Review of compliance

Somerset Redstone Trust Newstead House	
Region:	West Midlands
Location address:	43 Venns Lane Hereford Herefordshire HR1 1DT
Type of service:	Care home service with nursing
Date of Publication:	February 2012
Overview of the service:	Newstead House is located in Hereford and provides nursing care for older people.

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

Our current overall judgement

Newstead House was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 Newstead House had made improvements 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 09 - Management of medicines
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 4 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited the home to check if they had made the improvements which we had required them to make following a review in September 2011. We found that there had been some improvements but in some cases people were still at risk because the home was not ensuring that their needs were fully met.

We spoke with five people living at the home and some of their relatives. Most people told us that staff treated them with respect and that they felt that their privacy and dignity were promoted at the home. Staff were kind and caring in the way they spoke to people, and we saw that staff did not rush people, but allowed them as much time as they needed.

There was evidence that some people's care needs were not being fully met at the home and this put them at risk of poor outcomes.

We saw that people had drinks in front of them, and each person had at least one jug of

drink within reach. We saw that staff were encouraging people to drink, but records indicated that some people were not being given enough to drink. People were at risk of not receiving enough to eat or drink at the home, because hydration and nutrition were not managed safely.

Medication was not being managed safely at the home.

We found that staffing levels within the home had been increased and people told us that staff came quickly when they needed them. People spoke highly of most of the staff at the home, and said that they were "kind", "always cheerful" and "good at their jobs". The fact that some basic aspects of care, such as the safe management of a pressure ulcer, had not been addressed by the nurses was a concern. There were sufficient numbers of staff, but lack of action on the part of some staff meant that people could be at risk of not having their needs met.

People told us that they appreciated the opportunities which they had been given recently to put forward their views at meetings. The systems in place for making sure that the home was run in people's best interests were not effective.

What we found about the standards we reviewed and how well Newstead House 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

Staff at the home work hard to try to make sure that people's privacy and dignity are respected.

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

The home does not ensure that people receive safe care which meets their needs. We have issued a warning notice requiring Newstead House to become compliant with Regulation 9 (1)(a) and (b)(i) (ii) and (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 28 February 2012.

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

People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.

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

People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Outcome 13: There should be enough members of staff to keep people safe and

meet their health and welfare needs

There are sufficient numbers of staff, but lack of action on the part of some staff means that people could be at risk of not having their needs met.

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 systems in place for making sure that the home is run in people's best interests are not effective.

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.

We have taken enforcement action against Somerset Redstone Trust.

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

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 our previous visit to Newstead House, we had found concerns about the way that people's rights to privacy and dignity were being managed at the home. We returned to the home to check whether improvements had taken place. We spoke with five people living at the home and some of their relatives. Most people told us that staff treated them with respect and that they felt that their privacy and dignity were promoted at the home. Some people told us that they felt that staff did not always listen to them and did not always provide care which promoted their dignity and privacy. One person said "some staff are a bit abrupt, but most of them are lovely".

We saw that staff knocked before entering bedrooms and were careful to make sure that people had privacy when any personal care was being provided. Staff were kind and caring in the way they spoke to people, and we saw that staff did not rush people, but gave them as much time as they needed.

Other evidence
We saw notes of a recent meeting where people living at the home and their relatives had been encouraged to put forward their views. People told us that they appreciated the chance to discuss ways in which the home could improve. Staff told us that a comments box would soon be available so that people could make suggestions about

the home anonymously if they wished.

The Chief Executive of the Somerset Redstone Trust (the owners of the home) told us that he had written to everybody living at the home and their relatives following our last visit to ask for suggestions of ways in which the home could improve.

There was evidence in the care records that staff knew about people's preferences such as preferred time to go to bed in the evening. People told us that staff generally provided care and support in the way they wanted it provided. Care plans did not always make it clear that people or their relatives had been offered the opportunity to be involved in planning and reviewing their care needs. People told us that they had not seen the care plans, but most people and their relatives said that they would not wish to be involved as they saw this as something they would prefer staff to do for them.

Our judgement
Staff at the home work hard to try to make sure that people's privacy and dignity are respected.

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 major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
At our previous visit in September 2011 we had major concerns about the management of people's care needs. The home had provided a written report and had told us that the required improvements had been put in place. The purpose of this visit was to find out if the home was now complying with the Regulations and providing a safe standard of care.

We saw that most people were either sitting in their armchairs in their bedrooms or were in the communal lounges during the day. We saw that people who were in their bedrooms had their call bells within reach, so that they could call for assistance if they needed it. People were wearing appropriate clothing and footwear, and their hair and nails were clean.

At our previous visit we had been concerned that the home was not providing care which would help to prevent the risk of pressure area damage. We checked the care records for three people who had been assessed as being at high risk of developing pressure ulcers. It is important that people have regular changes of position if they are at risk of developing pressure ulcers. Staff should assist people to change position if they are unable to do this for themselves. The home was using charts to show when people had been assisted to change their position. We saw that the charts for the three people had not always been completed, with gaps of up to 15 hours recorded between position changes. Therefore there was no evidence to show that people's position had been changed as required.

One person had developed a pressure ulcer and the care records showed that nurses had been putting dressings on the ulcer. The Royal College of Nursing (RCN) and The National Institute for Health and Clinical Excellence (NICE) have produced guidelines for the management of pressure ulcers. These state "Patients should receive an initial and ongoing pressure ulcer assessment. This should be supported by photography and/or tracings (ruler for calibration)" and "The dressing should be documented in the plan of care with rationale for its use". There was no plan in place to tell nurses which dressings to use, and there was evidence that nurses had not all been using the same dressings. There were no recordings of the size of the wound and no photographs.

People who are at risk of pressure area damage need a good fluid intake, as this reduces the risk of ulcers developing. The RCN had stated that "A conservative estimate for older adults is that daily intake of fluids should not be less than 1.6 litres per day". We checked the records for three people at high risk of pressure area damage and saw that staff were recording their fluid intake. We saw that the amount taken in 24 hours was added up each day. The records showed that, for one person, over the past two days, their fluid intake had been 520ml and 700ml respectively over 24 hours. For another person, the fluid intake records indicated that on each of the previous nine days, their fluid intake had been less than 1 litre. We went to the person's bedroom and we saw that they appeared to be very thin with dry skin.

Other evidence
The home uses a computerised care planning system. We saw that some records were kept on the computer and some were printed out in a care plan folder. When we compared the information in the folder with that on the computer, we saw that there were many differences. In general, the computerised records were more up to date. We spoke with care staff and they told us that they would not use the computerised records to find out people's care needs but would look at the printed care plans. This means that they might not have access to the most recent information about each person.

There was inconsistent information in some of the care plans. For example, one person had been assessed on the computerised system as being at medium risk of developing pressure ulcers. However, when assessing the risk using a paper version of the assessment, the score showed a high risk of developing pressure ulcers. The records showed that one person had diabetes. The care plan stated "My glucose level requires occasional checking". There were no records of any measurement of the person's glucose levels. Staff told us that they do not carry out the checks as they are not needed. Therefore the care plans do not always accurately reflect the care that is needed or provided.

Our judgement
The home does not ensure that people receive safe care which meets their needs. We have issued a warning notice requiring Newstead House to become compliant with Regulation 9 (1)(a) and (b)(i) (ii) and (iii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 by 28 February 2012.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We saw that people had drinks in front of them, and each person had at least one jug of drink within reach. We saw that staff were encouraging people to drink, and one person told us "I don't drink much, they keep telling me I should drink". The person appeared well hydrated and had a beaker of water on their table with a cloth to catch any drips. The records showed that the person preferred to drink water.

People told us that the food at the home had improved. One person said "it's nice to have more variety" and another said "they seem to be trying harder". We saw notes of a meeting which the manager had held to find out what sort of food people would like to eat.

We have already reported in the section on Outcome 4 that the records for some people showed a very low fluid intake. We saw that one person was in bed with a cold cup of tea in front of them. Their lips were dry, so we looked at the fluid intake chart. This showed a low fluid intake over the previous ten days, with only 200ml recorded as having been taken in one 24 hour period. If records indicated that someone's fluid intake was exceptionally low on one day intake, we would expect to see that staff had made an extra effort on the next day to make sure that the person had enough to drink. However the records for the next day showed a fluid intake of 600ml over 24 hours, which is less than half the recommended amount of 1600ml.

Other evidence
When we checked the records of people's weights we saw that one person had recently lost a significant amount of weight. There was evidence that staff had ensured that the

weight loss would be discussed with the GP on her weekly visit to the home. When we checked the food intake records for this person, there were no recordings of any snacks offered or eaten between meals. There was no information in the care plan about the need for snacks or a fortified diet for this person.

Our judgement
People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not speak to people about their medicines.

Other evidence
The safe handling of medicines was assessed by a pharmacist inspector. We looked at the storage of medicines and a selection of people's medicine records and some care plans.

A Pharmacist from the supplying pharmacy had undertaken a visit and checked medicine management on 7 October 2011 and also a Pharmacist from Herefordshire PCT had undertaken a check on the safe handling of medicines on 31 October 2011. We saw copies of both reports which detailed recommendations and areas for improvement to ensure that people's medicines were handled safely.

We found that people's medicines were not always handled and managed safely. Procedures for the obtaining, recording, handling, using, administration and disposal of medicines were not always followed, which increases the risk of a medicine error.

There were systems in place to check that people had been given their medicines, however they did not always identify medicine errors and therefore action was not always taken to prevent them happening again. We looked at ten people's medicine administration records and found it was not always possible to determine if they had been given their prescribed medicines. One person had been given medicines that

were no longer fit for use and there was an increased risk that the medicines were no longer effective. This means that despite systems being in place they were failing to ensure that people were being given their prescribed medicines and there was an increased risk of a medicine error.

Personal care plans did not always record specific person centred information relating to people's medicines, in particular for medicines prescribed when required (often documented as 'PRN'). It is important that these details are available to inform staff when to recognise that medicines need to be given, especially for people who are unable to communicate verbally.

Medicines were stored securely and at the correct temperatures in order to protect people who use the service and to ensure the medicines are fit for use.

We looked at the arrangements and storage for controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements. We found other items which were not classed as controlled drugs were stored incorrectly. This increases the risk of unnecessary access to controlled drugs and means that the service was not complying with legal requirements. We were told that this would be dealt with immediately and the items would be removed.

Our judgement
People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We found that staffing levels within the home had been increased and people told us that staff came quickly when they needed them. People spoke highly of most of the staff at the home, and said that they were "kind", "always cheerful" and "good at their jobs". We saw that the care staff were working hard and were obviously busy, but they made sure that people were given time and did not feel rushed.

It is not enough just to provide sufficient numbers of staff: it is also important that staff carry out their duties so that people are cared for and supported so that their needs are met. The fact that some basic aspects of care, such as the safe management of a pressure ulcer, had not been addressed by the nurses was a concern. We were also concerned that some nurses at the home had failed to take action when the records showed low levels of fluid intake and insufficient repositioning of people, as described in Outcome 4.

Other evidence
When we brought matters to the attention of the nurses on duty, they dealt with them quickly. However, it is the responsibility of the staff at the home to make sure that people receive a safe standard of care.

Our judgement
There are sufficient numbers of staff, but lack of action on the part of some staff means that people could be at risk of not having their needs met.

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

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that they appreciated the opportunities which they had been given recently to put forward their views at meetings. The meetings had been set up following our previous visit so that ways of improving the service could be explored. We saw that the notes of the meetings were displayed around the home for people to read.

Other evidence
Following our review in September 2011, we met on two occasions with the new Chief Executive of Somerset Redstone Trust. He also provided us with a written report stating how the home would become compliant with Regulations. At this visit we found evidence that the required improvements had not been put into place fully. There had been some improvements in all the areas we looked at, but these improvements were not enough to ensure that people were consistently getting care which met their needs.

Throughout this report we have noted some areas of good practice, but these need to be set against some serious shortcomings which put people at risk of poor outcomes. We have described that the care records were inconsistent and we have also described instances where people were receiving an unsafe standard of care. Therefore we continue to have concerns about the way that the provider assesses and monitors the quality of the service.

We will continue to meet with the provider and we will return to the home to check if the required improvements are being made.

Our judgement
The systems in place for making sure that the home is run in people's best interests are not effective.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.	
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People are at risk of not receiving enough to eat or drink at the home, because hydration and nutrition are not managed safely.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities)	Outcome 09: Management of medicines

	Regulations 2010	
	How the regulation is not being met: People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There are sufficient numbers of staff, but lack of action on the part of some staff means that people could be at risk of not having their	

	needs met.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There are sufficient numbers of staff, but lack of action on the part of some staff means that people could be at risk of not having their needs met.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There are sufficient numbers of staff, but lack of action on the part of some staff means that people could be at risk of not having their needs met.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The systems in place for making sure that the home is run in people's best interests are not effective.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The systems in place for making sure that the home is run in people's best interests are not effective.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated	Outcome 16: Assessing and monitoring the quality of service

	Activities) Regulations 2010	provision
	How the regulation is not being met: The systems in place for making sure that the home is run in people's best interests are not effective.	

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

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

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

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

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

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**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 or section is not being met:	**Registered manager:**	**To be met by:**
	The home does not ensure that people receive safe care which meets their needs.		28 February 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	The home does not ensure that people receive safe care which meets their needs.		28 February 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**

	The home does not ensure that people receive safe care which meets their needs.		28 February 2012

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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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA