower once a week. They did not know if they could have a bath more often but said staff were obliging. We spoke to another person who had their hearing aid switched off and was unable to understand us. They appeared to be distressed and continuously tried to get out of their chair. Another person told us there were a range of activities provided by the home but it was their choice not to join in. They told us what they would really like to do was to go out. They described the home like, "A prison." During our feedback we did observe a few residents outside.

Other evidence
Pre admission assessments were in place but provided limited information about

people's needs or how they should be met. We looked at four care plans, two related to people we observed earlier in the day. When asked they had been unable to comment on their care plans because they were not aware of them. One person had been identified at high risk from falls but through our observations they were left unsupervised for over half an hour with no access to an alarm to summons staff help. They required a frame to aid their walking and this was not by them. They were described as confused and it had been recommended that they be assessed for depression. It was not clear if this assessment had been carried out and there was no care plan for this person's mental health. Some information in the care plan had been discussed with the family, but there was no evidence that the person had been consulted about their care needs and how they were met. When we spoke with the person they were able to give us an account of living in the home and were able to make choices when offered. .The person was at risk of pressure sores and there were previous entries of their skin breaking down. Records had been reviewed but there was no evaluation for June 2012 despite areas of high risk identified with falls, nutrition and skin care. Some records had not been completed so could not be evaluated.

We looked at daily records for some people and identified a person who was described as 'aggressive', but there was no behaviour management plan for them. A care plan reviewed also indicated that a person could be verbally aggressive but there was no management plan telling staff how they should deal with this. The deputy manager told is a safeguarding referral had been made in 2011 for one person in relation to their aggressive behaviour but there was no-one with challenging behaviour at present. We saw that the language used in the daily report for one person was inappropriate and threatening. They were warned not to use their call bell again. We considered this response punitive

We looked at further care plans and found assessments for moving and handling, skin integrity, nutrition, oral hygiene, pain assessment, and falls were up to date. Assessments for bedrails in two of the records had not been completed for people at high risk. One person's pain assessment stated they did not express pain but in another record stated that had intermittent pain. We do not know how this information was obtained or if the person had been asked if they experienced pain and were able to let staff know if they needed pain relief.

Through out the day we saw some planned activities taking place, provided by a full time activities co-ordinator. In the morning there was bingo and a film in the afternoon. Some people were complimentary about the range of activities which were displayed around the home. However a large number of people were in their rooms and seven people in communal areas had little stimulation. For example in one living area, the television was on with no one watching it. In another lounge there was no stimulation until a person believed to be the maintenance staff showed a care staff member how to put the television on. When asked which channel they were told it did not matter. None of the people using the service were asked their opinion? Staff did not interact with people in the lounge.

At lunch time meals were taken in the dining room for some people and soft music was played in the back ground.

Our judgement
The provider was not meeting this standard. We judged this to have a moderate impact

on people.

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 minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with people about the quality of the food and observed people as they were eating their lunch. We observed very little food wastage and people were generally complimentary about the food.

Other evidence
We observed lunch in one of the dining rooms, which was served at 12.30. People were served within fifteen minutes and their food was served hot. Many more people had their meals in their bedrooms. Staff told us that they had to assist at least 15 people with their meals and there was an allocation list so staff knew who they were assisting. People were sat in small groups in the dining room and the day's menu was on the board. We observed staff offering people a choice of meal. We observed several staff assisting people to eat and this was done appropriately and at people's own pace. However for people able to feed themselves they received very little interaction apart from staff telling them what was on their plate. We watched one person struggle to cut up their food unnoticed by staff. Earlier we observed people finishing off their breakfast; one staff member was standing over the person to assist them with their meal. This did not promote the person's dignity.

We observed staff giving people hot drinks at 11.00. Interaction was limited and we did not see staff offering a second drink or ensuring everyone finished their drink. One person asked for a biscuit and was told they were not allowed because they were not diabetic biscuits. This did not promote their choice or meeting their specific dietary requirement.

Records showed that actions were taken if people were identified at nutritional risk and people's dietary needs were known. People who needed them had food and fluid charts in place to monitor their intake. We looked at one who had food and fluid intake regularly recorded throughout the day but nothing throughout the evening/night.

There had been one recent complaint about no access to fresh water in a person's bedroom. This was being looked into.

Our judgement
The provider was not meeting this standard. We judged this to have a minor impact on people using the service.

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 moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we spoke with said they were happy that staff managed their medicines for them and said they managed them well. However one person was aware that there had been a delay obtaining one of their medicines so it was not given to them during this period.

Other evidence
As part of our review we looked at how information in medication administration records (MAR) and care notes for people living in the service supported the safe handling of their medicines.

During our inspection we conducted a sample audit of medicines which considered medication records against quantities of medicines available for administration. We were unable to account for some medicines that we looked at and found numerical discrepancies so we could not be assured people were receiving their medicines as prescribed. This included short courses of prescribed antibiotics for acute infections. We also identified gaps in MAR where we could not determine that the medicines had been given to people as prescribed. This included some records that had not been completed during the morning medicine round prior to our arrival. We also found that some records of the non-administration of medicines did not give accurate reasons why medicines were not administered. Some medicines were not given because they were not available and had not been obtained. This put some people at risk because they were not administered their medicines as intended by prescribers for varying periods of

time. Whilst we were told there was a system in place for frequent auditing and monitoring of MAR charts for issues arising we concluded this was not effective in protecting people against the unsafe management of their medicines.

For medicines that were prescribed for administration 'when required' (PRN) at the discretion of staff, we found there was insufficient written information to enable staff to make appropriate decisions about the use of these medicines. This included medicines of a sedative nature prescribed to assist in managing people's psychological agitation or anxiety. We found that there were records of prescriber reviews of people's medicines leading to changes. However where some care plans listed people's prescribed medicines we found these to be inaccurate and in need of updating following the changes.

For one person administering some of their medicines a risk assessment had not been completed and recorded. For another person this was documented in a care plan format but there was no information written about the aspects of safety examined when under review. Therefore this did not show that the person's ability to safely handle and administer their medicines was being closely monitored and supported.

When we asked a registered nurse on duty to access the medicine policy document, we found that this was dated 2010 with a review date of January 2012. We saw no evidence that the policy had been updated and so could not be assured that staff were managing people's medicines to current corporate policy and procedures.

We noted that medicines were being kept securely in treatment rooms within the home. Medicine refrigerator and room temperatures were being monitored and recorded on a daily basis and were within the accepted temperature ranges for the storage of medicines.

Our judgement
The provider was not meeting this standard. We judged this to have a moderate impact on people using the service.

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 compliant with Outcome 10: Safety and suitability of premises

Our findings

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

Other evidence
We received some concerns from the Local Authority about the safety of the premises and some identified trip hazards. On this visit we walked round the home and did not identify any hazards to people's safety. The home was well maintained and to a good decorative standard. We were told the home was completely refurbished two years ago. The home was clean although we did identify a strong odour from two of the bedrooms. The deputy manager told us they were waiting for authorisation to replace the flooring for something more appropriate in one of the rooms. They said that carpets were cleaned every day.

Rotas showed us that the home employed domestic and laundry staff seven days a week, although numbers were reduced at the weekend. The home employed a full time maintenance person. The provider might like to note that storage of clinical waste was in the sluice rooms, clinical waste bags were found on the floor and untied exposing the contents in two separate sluice rooms. This was discussed with the deputy home manager who spoke with the staff present to rectify the problem. The clinical waste bins were not easily identifiable. The bins were regular domestic bins, alternative bin types should be utilised to make it more distinctive to avoid errors by staff.

The hoists were stored in cupboards and corridors, they were not on charge. The batteries were identified in various stages of life from 25% to 100%. The deputy home

manager stated the hoist batteries were charged over night for use during the day. When asked for a copy of the protocol to stipulate this was the home's procedure, the deputy home manager told us one had not been written. This was concerning with some battery levels at 25%. The fish tanks were mouldy and had not been cleaned for an unknown period of time.
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Our judgement
The provider was meeting this standard. People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

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 non-compliant with Outcome 13: Staffing. 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 with three people on the first floor who told us that the home was short staffed on the day of our visit, but said there were usually enough staff on duty. Another person told us, "Staff are too busy to speak to us." We observed one person who was asleep until staff offered them a drink but the interaction was brief. We then observed them again throughout lunch and the interaction with staff was minimal. Staff just told them what food was on their plate. They did not receive any staff assistance although they struggled to cut up her food. Another person told us, "They are short staffed this week, but it hasn't particularly affected me." They then pulled their alarm as they were slipping off the chair and staff attended within a minute.

Other evidence
Prior to the inspection we were told by two different sources that the home was inadequately staffed. On the day of our unannounced visit, the manager was off duty and the deputy manager was in charge. They told us what the staffing levels were for that day and we obtained copies of the staffing rotas for the 02 July to the 29 July 2012. This showed some fluctuations in staffing levels. For example one rota showed carers working in one unit varied from two to three staff on each shift. On another rota staff numbers fluctuated from five to seven. The domestic and laundry rota showed a reduction in staff hours at the weekend. Staff patterns showed a lot of staffing working both an early and late shift on the same day. The rotas did not always include staff surnames which is important in terms of accountability, particularly where staff may have the same first name.

The deputy manager told us they were two staff short on the day of our visit. During the day a staff member on the ground floor was asked to assist staff in another area.

We carried out observations in different parts of the home. Low staffing levels were observed upstairs where people with dementia were cared for. People were left unsupervised and some were unable to verbally communicate. This meant that we could not be assured that they could seek staff assistance if required.

In another lounge we sat in the room for half an hour with seven people and the only staff interaction they received was at 11.00 am when tea was served to people with minimal interaction. People were mostly sleeping. One person continuously tried to get out of their chair unsuccessfully? and we did not see any means for people to communicate with staff if they needed support.

Care Plans for two people showed they were assessed as at risk of falls, one had six recorded falls. When the staff member in charge of the unit was asked if the people should be left alone they told us this was often the case.

We spoke with staff as they were supervising meal times. Staff told us that many people needed assistance with feeding, which took a long time. Another staff member told us that there had been a lot of changes to staffing recently and they were often short staffed. This meant they had time to meet people's routine care but little else. Another staff member told us there had been a lot of staff sickness but felt that adequate staffing levels were maintained. They said there were less staff around in the afternoon. They felt people's physical care needs were met but not always their social care needs.

During feedback the deputy manager told us that they do not use agency staff but have bank staff to cover staff vacancies. They confirmed that the home was fully occupied.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service

Outcome 14:
Supporting 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 competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
We spoke with a number of people using the service. They told us staff were generally very good, but one person said some were better than others. Another person told us that some staff did not speak English clearly and they found it difficult to understand them and equally staff found it difficult to communicate with them.

Other evidence
We spoke with three staff about their staff files, training and supervision. We spoke with other staff throughout the day but their feedback did not relate to this outcome. Staff training records showed that some training had lapsed but this was flagged up with staff by the manager and if they were unable to attend refresher training, they were unable to work.

Staff spoken with told us they had completed dementia e-learning and were regularly supported by other health care professionals such as the speech and language team. The service had their own in house manual handling trainers and training provided was both practical and through e-learning. One staff member told us that team leaders had train the trainer certificates and would delegate training to support staff. They also said staff were encouraged to research a subject and feed this information back to the team at staff meetings. Staff had a training and development file and this provided us with evidence that staff had received training relevant to their role. Some of the training had not been refreshed and dated back to 2008/09. Examples were medication training 2008 safeguarding vulnerable adults 2009/10. When we looked at the computerised training record we saw some training had not been undertaken. Such as health and safety law and infection control.

A second staff file provided evidence of training undertaken but most of the training was dated 2010 and there was no evidence that it had been updated. We could not find this person's training details on the computerised record. Other staff records showed us a lot of the training was up to date, according to the computerised records, which might suggest that the staff manual records had not been updated.

We saw some evidence of staff supervision provided on a one to one basis and through observations of staff's practice. The deputy manager told us they did internal audits such as observation of a meal time which would identify poor staff practices.

The provider may like to note that evidence was not provided to show that all training was up to date. There were systems in place to identify training which had lapsed and plans to address it. The same applied to staff supervision. On the records we saw we could confirm it took place but not how frequently it occurred.

Our judgement
The provider was meeting this standard. Staff received appropriate professional development.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The service was unable to clearly demonstrate how they were meeting people's individual care needs or delivering the care and support people required as identified by their assessment and subsequent care plan.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The service was unable to clearly demonstrate how they were meeting people's individual care needs or delivering the care and support people required as identified by their assessment and subsequent care plan.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The service was unable to clearly demonstrate how they were meeting people's individual care needs or delivering the care and support people required as identified by their assessment and subsequent care plan.	
Accommodation for persons who require nursing or personal care	Regulation 14	Outcome 05: Meeting

	HSCA 2008 (Regulated Activities) Regulations 2010	nutritional needs
	How the regulation is not being met: The service mostly met people's needs but suitable food was not available for one person and the support to enable people to eat and drink sufficient amounts for their needs was inadequate.	
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: The service mostly met people's needs but suitable food was not available for one person and the support to enable people to eat and drink sufficient amounts for their needs was inadequate.	
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: The service mostly met people's needs but suitable food was not available for one person and the support to enable people to eat and drink sufficient amounts for their needs was inadequate.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The service did not protect people against the risks associated with the unsafe use and management of medication by way of appropriate arrangements for the obtaining, recording and administration of medicines	

Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The service did not protect people against the risks associated with the unsafe use and management of medication by way of appropriate arrangements for the obtaining, recording and administration of medicines	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The service did not protect people against the risks associated with the unsafe use and management of medication by way of appropriate arrangements for the obtaining, recording and administration of medicines	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The service was failing to provide a sufficient number of staff at all times for the purpose of carrying out the regulated activity.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The service was failing to provide a sufficient number of staff at all times for the purpose of carrying out the regulated activity.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated	Outcome 13: Staffing

	Activities) Regulations 2010	
	How the regulation is not being met: The service was failing to provide a sufficient number of staff at all times for the purpose of carrying out the regulated activity.	

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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