Review of compliance

Quality Care (EM) Limited The Oaks Nursing Home	
Region:	East Midlands
Location address:	114 Western Road Mickleover Derby Derbyshire DE3 9GR
Type of service:	Care home service with nursing
Date of Publication:	July 2012
Overview of the service:	The Oaks is registered to provide the regulated activities of accommodation for people requiring nursing or personal care, treatment of disease, disorder or injury and diagnostics and screening. It provides care for up to 28 people of either gender who have Dementia.

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

Our current overall judgement

The Oaks Nursing 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 to check whether The Oaks Nursing Home had taken action in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 12 - Requirements relating to workers
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 30 April 2012, observed how people were being cared for, talked to staff and reviewed information from stakeholders.

What people told us

Most of the people who live at The Oaks Nursing Home would find it difficult to help us understand their views about the quality of the care being provided to them. We used a special tool designed to help us understand how people who have Dementia experience the care being provided to support them. We observed five people who live at the service in one of the lounges over two hours starting at 11.55am. We looked at how staff interacted with people and how care was being provided to support people with their needs. We looked for clear and observable signs which would show us how people felt about the care they were receiving.

We found mixed evidence about how people were treated by staff. We saw that some staff were kind and attentive, and promoted people's independence. We were concerned about the attitude and conduct of a member of qualified staff who did not assist people in a way which upheld their dignity and met their needs.

We were concerned about the arrangements to keep people safe from harm and protect their rights. We saw that a person the local authority had identified as presenting a risk of harm to themselves and others was agitated with others living at the service. We witnessed incidents between her and others living at the service which staff missed as they were busy assisting others.This meant that the person and other people living at the

service were at risk of harm. We were concerned about how a nurse managed behaviour which may challenge and about the restrictions on one person's freedom which was unlawful.

We inspected all communal areas and the bedrooms of twelve people using the service. We found the areas we visited to be clean and well maintained with no unpleasant odours.

We found continued evidence to show that staff had not been recruited safely and in a way which ensured that they were safe to work with vulnerable people.

We had concerns about the conduct of a member of staff which we shared with the provider to ensure the safety of people living at the service. They shared the concerns but there was no evidence to show they had taken any action to discuss this with the member of staff or to assess their performance. This showed us that the systems in place to support staff and ensure they were competent were not sufficiently frequent, rigorous and robust.

What we found about the standards we reviewed and how well The Oaks Nursing Home was meeting them

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

The provider was not meeting this Regulation.

People's independence was promoted but their dignity was not respected by all staff members.

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

The provider was not meeting this Regulation.

People were not protected from the risk of abuse because the provider had not taken all reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider was meeting this Regulation.

People living at the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

The provider was not meeting this Regulation.

People could not be assured that they were supported by suitably qualified, experienced

and skilled staff who had been effectively recruited.

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

The provider was not meeting this Regulation.

People were not cared for by nurses who were supported to deliver care and treatment safely and to an appropriate standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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

In a previous review, we found that action was needed for the following essential standards:

- Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
- Outcome 09: People should be given the medicines they need when they need them, and in a safe way
- Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Most of the people who live at The Oaks Nursing Home would find it difficult to help us understand their views about the quality of the care being provided to them. We used a special tool designed to help us understand how people who have Dementia experience the care being provided to support them. We observed five people who live at the service in one of the lounges over two hours starting at 11.55am. We looked at how staff interacted with people and how care was being provided to support people with their needs. We looked for clear and observable signs which would show us how people felt about the care they were receiving.

We found mixed evidence in this outcome area.

We observed that the senior carer was consistently kind, caring and attentive to people living at the service. This staff member showed consideration for people and their feelings and managed difficult situations easily.

We saw that people were provided with specialist equipment to assist them to eat independently which meant they could maintain their skills and abilities.

We also saw that with the exception of one person, all of the staff assisted people to eat at a good pace, making sure they had finished the food in their mouth before offering more to them.

We saw a qualified member of staff was hurrying the person being assisted, putting more food in their mouth whilst they were still finishing off the last mouthful. This was not only undignified but created a risk of the person choking on their food. This person was flinching as this member of staff came near them with the spoon, we did not see the person respond like this to any other staff member who assisted them. We were concerned this may indicate that they were intimidated by the member of staff. We passed on these concerns to the providers for them to take action.

We were concerned about how this member of staff responded to people living at the service more generally. When the staff member was assisting a person to eat they were looking around the dining area, talking to other staff and shouting directions to staff across a communal area. This showed the member of staff was not concentrating on the person they were assisting. We saw this member of staff instruct another who was assisting a person to eat to, "come and take over from me." This meant the staff member had to leave one person part way through their meal to go and assist another. The person then had to wait for a further 10 minutes for someone to carry on assisting them to eat. This was a considerable interruption to the dining experience of that person.

We observed that most of the staff started out communicating well with people they were assisting to eat though they soon lapsed into silence. This meant staff were not communicating effectively with people. We also saw three staff talk about staffing arrangements and lounge cover in the middle of a communal area where people were sitting. This did not help create a homely atmosphere and showed staff were still following an old practice we had been told had stopped.

Other evidence
The local authority and primary care trust visited the service again in April and told us that some staff were still not interacting effectively with people living at the service. They told us they observed that care staff did not communicate well when they were assisting people in the hoist. We did not find that this was the case with the people we observed, but this did suggest staff may be inconsistent in how they delivered this aspect of care.

The local authority told us they were particularly concerned about the interaction with and quality of care for the people with higher dependency needs. We observed that four of the five people we observed slept for the majority of the time, and apart from being assisted to eat, had minimal interactions with the staff. The interactions we did see were kind and genuine, but our evidence did support the observations of the local authority and primary care trust staff.

We had minor concerns in this outcome area following our last inspection of the service on 21 March 2012. The providers told us they would take action to address the areas of concern by providing supervisions and a yearly appraisal for all nursing staff. We saw evidence during our last inspection that staff had received training on dignity issues and they confirmed this to us in interview.

We asked staff about the approach of the nurse we had observed. They felt the staff member could be "loud." A senior staff member told us that care staff went to them for advice, but another said they still looked to the nurse for direction. This was concerning as the attitude and behaviour of the nurse we saw were not appropriate and care staff may believe that this is how they should respond to people in their care.

Our judgement
The provider was not meeting this Regulation.

People's independence was promoted but their dignity was not respected by all staff members.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 07: Safeguarding people who use services from abuse. 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
Most of the people who live at The Oaks Nursing Home would find it difficult to help us understand their views about the quality of the care being provided to them. We used a special tool designed to help us understand how people who have Dementia experience the care being provided to support them. We observed five people who live at the service in one of the lounges over two hours starting at 11.55am. We looked at how staff supported them with their care needs and kept them safe.

We observed a person the local authority had identified as presenting a risk of harm to themselves and others. We saw that this person's behaviour was unpredictable, saw that they were restless and therefore difficult for staff to keep track of. This was because most of the people who live at the service needed a lot of physical assistance to meet their needs. We saw this person pull food and drinks away from other people, grab hold of their arms and become verbally agitated with them. The staff did not notice these incidents occurring as they were busy assisting others and therefore took no action to address them. This meant that the person and other people living at the service were at risk of harm.

We saw a qualified member of staff respond inappropriately to this person when they would not do what the staff member wanted. We saw there was a stand off between the staff member and the person; the staff member appeared to become increasingly agitated and directive towards the person living at the service. We saw the staff member banging their hand on the table to try and get the person living at the service to

do what they wanted. This was a wholly inappropriate response towards a person whose understanding and communication was affected by their illness and it was not effective in diffusing the situation. We eventually saw a member of care staff step in and quickly and effectively diffuse the situation.

We remained concerned about how staff managed restrictions to a person's freedom in respect of their access to cigarettes. The providers had told us that this person no longer had restricted access to their cigarettes and could have one when they wished. However, we observed a member of staff approach a nurse to inform them that the person was asking for one of their cigarettes. The nurse was agitated at this request and stated, "they had one 30 minutes ago, they can't have another." We saw the nurse go and tell the person this. This meant the person was still experiencing restrictions on their rights to make their own decisions.

Other evidence
The local authority and primary care trust visited the service again in April and told us they had concerns in relation to the identified person's access to their cigarettes. They considered that the poor care planning was resulting in a deprivation of liberty.

We looked at the care plan for this person. The staff had not assessed the person's capacity to make a decision about when they had a cigarette. There was no evidence that there had been any consideration as to whether it was lawful for the nurses to keep and restrict the person's cigarettes. This meant the person's rights were not being upheld.

The local authority also told us they were concerned about the inadequate monitoring of a person with a long history of physically abusing others. They told us the staff at the service were failing to follow the safeguarding plans they had put in place. Our observations confirmed this. Staff had not noticed the person's agitation and aggressive incidents taking place as they were busy with other duties. This placed the person and others at risk of harm.

We looked at the safeguarding records and saw that incidents were being referred to the safeguarding team in line with locally agreed procedures. However, we saw one incident which should have been notified to us to enable us to effectively monitor the service and it had not been.

Our judgement
The provider was not meeting this Regulation.

People were not protected from the risk of abuse because the provider had not taken all reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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 inspected all communal areas and the bedrooms of twelve people using the service. We found the areas we visited to be clean and well maintained with no unpleasant odours.

One person we spoke with told us, "I think my room is nice, it is clean."

We observed people had a choice of three communal lounges to use. In the main, we found these to be clean and homely with the exception of one area attached to the dining area. This area was cut off from the other lounge areas and was not as homely and comfortable as other lounges. The television was positioned on the wall where it would be difficult for people to be able to see it if they chose to. The acting manager told us there were plans to change this area in the near future.

We saw the garden areas outside the home were well maintained and attractive with access for people using the service.

We spoke with a relative who said she had noticed there were improvements being made to the environment. She felt this made the home look fresher. She said she had always found the home to be clean and tidy.

During our observations we noticed that the dining area was not large enough to enable people to sit and eat their meal without interruption. We witnessed staff often having to stand up to allow equipment and people to pass through whilst they were in the process of assisting people to eat. Sometimes these interruptions were quite protracted. The

provider may wish to note that the current dining arrangements mean that people's dining experience is being affected. This may affect their appetite and diet.

Other evidence
The acting manager told us they had recently established a contract with a maintenance company, including the provision of an on call service. This meant repairs could be attended to quickly to make sure the home was safe for people to live in. Staff from this company were working in the service on the day of our inspection, making improvements to the corridors in the home. We saw a room had been renovated in order to install a new hairdressing room for people using the service. Space had also been created for a new office rather than this being at the top of the building and inaccessible for people living at the service and visitors.

The home also employed a 'handyman' and staff we spoke with told us he was quick to make repairs when they were reported.

The provider might find it useful to note that some bedrooms we visited did not appear to be personalised with the individual's pictures or possessions. Two bathrooms were also quite plain and did not appear homely.

We saw evidence that fire equipment had been regularly tested and maintained by an external company to make sure it was working and safe to use. Fire equipment was accessible and fire doors were closed where specified reducing the risks to people in the event of a fire.

We found portable electrical equipment had been regularly tested and verified as safe to use.

Clinical waste removal contracts were in place with a secure waste bin outside of the home for staff to use. The laundry area was free from clutter and well organised. There was appropriate equipment in place to support staff to maintain effective infection control procedures in the laundry. The provider may find it useful to note that there was no evidence of protective equipment such as aprons and gloves available for staff in the communal toilets and bathrooms. This meant there was a preventable risk of staff assisting people with personal care without the necessary protective equipment to prevent the spread of infections.

Windows in the home were fitted with restrictors to ensure security and ensure the safety of people living at the service.

Our judgement
The provider was meeting this Regulation.

People living at the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Outcome 12:
Requirements relating to 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is non-compliant with Outcome 12: Requirements relating to workers. 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 observed people who lived at the service but our evidence from these observations did not relate to this standard or regulation.

Other evidence
We set a compliance action in this outcome area following our last inspection of the service on 21 March 2012. The providers sent us an action plan and they told us that they had assessed all recruitment documentation. They said a new checking system had been put into place an easily followed format. They also gave us verbal assurances that they had checked all recruitment files and that they now complied with legal requirements.

We looked at the recruitment files of nine members of staff employed by the service. We found there were issues of concern in all nine of the files. This meant we were concerned about the effectiveness of the recruitment procedures in place.

One of the staff files we looked at did not contain evidence of any references obtained prior to the staff member starting working at the home.

In several cases, references about staff member's conduct in their previous employment had been sent to personal addresses, rather than the business address of the company. This meant the providers had no way of verifying the identity of the referees or of checking they were in a position to comment on the person's suitability to work with vulnerable people.

We saw that a reference for two members of staff had been obtained from the home address of a person who claimed to have employed them both. This person gave a reference for one of the members of staff in 2011, despite documenting on the reference they had retired from the service in 2008. This meant they had not worked at the service for the last three years of the person's employment and could not comment on their conduct in relation to this time period.

The recruitment files of two members of staff did not contain evidence that a criminal records bureau check (CRB) had been carried out. This meant these staff were employed without an appropriate check to make sure they did not have any convictions which may present a risk to people living at the service.

We saw that in some staff files, where the original criminal records check document had been destroyed in line with the provider's policy, a form had been kept to provide evidence the check had been carried out. However, the form did not state whether any convictions had been disclosed on the form which may need assessing to make sure there was no risk to people living at the service. This meant there was no way of auditing if there were any convictions disclosed and if a risk assessment was needed to ensure the member of staff was safe to work with vulnerable people.

We saw a number of files where there were gaps in people's employment history without any explanation. This meant that the providers could not be assured that those staff members had not worked with vulnerable adults or children during these periods and failed to disclosed it. Therefore the providers could not be assured that the employment history of these staff did not present a risk to the vulnerable people in their care.

Some files did not contain evidence to demonstrate that staff were physically and mentally fit to work at the service which may place them and people living at the service at risk of harm.

We found there was inconsistent information in one staff file about the reasons they left their previous employment in a health or social care setting. The information from a referee was in direct conflict with information given by the employee on their application form and in interview. There was no evidence this discrepancy had been discussed with the employee to assess whether they were trustworthy and fit to work with vulnerable people.

We spoke with the providers about our findings. They told us that the files had been checked by a team of people; though they confirmed they had not double checked them personally to ensure their system had been implemented appropriately and to the required standard.

Our judgement
The provider was not meeting this Regulation.

People could not be assured that they were supported by suitably qualified, experienced and skilled staff who had been effectively recruited.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
We observed people who lived at the service but our evidence from these observations did not relate to this standard or regulation.

A relative we spoke with told us that there had been a lot of changes in staff. She said that there had been some staff who did not work as hard as others but said this had improved. She said she had some concerns about people's ability to understand some of the staff.

Other evidence
We set a compliance action in this outcome area following our last inspection on 21 March 2012. We wanted to check whether improvements had been made.

When we looked at seven staff files we found there had not been any supervision undertaken on staff since our last visit, but we saw that the providers were in the middle of doing appraisals with all of the staff.

Following our last inspection, we were concerned about the competence of the nursing staff at the home. We were once again concerned about the approach, attitude and skills of the nurse we observed. We were concerned that this person had only had clinical supervision twice; the last time in February 2012 and this had not raised any concerns about their performance.

We spoke with the providers about the conduct of this member of staff and they informed us they had their own concerns but had no alternative but to use the member

of staff as they had a small pool of qualified staff available. There was no evidence that they had raised these concerns with the staff member. There was no evidence that they had been monitoring the person's performance. This evidence showed the supervision process was not frequent or robust and had not included any observation of practice.

Our judgement
The provider was not meeting this Regulation.

People were not cared for by nurses who were supported to deliver care and treatment safely and to an appropriate standard.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider was not meeting this Regulation. People's independence was promoted but their dignity was not respected by all staff members.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider was not meeting this Regulation. People's independence was promoted but their dignity was not respected by all staff members.	
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: The provider was not meeting this Regulation.	

	People were not protected from the risk of abuse because the provider had not taken all reasonable steps to identify the possibility of abuse and prevent abuse from happening.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The provider was not meeting this Regulation. People were not protected from the risk of abuse because the provider had not taken all reasonable steps to identify the possibility of abuse and prevent abuse from happening.	
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: The provider was not meeting this Regulation. People could not be assured that they were supported by suitably qualified, experienced and skilled staff who had been effectively recruited.	
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: The provider was not meeting this Regulation. People could not be assured that they were supported by suitably qualified, experienced and skilled staff who had been effectively recruited.	
Treatment of disease, disorder or injury	Regulation 21	Outcome 12:

	HSCA 2008 (Regulated Activities) Regulations 2010	Requirements relating to workers
	How the regulation is not being met: The provider was not meeting this Regulation. People could not be assured that they were supported by suitably qualified, experienced and skilled staff who had been effectively recruited.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The provider was not meeting this Regulation. People were not cared for by nurses who were supported to deliver care and treatment safely and to an appropriate standard.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The provider was not meeting this Regulation. People were not cared for by nurses who were supported to deliver care and treatment safely and to an appropriate standard.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The provider was not meeting this Regulation.	

	People were not cared for by nurses who were supported to deliver care and treatment safely and to an appropriate standard.

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.

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
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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