Review of compliance

Caulfield & Gopalla Partnership Newnton House Residential Care Home	
Region:	London
Location address:	Newton House, 4 Newnton Close Hackney London N4 2RQ
Type of service:	Care home service without nursing
Date of Publication:	September 2011
Overview of the service:	Newnton House is a residential care home providing care, support and accommodation for up to nine men with mental health support needs. The home is located in Stamford Hill in Hackney close to local shops and public transport.

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

Our current overall judgement

Newnton House Residential Care Home 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 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 06 - Cooperating with other providers
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People living at the home told us they were well supported and felt safe. People said the staff were kind and they felt involved with their care. People were able to raise any concerns with the manager. Two people we spoke to could not think of anything at all about the home that could be improved but others did identify some improvements, for example having a small fridge in the bedroom, or changing their 'keyworker' at the home. We were contacted by the relative of one person who had lived in the home with concerns about their care. These concerns triggered this inspection.

Overall people were happy with the home and the staff.

What we found about the standards we reviewed and how well Newnton House Residential Care 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 recognised and supported people's individual needs. People using the service were encouraged to lead active lives. People felt involved in decisions about their care and the running of the home.

Overall , we found that Newnton House was meeting this essential standard.

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

The people living at the home were generally experiencing effective care. However we found that the care plans and observation notes did not always contain precise enough information to identify warning signs. Some daily practices had been allowed to develop at the home that were potentially risky. We saw some evidence that the provider was already addressing these concerns.

Overall, we found that improvements were needed for this essential standard.

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

The home provided people with information about meals. People enjoyed the meals prepared by staff and were offered variety and choice. People were encouraged to cook for themselves.

Overall, we found that Newnton House was meeting this essential standard.

Outcome 06: People should get safe and coordinated care when they move between different services

The home worked in partnership with other agencies and health and social care professionals for the benefit of people living at the home.

Overall, we found that Newnton House was meeting this essential standard.

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

The provider took appropriate steps to train staff about the protection of people using services from the risk of abuse. However in practice, the provider had not responded appropriately to the safeguarding concerns raised in a complaint.

Overall, we found that improvements were needed for this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People using the service generally experienced a clean and hygienic environment.

Overall, we found that Newnton House was meeting this essential standard.

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

At the time of our visit, there were sufficient numbers of trained and experienced staff working to meet the residents' needs.

Overall, we found that Newnton House was meeting this essential standard.

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

Staff and managers at the home were trained for their roles and supervised.

Overall, we found that Newnton House was meeting this essential standard.

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 provider was monitoring the quality and safety of the care it provided.

Overall, we found that Newnton House was meeting this essential standard.

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

The provider did not always ensure that it notified the Care Quality Commission as required.

Overall, we found that improvements were needed for this essential 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 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. Any regulatory decision that CQC takes 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

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
At the time of the inspection, eight people lived at the home. We spoke to four people who used the service on the day we visited. A fifth person not want to speak to us but we observed this person interacting well with the staff and enjoying a meal and television while we were there. The other three people were all out.

The people we spoke to were happy with the home. One person said 'everything is going right'. This person said he was able to go out and about in Hackney with the support of a care worker or his relatives.

People told us that the staff were kind. One person said 'we can have a laugh and a joke' when talking about care workers at the home.

We observed that people living in the home were largely able to come and go when they wanted and that the staff respected people's privacy for example knocking and waiting to be invited into people's rooms.

People said they had been involved in decisions about their care, for example attending formal meetings to review their care with health and social care professionals and they felt able to raise any concerns with the manager or deputy manager. People signed

their care plans when they were updated which provides further evidence that they were involved in this process.

The home ran regular house meetings that people attended it they wanted to.

Other evidence
We looked at people's care plans. The plans reflected people's individual needs and to some extent their cultural and social preferences, for example, whether people wanted to attend formal religious services.

We interviewed two members of staff who were on duty on the day we visited as well as the deputy manager. Staff were keen to respect people's choices.

Our judgement
The provider recognised and supported people's individual needs. People using the service were encouraged to lead active lives. People felt involved in decisions about their care and the running of the home.

Overall , we found that Newnton House was meeting this essential standard.

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 moderate 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 home provides a community based service for people who have a history of mental health problems, some of whom also have a learning disability. Most people referred to the home have previously spent long periods in a secure hospital setting. The staff we spoke to were clear about the aims of the service and how they were supporting the men who lived there. We were given an example of how the home had helped one person develop their independence so they had recently been able to move out.

The people we spoke to were generally happy with the care they received. We asked people how the staff supported them. They gave us examples of how the staff reminded them get them up in the morning so they did not miss events or appointments, called them for medicine, cooked meals and helped them with tasks like shopping.

One person said 'the home is good' but wanted to move out and live more independently. This person was able to cook for himself but was not yet able to manage his own medication and said this was his next goal.

Another person said he did not like the side-effects from his medication. He felt his doctors did not understand or listen to him when he raised it with them. We discussed this with the deputy manager present at the resident's request. It was clear that the deputy manager was familiar with the problem and that care workers from the home supported this person when he attended medical appointments. This person also told us that 'everything is alright' at the home and 'I don't want to leave here'.

The home operated a key-working system. Where one member of staff regularly met with particular service users on a one-to-one basis. People seemed to like this system although one person wanted to change his key-worker and another wanted his key-worker to go out with him more often.

Everyone we spoke to felt safe at the home.

Other evidence
We were contacted by the relative of a person who was concerned about the care their family member had received while living at the home. Their concerns triggered this inspection and we looked in detail at the way people's care needs were being met at the home. At the time of this inspection, the specific complaint was being investigated by the local council safeguarding team and the outcome was not yet known.

The home kept care plans that recognised people's individual needs. Each plan included a risk assessment (for example, listing the warning signs of the onset of mental health problems specific to that individual). The home had also included health action plans in people's files with a record of people's health appointments and health conditions.

Some of the people living in the home had long term physical health problems, for example diabetes. We found that the plans for people with diabetes clearly identified the condition and associated actions that staff and the residents needed to carry out eg weekly blood glucose testing, increasing physical activities and dietary changes. The staff supported people to attend diabetic clinic appointments. The home had also provided some training to staff specifically about diabetes.

However, the plans were not always this comprehensive. One person had been admitted to the home with chronic obstructive pulmonary disease. This is a long term condition which tends to get progressively worse over time and leaves people vulnerable to chest infection. The daily observation notes showed that this person had been complaining of shortness of breath and had been wheezing. We raised this with the deputy manager who said that the notes did not indicate anything out of the usual for this person. Even so, in our view, there was little clear information in this person's care plans and risk assessment to help staff recognise warning signs or indicate what they should do. This person had complex needs and other aspects of his physical health were being actively monitored by staff.

We reviewed the daily observation notes and care plans for a number of people living at the home. We found these were of variable quality. Some entries in the daily notes, particularly those written by the manager, were very clear and informative and focused on the care and wellbeing of the individual concerned. Others were vague and it was difficult to tell what care had been given to people and why, for example one entry simply read: '[x was] given support by staff all day'. Another person's care plan specified the things that the person liked to do in very general terms: 'indoor' and 'outdoor activities'.

We saw that the manager of the home had recently also identified this issue and was addressing record keeping through supervision meetings with particular members of staff.

As noted under outcome one, the staff were keen to respect people's choices but the home did not always seem to recognise the tensions between people's choices with their care needs. For example, the deputy manager told us that some people liked to sleep longer on some mornings and it had been normal practice in the home to delay prompting these residents for their medicines until they were ready to get up. We were told that this practice had now changed and everyone was prompted for their medicines as prescribed. The people we spoke to who lived at the home confirmed this as did the home's recent records. Even so we were concerned that this sort of practice had been allowed to develop at the home given the potential risks.

Our judgement
The people living at the home were generally experiencing effective care. However we found that the care plans and observation notes did not always contain precise enough information to identify warning signs. Some daily practices had been allowed to develop at the home that were potentially risky. We saw some evidence that the provider was already addressing these concerns.

Overall, we found that improvements were needed for this essential standard.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The people we spoke to were happy with the food. Shopping was organised around a weekly menu and people said they had opportunities to discuss this and get involved in the shopping. We did not observe a meal during our visit but the meals seemed well balanced and varied. People had access to fruit and vegetables and were able to select alternatives to the planned menu items if they wanted something different.

The home encouraged people who were able to cook for themselves. Two people were doing this. One person we spoke to said he wanted to cook for himself but had not yet done so. He said he this was something he wanted to try doing in coming months.

People were individually given an allowance from the home's food shopping budget to choose food and drinks that they wanted themselves. One person said his food tended to be taken by other people and wanted to have a small fridge in his own room. He had raised this with the staff.

Other evidence
The kitchen was stocked with a good range of foods. The staff told us that they tried to obtain people's preferred foods.

We reviewed the care plans for one person with an eating disorder who had lived at the home. We found that the home had monitored this person's food intake on a daily basis and had provided him with high calorie food supplements as prescribed. The care plan included an agreed threshold weight which would trigger an admission to hospital. Staff monitored this person's weight.

Our judgement
The home provided people with information about meals. People enjoyed the meals prepared by staff and were offered variety and choice. People were encouraged to cook for themselves.

Overall, we found that Newnton House was meeting this essential standard.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people who use the service about this outcome.

Other evidence
People had been placed with the service by a number of different authorities. The deputy manager at the home reported that the home had very good working relationships with other agencies.

Health and social care professionals regularly visited the home to meet their clients. Members of the home's staff attended and contributed to formal multi-agency reviews of people's care. The deputy manager felt that staff views were respected at these meetings.

The home had been struggling to meet the needs of one person who had been placed at the home. The manager had alerted the relevant specialist health team and this had triggered a formal review of the person's care. The person and his relatives also attended this meeting. The review had resulted in a decision to find a more appropriate placement for this person.

Our judgement
The home worked in partnership with other agencies and health and social care professionals for the benefit of people living at the home.

Overall, we found that Newnton House was meeting this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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
On this occasion we did not ask people using the service about this outcome.

Other evidence
At the time of this inspection, there was one outstanding safeguarding concern which had been triggered by a complaint from a relative of a person who had been using the service.

The provider initially investigated the complaint in line with its complaints policy but did not seem to recognise that the complaint raised safeguarding concerns and did not raise an alert with the local authority nor notify the Care Quality Commission. The deputy manager told us this was because the provider wanted to complete their internal investigation and establish the facts first. The manager later explained that a misunderstanding had occurred and he had believed that a senior director would notify the relevant authorities. We found this level of confusion concerning.

We spoke to members of staff who were on duty on the day of our visit and looked at the staff training records. Staff had received training on the protection of vulnerable adults. This training covers types of abuse and what staff should do if they believe that someone using the service might be being abused. The deputy manager confirmed that safeguarding training was mandatory for all members of staff.

Our judgement
The provider took appropriate steps to train staff about the protection of people using

services from the risk of abuse. However in practice, the provider had not responded appropriately to the safeguarding concerns raised in a complaint.

Overall, we found that improvements were needed for this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People living at the home were encouraged to clean up after themselves, to help with their laundry and maintain good personal hygiene. No one we spoke at the home to raised any concerns about cleanliness or hygiene.

Other evidence
We observed the communal areas of the home on the day that we visited. All areas of the home were clean and tidy. The home employs a cleaner but we also observed care staff tidying and cleaning on the day we were there.

Staff were trained in infection control.

The home had been rated four stars ('very good') for its food hygiene by the London borough of Hackney in 2009.

Our judgement
People using the service generally experienced a clean and hygienic environment.

Overall, we found that Newnton House was meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Nobody living at the home raised any concerns about staffing.

Other evidence
The staff duty rota clearly set out who was on rota each week. The rota showed us that there were enough staff at the home during the day and night. The staff were appropriately experienced and qualified (to NVQ 2 level as a minimum).

The home had two members of staff on duty during the morning, three staff members on duty in the afternoon and two people on duty overnight (one of whom was on a sleeping shift). On the day of our visit the manager was on leave and the deputy manager was in charge. She was also able to telephone the manager at a sister home nearby if necessary and this manager also visited the home regularly while the usual registered manager was away.

We looked at the files for three members of staff. We looked to see that their recruitment process had been robust, that they are legally entitled to work in the UK and that they had up-to-date Criminal Records Bureau and Independent Safeguarding Agency checks. All documentation appeared to be in place.

We also talked to the deputy manager and the other members of staff on duty on the day we visited about their recruitment processes and staffing.

Our judgement

At the time of our visit, there were sufficient numbers of trained and experienced staff working to meet the residents' needs.

Overall, we found that Newnton House 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

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
On this occasion we did not ask people who use the service about this outcome.

Other evidence
We spoke to the deputy manager and two members of staff about the training and support they received and the supervision arrangements for staff. We also looked at the staff training and supervision records.

The staff spoke very positively about their work and their roles in the home. One person said they found this particular client group very rewarding to work with because they could see the progress that people made: 'You see people becoming more independent over time. You help with that strategy. At first […] couldn't make a cup of tea and now he is making breakfast himself'.

Staff received mandatory training (including fire safety, food hygiene, first aid, safeguarding vulnerable adults, health and safety, infection control, drugs awareness and medicines handling). Successful completion of training was recorded in individual's files. Staff also had training on topics relevant to their roles, for example some staff were studying for the NVQ level 3 in health and social care, and some staff had received training around challenging behaviour, learning disability and the Mental Capacity Act.

All staff completed an induction programme when they were recruited. One member of staff we spoke to had recently been recruited and was currently undergoing this.

The provider has an annual appraisal system for staff and staff also had supervision meetings with their manager every 4-6 weeks. The meetings covered staff members' performance, their training and development and any current issues involving people using the service. We saw that the manager used these sessions to promote learning, for example, asking staff to consider particular topics such as schizophrenia and best interest meetings in advance of the meeting.

Our judgement
Staff and managers at the home were trained for their roles and supervised.

Overall, we found that Newnton House was meeting this essential standard.

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
People using the service told us they had opportunities to comment on the quality of care for example during fortnightly house meetings. We looked at the notes of these meetings. People had discussed topics like room maintenance, having a barbeque and the shopping list. Sometimes residents had taken the notes themselves.

Other evidence
The deputy manager told us that the home used their care planning and key working system (where one member of staff has regular one to one meetings with a service user and monitors their progress) as a way of monitoring that the service was meeting people's needs and achieving good outcomes. The home also sought feedback from placing authorities about the service for example at people's review meetings.

We asked what changes the home had made in response to feedback and were told the smoking area and kitchen cupboards had recently been improved in response to comments from people using the service,

The home held staff meetings and we were told these were a vehicle for learning from incidents and complaints, for example the recent complaint from a relative of a service user. The notes of the staff meetings were very general in nature and it was difficult to verify this. Staff members' recent supervision records suggested that the manager was following up some quality issues with individuals.

The provider had recently commissioned an audit report from an external consultant but

the results of this were not yet available.

Where we had concerns (for example see outcome 4) we found some evidence that these had also been identified by the provider and were being acted on.

Our judgement
The provider was monitoring the quality and safety of the care it provided.

Overall, we found that Newnton House was meeting this essential standard.

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 minor concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
On this occasion we did not ask people using the service about this outcome.

Other evidence
The provider did not notify the Care Quality Commission that it had received a complaint which included allegations of neglect and 'acts of omission' by staff at the home. Our concerns about this are discussed in more detail under outcome 7.

The manager explained that this had occured through a misunderstanding and he had believed that another senior director was submitting a notification.

The provider has notified the Care Quality Commission promptly as required in the past.

Our judgement
The provider did not always ensure that it notified the Care Quality Commission as required.

Overall, we found that improvements were needed for this essential standard.

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 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	Why we have concerns: The provider did not always ensure that it notified the Care Quality Commission as required.	

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 within 7 days of this report being received.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The people living at the home were generally experiencing effective care. However we found that the care plans and observation notes did not always contain precise enough information to identify warning signs. Some daily practices had been allowed to develop at the home that were potentially risky. We saw some evidence that the provider was already addressing these concerns.	
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 took appropriate steps to train staff about the protection of people using services from the risk of abuse. However in practice, the provider had not responded appropriately to the safeguarding concerns raised in a complaint.	

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 this report being received.

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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