Review of compliance

<table>
<thead>
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<th>Nightingale House</th>
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<td>Nightingale House (Nightingale Lane)</td>
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<th>Region:</th>
<th>London</th>
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| Location address:| 105 Nightingale Lane  
                 | Wandsworth Common  
                 | London             |
|                  | SW12 8NB        |
| Type of service: | Care home service with nursing |
| Date of Publication: | April 2012 |
| Overview of the service: | Nightingale House (Nightingale Lane) provides residential and nursing care for up to 215 older Jewish people, and is divided into three units. The Main Building provides nursing care for people with dementia. The Gerald Lipton Centre provides residential and nursing care for older people. The Wohl Wing provides residential care for people with dementia. |
| The home is owned by Nightingale House, which is a registered charity, and is their only nursing home. |
Our current overall judgement

Nightingale House (Nightingale Lane) was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 12 January 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

Most of the people we spoke with said they liked living in the home and felt safe there, although there was the "odd hiccup". People were generally positive about the staff and found them kind and caring. They said that there were always staff available, and they felt able to approach them if they had any concerns.

However, some people and their relatives felt that some of the staff lacked initiative, and could do more to remind people when activities are available. In the Gerald Lipton Centre several people said they were dissatisfied with the lack of activities. One person said "the main issue is the boredom", and another person said that if they didn't want to participate in the planned activity there was nothing else to do.

What we found about the standards we reviewed and how well Nightingale House (Nightingale Lane) was meeting them

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

People are generally treated with dignity and respect. However, in some areas the staff are very task orientated, and do not provide people with choices or explanations of what they are doing. The home is working to provide a more person centred approach to care.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, access to activities was limited in some areas, and some staff were very task-orientated which could reduce the quality of care and put people at risk.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People who use the service are supported to feel safe. There are appropriate procedures designed to safeguard them and to respond to any potential safeguarding concerns.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard.

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

There are generally sufficient numbers of appropriately trained and supported staff, to provide people with safe and reliable care. However, there are some gaps in staff training which may put people at risk.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

The home has processes in place for monitoring the quality of the service provided. People using the service and their relatives have opportunities to contribute towards this.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard.

Actions we have asked the service to take

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

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. 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 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
There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We spoke with the relatives of people living in the Main Building, who said they were generally happy with the home although there was the "odd hiccup". They said the staff always notified them if something went wrong but they could sometimes appear defensive when questioned about this. There was a Residents' Steering Group for people and their relatives to make decisions about the service. The people we spoke with in the Wohl Wing said they felt respected by the staff. We saw that staff interacted positively with people using the service, supported them to make choices and treated them with dignity and respect.

Most rooms in the home are single with an ensuite shower and toilet. There were also a small number of suites for married couples.

We saw that it was difficult to orientate oneself in the Main Building, particularly for people who may be confused or have poor eyesight. The corridors and doors were painted the same colours, and only a small number of the rooms had names or photographs on the doors to identify who they belonged to.

In the Gerald Lipton Unit most of the doors displayed the name of the person whose room it was, but also the name of a person who had donated money to the home, which
could be confusing. There was no information such as what day it was on display, and one person said that there was "no way of knowing what day, date or season it is."

In the Wohl Wing people had their preferred name and a relevant photograph on their room door. The photograph may be of themselves at a younger age, family members, or a hobby or interest. Next to each room door was a display cabinet or 'memory box' which contained mementos, photographs or reflections of their interests. We saw that staff approached people in a positive and respectful way, and that people were offered choices and supported to have their needs met.

Other evidence
Most of the interactions we saw between staff and people using the service were polite and respectful, and in many areas they were positive and friendly. They took account of the person's needs, for example by speaking clearly or bending down to the person's eye level. However, we also saw a number of interactions that were very task focused, particularly in the Main Building and in the Gerald Lipton Centre. This included staff talking over people who were eating their lunch, and moving people without talking to them first and explaining what was happening. For example, one person who was sleeping in a chair was woken up and immediately put in a standing hoist. We also saw staff move chairs, in order to help people stand up, without warning them first.

Staff told us that the home was working with Bradford University to implement a way of working with people that focused on their individual needs and moved away from a 'task-orientated' approach to care. This had been implemented on the Wohl Wing, and was being rolled out across the rest of the home. A project worker from Bradford University was working in the Main Building on the day of inspection.

In the Main Building the care records showed that people had been involved in planning their own support plans, and families had been encouraged to help create life histories and memory boxes. In the Wohl Wing the care plans were written from the person's point of view (for example "I would like..."). However, the daily care record was written in a task orientated manner (for example "toileted twice this morning", "slept well") which did not reflect the interactions we saw between staff and people using the service. It was not clear if people had been involved in their care planning, but the records showed some evidence of discussion with relatives.

The home had achieved the Gold Standard Framework, a national programme for improving end of life care and choices. There were attractive notice boards on display throughout the home explaining the different aspects of care and support given to people during the end of their life. Care records showed that end of life choices had been discussed with people (where possible), their families and other health care professionals. These decisions were clearly recorded so that staff could quickly find this information.

The home provided care for Jewish people in a kosher environment, with an onsite synagogue and rabbi. Staff told us that Jewish customs, holy days and festivals were observed, and we saw objects and information in the home that reflected this. The manager confirmed that many of the staff were not Jewish, but said they were all educated in Jewish culture and traditions. Staff said that people must be Jewish to live in the home, but they can choose their level of religious observance.
The manager told us that male care staff may deliver personal care to women living in the home, and that this was with the woman’s consent. However, it was not clear how some of the people in the home, such as those with dementia, would be able to express this choice.

We saw that people were offered a choice of food at mealtimes, and if they did not want was on the menu they could choose an alternative. People were able to ask for food and drinks outside the main mealtimes.

There is a residents’ guide for people using the service, and relevant information on noticeboards around the home. We saw residents’ and relatives’ newsletters, which the manager said were circulated within the home and by email.

**Our judgement**

People are generally treated with dignity and respect. However, in some areas the staff are very task orientated, and do not provide people with choices or explanations of what they are doing. The home is working to provide a more person centred approach to care.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
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
The people we spoke with in the Main Building said that some of the staff were excellent, kind and caring, but some lacked initiative and did not offer their relatives as many opportunities to take part in activities as they could. They said this meant their relative living in the home was often left doing nothing.

In the Gerald Lipton Centre we saw that staff addressed the physical needs of people quickly, such as when someone was asking to use the bathroom, or needed support to move.

The people we spoke with in the Wohl Wing said they liked living there, and that the staff were kind and helpful. They said they could approach staff when they wanted anything.

We saw that there were activities available throughout the home. This included in the Gerald Lipton Centre, however we had negative comments from several people about the lack of activities there. One person said “the main issue is the boredom”, and we observed that many people simply sat in a line of chairs throughout the day. Another person told us that if they didn't take part in the planned activity (on the day of our visit it was pottery) there was nothing else to do.

Other evidence
The home was working with specialists in dementia from Bradford University to improve dementia care. This included how staff worked and interacted with people, the activities
available and the environment. Although the home was in the process of implementing dementia care mapping (for improving the experience of people with dementia) and person centred care, and this was reflected in some staff behaviour towards people, there was limited evidence of this in the written care records. The records did contain information about people's life histories, and showed that people's needs had been assessed and care plans developed.

The care records showed that discussions had taken place about end of life care and whether people wished to be resuscitated. Assessments of people's capacity to make decisions was recorded, and included important decisions around health and finances, and everyday decisions such as buying small items from the shop and deciding what to wear. Some people in the home had been formerly assessed under the Mental Capacity Act.

In the Main Building there were a number of facilities for people using the service and their visitors. This included a café, shop, post box, and an art and activity centre. There were landscaped gardens around the home, and outside the Wohl Wing there are a number of features to remind people of the past such as an old car and an old-style red telephone box.

In the Main Building and the Wohl Wing there were objects, decorations and photographs to support reminiscence of the past. Some floors in the Gerald Lipton Centre had been laid out to encourage people to use the different communal areas for example with music or board games, but staff said people tended to congregate around the main communal areas.

We saw people carrying out individual activities, for example knitting, playing cards, and reading the newspaper. There is a local and unit-wide activity programme, which included music and pottery. Most of the floors in the home have an activity co-ordinator, although there was a vacancy for an activity coordinator on at least one of the floors. The home has a number of volunteers who lead and support activities within the home, and run the shop.

We saw some positive interactions with the activity co-ordinators and volunteers across the home, and with some of the care staff who engaged people in activities. They invited people to take part, and were positive and encouraging. They responded to people's individual needs and were person centred.

Care records showed that people's healthcare needs were assessed and monitored and they were visited and treated by other healthcare professionals when required. The home has its own GP practice, physiotherapy and occupational therapy department, and pharmacy on site. Dentists and other healthcare professionals visited the home when necessary.

In the Main Building we saw a member of staff push a person in a wheelchair without checking their feet were positioned on the foot plates first, and the person's feet were in fact dangling between the foot plates. We brought this to the attention of the staff and manager.

The home had identified that it had slightly high levels of falls than expected and was working to address this. In the Wohl Wing staff demonstrated a sensor system in the
flooring. This could be activated at night and alert staff if a person got out of bed, or if they had not returned to bed within a certain period of time. We saw that the units had lifting aids and hoists so that staff could safely support people to move around the home, and in and out of chairs, beds and baths.

The home has processes in place for the safe handling and administration of medication.

**Our judgement**

The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, access to activities was limited in some areas, and some staff were very task-orientated which could reduce the quality of care and put people at risk.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
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

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<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 07: Safeguarding people who use services from abuse</td>
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<th>Our findings</th>
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| **What people who use the service experienced and told us**
The people we spoke with said they liked living in the home and felt safe there. One person said she would rather be in her own home, but accepted that she forgot things sometimes and was safer here.  

**Other evidence**
The home had safeguarding processes, and demonstrated how it investigated and monitored safeguarding concerns and co-operated with the local authority safeguarding teams. We saw a care plan that had been developed in response to a recent safeguarding concern.

Training records showed that most staff in the home had had recent safeguarding training. The staff we spoke with described how they would raise any safeguarding issues, and said they felt able to approach their managers to express any concerns they had about care in the home.

Records showed that the home had processes for monitoring capacity and making and managing formal Deprivation of Liberty (DOLs) applications under the Mental Capacity Act. Some of the people in the home are subject to DOLs, and we saw records of DOLs' decision related to people's health, finances, what they wanted to wear, and if they wanted to leave the home.

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<td>People who use the service are supported to feel safe. There are appropriate</td>
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procedures designed to safeguard them and to respond to any potential safeguarding concerns.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard.
Outcome 14: 
Supporting staff

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

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

What we found

Our judgement
There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
Most of the people we spoke with, and their relatives, said that they liked the staff and they were very kind. They said that there were always staff available, and they felt able to approach them if they had any concerns. However, some people and their relatives felt that some of the staff lacked initiative, and could have done more to remind people when activities were available.

Other evidence
The manager told us that there were some staff vacancies but the home was in the process of recruiting to these posts. The home has its own ‘bank’ of staff it uses to cover temporary shortages. Staff told us that there were usually adequate numbers of qualified nurses and care workers working in the home.

The staff we spoke with said they felt supported, got on well with their team, and felt able to approach their managers if they had concerns. Most of the staff were up to date with their mandatory training, although there were gaps on some of the units. Staff told us that their training included food hygiene, infection control, safeguarding, and moving and handling. Most senior carers have completed person centred care and dementia training, and have national vocational qualifications (NVQs) in care. We saw evidence of regular supervision and staff meetings. Most of the staff we spoke with said they had had recent supervision which they found helpful.

There was an onsite therapy department with full time occupational therapists, physiotherapists and assistants. There was a GP practice for the home onsite, with a GP and an Advanced Nurse Practitioner available during office hours.
Our judgement
There are generally sufficient numbers of appropriately trained and supported staff, to provide people with safe and reliable care. However, there are some gaps in staff training which may put people at risk.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
Outcome 16: Assessing and monitoring the quality of service provision

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

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement
The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Residents' surveys had been carried out, and the most recent one (from 2011) is available on the home's website. It included identified areas of concern, and what the home had done to address these.

We saw minutes of residents' meetings, relatives' forums and the relatives' steering committee, that showed that people's views were listened to.

Other evidence
The home had processes in place for monitoring the quality of the service. We saw that this started at unit level, and fed up to an overview by senior management.

We saw that staff had regular handovers, and there is a meeting of clinical managers three times a day to share key information about the people using the service, and other issues affecting the home such as infections or health and safety concerns.

Staff told us that senior managers visited the units each day, and the chef also visited the units daily to monitor the provision of food. We saw records of audits of care that were carried out in each of the units. These included audits of medication, care records, health and safety, and hand washing.

We saw minutes of meetings that showed issues were raised and the quality of the service was monitored. These included staff meetings, cross department meetings, management meetings, and the clinical governance board.
The home had processes for managing incidents, accidents and complaints; and we saw that these were routinely investigated, reviewed and monitored. The deputy director of nursing gave some examples of complaints and the action that had been taken to rectify them. We saw that the service had identified a common theme from a number of complaints and taken action to address this. For example, there had been complaints about clothes shrinking when washed. The service researched washing powders that helped make sure clothes were infection free even when washed at low temperatures.

**Our judgement**
The home has processes in place for monitoring the quality of the service provided. People using the service and their relatives have opportunities to contribute towards this.

Overall, we found that Nightingale House (Nightingale Lane) was meeting this essential standard.
Improvement actions

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

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<th>Regulated activity</th>
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<th>Outcome</th>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 01: Respecting and involving people who use services</td>
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**Why we have concerns:**
People are generally treated with dignity and respect. However, in some areas the staff are very task orientated, and do not provide people with choices or explanations of what they are doing. The home is working to provide a more person centred approach to care.
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**Why we have concerns:**
The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, access to activities was limited in some areas, and some staff were very task-orientated which could reduce the quality of care and put people at risk.

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The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, access to activities was limited in some areas, and some staff were very task-orientated which could reduce the quality of care and put people at risk.

**Why we have concerns:**
There are generally sufficient numbers of appropriately trained and supported staff, to provide people with safe and reliable care. However, there are some gaps in staff training which may put people at risk.
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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.
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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<tr>
<td>Author</td>
<td>Care Quality Commission</td>
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<td>Audience</td>
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### Care Quality Commission

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<td>Telephone</td>
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<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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| Postal address| Care Quality Commission  
Citygate  
Gallowgate  
Newcastle upon Tyne  
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