Review of compliance

Magicare Limited Priscilla Wakefield House	
Region:	London
Location address:	Rangemoor Road London N15 4LU
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	Priscilla Wakefield House is a care home registered to provide care and accommodation to 112 people. At the time of this inspection there were five units in the home; Nickleby for older people requiring residential care, Dorritt 1 and Dorritt 2 for older people who need nursing care and Havisham and Pickwick units for younger adults who may have dementia or acquired brain injury and physical disability and who need nursing care. One floor in the

	home was vacant at the time of this inspection.

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

Our current overall judgement

Priscilla Wakefield House was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

Outcome 04 - Care and welfare of people who use services
Outcome 13 - Staffing
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 18 February 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 spent time in all five units in the home. We spoke to people in four units. Some people were unable to tell us what they thought about the home, so we observed them and their interaction with staff to see their experience. We also spoke to three relatives who were visiting the home during our visit.

At the last inspection of the home in October 2010, we made a number of compliance and improvement actions. Magicare Ltd told us they had made all the necessary improvements. We checked on these same things at this inspection to ensure the improvements had been made. We also talked to staff on duty.

People said they thought they were looked after well and they liked the staff. They thought staff were kind and caring. People said they liked the food and the activities on offer. Two people said they would like more activities to occupy their time.

We observed the majority of staff treated people with respect, were caring and supportive.

What we found about the standards we reviewed and how well Priscilla Wakefield House was meeting them

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

and supports their rights

During our inspection, we found no evidence of unsafe care and people we spoke to said they were satisfied with the care.

Further work is needed to ensure care is provided appropriately to meet each individual's needs, risks to an individual 's safety and welfare have been identified and addressed, and that everyone has access to sufficient stimulating activities.

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

People like the food provided at the home and their nutritional needs are met however we observed some people waited a long time for their breakfast.

People would benefit from breakfast foods being available as soon as they get up.

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

Magicare Ltd makes arrangements to safeguard people against abuse by training staff in protecting vulnerable adults from abuse. Whilst staff showed an understanding of safeguarding issues, unexplained injuries are not being promptly reported and investigated in all cases, which could mean that people may not get medical attention when they need it.

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

Although the safekeeping and disposal of medication is good, there have been two recent medication errors so medicines have not always been administered safely. Magicare Ltd have responded quickly once the errors were known. As there has been more than one recent error, Magicare may wish to take further action to protect people from the risk of unsafe administration of medicines.

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

Magicare Ltd has not provided their own agreed staffing levels at night and therefore people have been at risk of their health and welfare needs not being met at night.

A needs analysis and risk assessment as a basis for deciding sufficient staffing levels was not in place. This would help determine whether the current agreed staffing levels are adequate and that these levels provide sufficient staff during the day and night to meet everyone's needs.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

Magicare Ltd had not notified us of incidents which are required to be reported to us under regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Actions we have asked the service to take

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

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. 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.

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

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

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

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

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We looked at care during the night shift, people's views on the general care, four people's daily care needs in detail, activities and the quality of interaction between staff and people living in the home.

We met with three relatives who were visiting the home and spoke to a number of people living in the home. We also spent time observing in four of the five units to see what people experienced.

Night care

We asked people if staff came quickly when they pressed their buzzer to ask for help. People said staff usually came within a few minutes to help them.

We received an allegation that, due to low staffing levels at night, staff were asking people to get up very early in the morning (5am) for staff convenience. We arrived unannounced at 6am and visited all five units to see how many people were up. We found no evidence that this allegation was true. There were only four people up in the home at 6am and we checked their records and found they were all up by choice and not at staff request. There were two nurses on duty with seven care assistants. One nurse was caring for a sick resident. The other was testing blood sugar levels of a diabetic person in order to give his insulin. The care assistants were busy in people's bedrooms. A few people were awake in bed and staff were assisting these people with personal care and taking them cups tea. We did not enter people's bedrooms but we

listened to staff talking to people and heard them speaking respectfully and asking the person if they were alright and wanted anything. We also saw that staff were changing sheets where this was needed.

We saw one person sleeping on a mattress on the floor of his room. Although this is acceptable if it is agreed and for for safety reasons, there was no record of this decision on the person's care plan. A decision like this should have been recorded in the care plan. The deputy manager said she would look into this.

We saw that some people had their bedroom doors open, some had closed doors and some had lights on. This suggested people had choice. The communal areas were warm and people could get up and sit in the lounge if they wished to. Three people did this early in the morning. We asked people if they could go to bed and get up when they wanted and all said they could.

General care issues

One person said, "It is alright. I'm feeling happy here.The staff is alright."

We spent time observing people living in the home to see what their experience was like. We saw staff talk kindly and patiently to people. We saw that staff knew people well and understood their needs.

We observed staff dealing with residents on four units and found, with one exception, staff to be caring and supportive. We discussed the exception with the deputy manager who said she would look into this.

Staff talked to people while they were helping them, explained what they were doing, smiled a lot and talked respectfully.

One person had complex needs and staff said this person was unable to eat with the other residents due to some challenging behaviour. We observed that the way staff dealt with this situation upset this person. They were taken to their room while the meal was served then had their own meal unsupervised in the lounge. At both mealtimes we heard this person become upset when taken to their room. We also observed they ate alone and staff were mopping the floor during their meal. We informed the deputy manager that the mealtime experience could be improved for this person.

We talked to some people living in the home about their experience. The majority of people said they liked the staff, were treated with respect and thought they were looked after well. They said staff were "kind", "helpful" and "do a good job." They said that staff were aware of their likes and dislikes and that they could get up and go to bed at what time they wanted. Some people, including two relatives that we spoke to, thought the home might be short staffed. They felt that staff were helpful but busy.

Activities

Two residents and one relative said they thought there could be more meaningful things to do. They said that they would like to take part in normal daily activities that they did before they moved here, such as housework and going out.

Other evidence
We looked at a sample of four people's care plans to see what their needs were and then checked whether these needs were being met. We discussed care plans with the deputy manager who told us that if the person is unable to understand and sign their care plan their family will be asked to read and agree to it. We asked a few staff some questions about the care needs of some people living in the unit they work in. Staff knew people's needs well.

We discussed with the deputy manager how daily care records could be improved for some people to make them more useful and record their wellbeing. We also noted in one person's care plan review and daily records that staff had recorded some comments that indicated they may not have a clear understanding of the person's disability.

We saw one person eating tissues three times during the inspection but there was no risk assessment available to advise staff on the risks of this behaviour and how to minimise the risk.

We looked at the care plan for one person who had a pressure sore. We looked for evidence that this person was receiving the proper care to help heal the sore and that professional help had been sought. We had no concern from our inspection of the records as the records showed that treatment was being provided.

Activities

There was an activity programme displayed in the reception area in the home. This programme included games, one to one sessions, arts and crafts, keep fit, coffee club and a planned outing to a shopping centre for the next week. Staff told us that the full time activity coordinator had recently left and the company was looking for a new person to take charge of activities.

We also talked to some people about activities. One person said they did not have enough to do and would like more stimulating activities. Another said she would like to go out more often. This person's relative was visiting the home and said she took her out regularly but that she was used to going out every day and so would like to get out more. One person could not speak to us but we read his care plan and saw that he liked to go to the shops or park, listening to music and sitting in the garden. We saw that staff took this person to the shops during the inspection so this was evidence that staff knew the activities he liked. We saw that people in Havisham unit had been to the park and shops on a regular basis. Other people said they enjoyed having opportunity to take part in activities.

Our judgement

During our inspection, we found no evidence of unsafe care and people we spoke to said they were satisfied with the care.

Further work is needed to ensure care is provided appropriately to meet each individual's needs, risks to an individual 's safety and welfare have been identified and addressed, and that everyone has access to sufficient stimulating activities.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We saw one person, who we first observed at 6.30am, indicating to staff twice that he wanted food. Staff told us that tea and biscuits were given when the person got up but that breakfast was served by day staff. Day staff came on duty at 8am but breakfast was not served to this person until 10.15am. The nurse said this person had been awake since 4am. This was an unacceptably long time for somebody to wait for their breakfast. We discussed this with the deputy manager and asked why people could not have cereal, toast and fruit when they got up in the morning while waiting for the cooked breakfast to be served later. She said there was no reason why people could not have some breakfast when they asked for it.

We did observe that after breakfast, drinks and snacks of fruit and crisps were available in the lounges. This was very good as people could help themselves and also we saw staff offer fruit to people regularly as it was easily available.

People told us they liked the food. Comments included; "the food is alright," "I generally like it" "they feed us well" and "I like soup and fish. I sometimes get it. I have no complaints. We get plenty of tea." One person said they liked the food, could always get what they wanted and thought the food was "very good." We saw that a cooked breakfast was provided and that there was a choice of meals at lunchtime.

One person said they preferred their main meal in the evening and that staff were going to make sure this was arranged for her. One person said the lunches were more varied and interesting than the evening meals. We observed breakfast and lunch and saw that people were given choices of meals and drinks which is positive. Staff helped

those who needed help by cutting their food for them or helping them to eat it.

Other evidence
We saw that there was regular monitoring of people's weight and food charts were completed to record what people had eaten where there was a concern about their weight. A chef is employed to prepare the meals. We saw that the meals looked appetising and people appeared to enjoy them.

Our judgement
People like the food provided at the home and their nutritional needs are met however we observed some people waited a long time for their breakfast.

People would benefit from breakfast foods being available as soon as they get up.

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

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not discuss this with people living at the home. We did ask two people and one relative if they felt safe at the home. All said they did.

Other evidence
At the last inspection of this home in October 2010, we found that a resident had an unexplained bruise that had not been investigated or reported. The manager informed us that he had told all staff that an unexplained injury to any resident must be recorded on a form and given to the home manager plus the injury needed to be reported to the person's family or social worker. At this inspection, we noticed a resident had a bruise that had been recorded in his care file but that had not been reported to the manager, and there was no record of the home trying to investigate how the bruise had been caused. There was no record of a decision as to whether or not the person should be checked by a doctor. Although there is a procedure in place there was no written evidence that it had been followed in this case.

We spoke to a selection of staff and asked them if they knew what to do if a resident told them they had been abused, or if they suspected a colleague senior to them had mistreated one of the residents. All staff showed good understanding of the procedure to follow. Staff said they had attended training in safeguarding vulnerable adults both on line training and face to face sessions. One new staff had not received the training yet.

The manager reported to us after the inspection that a member of night staff was going

to be subject to disciplinary action due to an allegation from a resident that s/he shouted at them. This is an appropriate response.

Our judgement
Magicare Ltd makes arrangements to safeguard people against abuse by training staff in protecting vulnerable adults from abuse. Whilst staff showed an understanding of safeguarding issues, unexplained injuries are not being promptly reported and investigated in all cases, which could mean that people may not get medical attention when they need it.

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 compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not ask people about their medicines at this inspection. We observed staff giving people their medicines. This was done safely and staff supported the person to take their medicine with a drink. We had no concerns about the way we saw nurses giving the medication during this inspection.

Other evidence
We observed staff giving out medicines at breakfast time on two units. We found that staff did not leave any medicines unattended and locked the medicines trolley when they left it. They did not sign for the medicine until they had seen the person take it. This is all good practice in safe administration of medicines.

At the last inspection we found that guidance about medicines that are given as and when needed (for example, painkillers,) was not specific enough. We discussed this with the deputy manager and she told us that the guidance is now clear and includes whether or not the person can tell staff they are in pain. If they can't talk, it describes how to tell if a person is in pain. This is good as it helps staff to ensure that people who cannot speak are not in pain.

Disposal of medicines takes place regularly and the home is using Boots to dispose of their medicines. The deputy manager said that they are receiving good pharmacy support from Boots, which helps staff to ensure that medicines are given safely and unused medicines are disposed of quickly and safely.

After the inspection the manager told us that two staff had been removed from medication duties as they had both made an error with a resident's medication. Safeguarding alerts had been raised about both incidents. The home acted appropriately by stopping these staff giving medication to reduce the risk of any further mistakes.

Our judgement
Although the safekeeping and disposal of medication is good, there have been two recent medication errors so medicines have not always been administered safely. Magicare Ltd have responded quickly once the errors were known. As there has been more than one recent error, Magicare may wish to take further action to protect people from the risk of unsafe administration of medicines.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We asked some people living in the home for their views on staff and we also asked three relatives. Everybody said that the staff were kind and caring and looked after people well. Some people felt that there were not enough staff as staff seemed to them to be busy.

We did observe some excellent examples of interaction between staff and people living in the home. We saw staff supporting people in a sensitive and respectful way. The majority of staff that we saw on the day of the inspection showed the right skills and knowledge to support people.

Other evidence
We received an allegation that there were not enough staff on duty at night to look after people properly.

We arrived for this unannounced inspection at 6am to check how many night staff were on duty. We also talked to some staff to get their views about whether there were enough staff on duty. We looked at staff rotas and we discussed staffing with the deputy manager.

We found that the agreed night staffing for the home at the time of the inspection was two nurses and seven care assistants working at night. At the time of the inspection we found that there were this number of staff on duty. We spent two hours from 6am to 8am walking around the five units to see what night staff were doing. All staff were

busy for the whole two hours caring for people but there was no evidence that people were waiting for help or that anyone's needs were not being met.

However after the inspection visit, when we checked the staff rotas we found that the home had operated below the agreed staffing levels on several occasions. Therefore the home had been short staffed. The manager told us that on the nights where there were not the agreed number of staff on duty that he had put arrangements in place to make sure people's needs are met. These steps included asking day staff to stay late and give evening medication and asking the deputy manager to start work at 5.30am. The deputy manager said she comes in at 5.30am three times a week and that staff appreciate this support. She told us that she is aiming that there will be two nurses and eight care assistants on duty at night. Both nurses on duty also said there should be 9 or 10 staff in total at night.

The manager said the minimum requirement at night is two nurses and six care staff but the agreed staffing level is two nurses and seven care staff.

Night staff said that in a medical emergency they would call an ambulance and in any other kind of emergency they could phone the deputy manager for advice or the manager, who stays in the home four nights a week.

We checked the staff rotas and other records provided to us by the manager. Records showed that in the two months before this inspection there were less then the agreed seven care assistants at night on eighteen nights. There were less than the agreed two night nurses on ten nights. This continued after our inspection on six more nights.
A failure to provide the agreed staffing levels could put people at risk of not having their care needs met.

Staff told us that Nickleby unit was short staffed for the whole of the previous weekend. We noted that there were two care assistants on duty in this unit at night for eighteen people. It was not possible to check whether two staff could meet everyone's needs without checking each person's care plan to see what their night time care needs were.

There was no written assessment available to see what the care and nursing needs of people on each unit were at night. We advised the provider to carry out a staffing review to determine the staffing needs for each unit depending on the needs of current residents.

The week after the inspection Magicare Ltd told us that they had not been aware that there had been less than the agreed staff levels at night and said they would ensure they kept to their agreed staffing levels with immediate effect. We will check this in a few weeks time.

Our judgement
Magicare Ltd has not provided their own agreed staffing levels at night and therefore people have been at risk of their health and welfare needs not being met at night.

A needs analysis and risk assessment as a basis for deciding sufficient staffing levels was not in place. This would help determine whether the current agreed staffing levels are adequate and that these levels provide sufficient staff during the day and night to meet everyone's needs.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are moderate concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
We did not ask people about this.

Other evidence
Magicare Ltd had not notified us of some events which they are required to inform us about. These included allegations of abuse. The manager agreed to ensure this would happen following our inspection.

Our judgement
Magicare Ltd had not notified us of incidents which are required to be reported to us under regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Action
we have asked the provider to take

Improvement actions

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

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
	Why we have concerns: During our inspection, we found no evidence of unsafe care and people we spoke to said they were satisfied with the care. Further work is needed to ensure care is provided appropriately to meet each individual's needs, risks to an individual 's safety and welfare have been identified and addressed, and that everyone has access to sufficient stimulating activities.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	Why we have concerns: Although the safekeeping and disposal of medication is good, there have been two recent medication errors so medicines have not always been administered safely. Magicare Ltd have responded quickly once the errors were known. As there has been more than one recent error, Magicare may wish to take further action to protect people from the risk of unsafe administration of medicines.	

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

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

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

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

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People like the food provided at the home and their nutritional needs are met however we observed some people waited a long time for their breakfast. People would benefit from breakfast foods being available as soon as they get up.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: Magicare Ltd makes arrangements to safeguard people against abuse by training staff in protecting vulnerable adults from abuse. Whilst staff showed an understanding of safeguarding issues, unexplained injuries are not being promptly reported and investigated in all cases, which could mean that people may not get medical attention when they need it.	
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: Magicare Ltd has not provided their own agreed staffing levels at night and therefore	

	people have been at risk of their health and welfare needs not being met at night. A needs analysis and risk assessment as a basis for deciding sufficient staffing levels was not in place. This would help determine whether the current agreed staffing levels are adequate and that these levels provide sufficient staff during the day and night to meet everyone's needs.	
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	How the regulation is not being met: Magicare Ltd had not notified us of incidents which are required to be reported to us under regulation 18 of the Care Quality Commission (Registration) Regulations 2009.	

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

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

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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