Review of compliance

Moseley and District Churches Housing Association Carpenter Place	
Region:	West Midlands
Location address:	103 Oldfield Road Sparkbrook Birmingham West Midlands B12 8TN
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Carpenter Place offers care and accommodation for up to 35 people. There are 28 single flats and 4 double flats.

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

Our current overall judgement

Carpenter Place 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 to check whether Carpenter Place 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 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 10 - Safety and suitability of premises
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 23 January 2012, carried out a visit on 28 February 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 Carpenter Place on the 23 January 2012. We found that some people living in the home were at risk of receiving poor quality care due to the lack of care plan recording to meet their needs. In particular there were shortfalls in the monitoring and reviewing of the needs of people whose care records we looked at.

We received action plans from the manager of the home following our visit which informed us how they were going to address the shortfalls we had found at our visit.

Following this visit, we returned to the home on the 28 February 2012 to check whether the improvements had now been put in to practice. During this visit, we spoke with some of the people living in the home and asked staff about people's needs. We also looked at people's care plans.

We spoke with some of the people who lived in the home whilst we looked around the building. The comments that we received from people included, "Happy in my flat" and

''Meals are okay.''

We observed people choosing how they spent their day. For example, some people told us they were going to a day centre; others went out to local shops and for a walk. A person told us, ''We play cards and dominoes'' and another person told us that they had been to a local supermarket the day before to buy some slippers and shoes.

All of the people who lived at Carpenter Place had their own flats and people that we spoke with agreed to show us their flats. We observed that some people's flats were personal to them and reflected their own choices and tastes. Other people's flats needed improvement work in relation to their furniture and curtains.

We found the standards of cleanliness and hygiene practices in the home needed to be improved as there were some unpleasant smells in some people's flats and communal areas.

What we found about the standards we reviewed and how well Carpenter Place was meeting them

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

People are treated with dignity and respect but suitable arrangements are not in place to ensure people's privacy is always maintained. There are some shortfalls in the way in which people are involved in making decisions about their care, treatment and support.

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

Overall, we found that further improvements are needed in the assessment and planning of care to ensure people's needs are consistently met.

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

People are protected from the risk of abuse or harm.

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

There are inconsistencies in staff practices and the systems that are in place to promote good standards of cleanliness and hygiene.

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

The premises are suitable to meet the range of needs of people who lived in Carpenter Place but repairs and improvements are required to provide a comfortable environment for people.

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

Staffing arrangements ensure that people receive the right care, at the right time.

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

Systems to monitor the quality of the service and facilities need to be developed further to ensure risks to the quality and safety of care provided are adequately managed and responded to.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
When we visited the home on the 28 February 2012 we observed staff respecting people's privacy as they knocked on people's flat doors and waited before entering. A person living in the home told us that staff always knocked their door and would not enter until they had responded.

In some of the flats that we looked at, we observed that the main curtains did not draw together when closed. A person living in the home told us that they felt as though they ''were on show'' as people outside could see into their flat particularly at night when they had their light on. This person drew our attention to their kitchen window which had no curtain and people could also see in here.

We looked at how people who lived in the home were encouraged to maintain links with the local community. We observed that people were choosing to go out in the community. For example, we spoke with some people who were going to spend their day at a centre in the community. Another person shared with us that they liked to go to church. This was also detailed in their care records with a note that their key worker would be following this up. However, it was unclear whether this was being followed up but the manager assured us that it would be. We observed some people going to the local shops and for walks. We did discuss with some staff whether they would

recognise if people did not return to the home and staff told us that they would without people having to sign in and out of the home.

We observed that the meetings for people living in the home were displayed on the notice board. We were told that if people were unable to come out of their flats minutes of the meetings would be given to them. We reviewed some of the minutes for recent meetings that had taken place. These had been used to ask people what activities they wanted to do, discuss repairs and maintenance issues and to updates people on staffing and as a way of listening to any concerns. These should have ensured people were able to influence improvements in the home and how it was run.

Other evidence
In some of the care plans that we looked at, there were no clear details to show that each person or their representatives had been involved in how they would like their needs met. We could not be certain that people were always receiving care in the way they preferred to respect their own levels of independence and lifestyles.

Our judgement
People are treated with dignity and respect but suitable arrangements are not in place to ensure people's privacy is always maintained. There are some shortfalls in the way in which people are involved in making decisions about their care, treatment and support.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
At our visit to the home in January 2012, we had concerns about care plans and risk assessments as we found that these did not always accurately reflect people's current care needs.

The purpose of our visit on the 28 February 2012 was to ensure that people were now receiving care which met their needs, and that care plans and risk assessments reflected this.

We spoke with some of the people who lived in the home whilst we looked around the building. The comments that we received from people included, ''Happy in my flat'' and ''Meals are okay.''

We observed a community nurse visiting the home and we were told that they were reviewing people's medical needs. Staff that we spoke with confirmed that the nurse was also responsible for administering insulin to people who had diabetes.

We found that there were some shortfalls in the care records that we looked at as people were not always receiving regular eye and foot care check ups to ensure their needs were met appropriately. For example, we found that a person last had their eyes checked in 2010 but it was detailed on their records that this should be carried out each year. In the records of two people we identified that they last had their feet checked in 2008 with one person having diabetes and therefore it was important their feet were checked regularly.

The provider was required to keep accurate records of all aspects of the management of medicines. We checked the medication records for some people whose care and support we had looked at during our visit. We found that generally, charts had been completed. This meant that people should have been receiving their medicines as prescribed by their doctors to meet their health conditions.

At lunchtime, we spent some time in the main dining room and identified that a person was waiting a long time for their meal with little acknowledgement from staff passing by. We also observed a senior member of care staff carrying out lunchtime medicine rounds. We found that some people were assisted with their inhalers and eye drops whilst trying to eat their meals. This meant that people were interrupted whilst eating. A person who was restless and needed some encouragement to eat their meal became more restless after receiving their eye drops.

We looked at how people's welfare and wellbeing was being promoted when meeting individuals' social needs. A person told us that they liked gardening and staff were going to help them to get a greenhouse. Another person told us that they played cards and dominoes. We observed that in the afternoon some people were playing dominoes with staff support.

Other evidence
During the course of our second visit, we looked at a selection of care records relating to four people living in the home. We saw that some improvements had been made to the arrangements of care records so that staff could follow these easily when meeting people's needs. However, we found that further improvements were still necessary and the manager acknowledged this.

We found a variety of care plans to cover people's needs which included washing, dressing, physical abilities, diet, continence, health, medicines and social interests.

The care plan for one person did not accurately reflect their current care needs. For example, it detailed that there were no difficulties in relation to supporting this person with their personal care. However, we found from talking with staff that this person sometimes declined to carry out their personal care tasks. In another person's care records we found that the key worker and day staff were to ensure that this person had enough stimulation in the day. This was to support their changes in behaviour. However, it was not clear from reading the care records what activities were being provided to this person. This meant we could not be certain that whenever people's needs changed all staff had this information so that individuals received appropriate and safe care.

We observed a person cooking their meal in their kitchen but they were having some difficulty in reaching work surfaces and their cooker. We looked at their care records but could not find any risk management plans to inform staff of the support this person would need to ensure their needs were met safely. We discussed our observations with the manager and we have now received an audit report. This includes this person being consulted in relation to making improvements to their kitchen so that it safely meets their needs.

We found that some of the records in relation to people's health care needs did not always include details about the support they required to meet their needs. For

example, in one person's records we could not find any plans which gave staff information about their diabetes. In another person's records we found staff were assisting them with applying prescribed cream. There was no plan in place to inform staff the reasons the person required this cream. A member of staff told us why the person needed this cream and another member of staff said that the person was not having any cream applied. We could not be confident that people's health needs were being met consistently by all staff.

Risk assessments were in place for areas such as nutrition, falls and continence. Some of the risk assessments needed to be updated to accurately reflect people's needs. For example, one person needed some support with their behaviour but information was lacking about the possible known triggers. This information was important to guide staff as to how they should manage this person's behaviour safely using the most effective and safe methods, or what could be done, to avoid the behaviours happening. We also found that this person had recently been prescribed some medicine by their doctor but we could not see this included in their care and management plans.

Assessments had been completed to determine if people were at nutritional risk. However, we found that people's weights were not always being done as required and detailed in the assessments that we looked at. For example, in one person's records it was noted that they should be weighed weekly but this was not always being done. In another person's records we saw that they were declining to be weighed but could not find a risk management plan to cover this. Therefore we cannot be confident that people's weights were being consistently monitored and reviewed to ensure that people's nutritional needs were being met and people remained healthy.

Our judgement
Overall, we found that further improvements are needed in the assessment and planning of care to ensure people's needs are consistently met.

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 compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
When we visited the home on the 28 February 2012 we did not speak directly to people living in Carpenter Place regarding safeguarding procedures. However, all of the people we spoke with did not share any concerns with us about feeling unsafe or unsupported by staff when raising any concerns.

We were confident that the manager had notified us of any incidents that affected people's wellbeing and safety. Where appropriate, meetings had been held which made certain all the people living in Carpenter Place were safeguarded from the risk of abuse and we have had sight of the minutes of these meetings.

Training records showed that staff had received training in the safeguarding of vulnerable adults and where refresher training was due; this was detailed on the training records.

Staff we spoke with were able to tell us what they would do to protect people who lived in the home in the event of an allegation being made or witnessed. All of the staff we spoke with said that they would ''always report incidents to the manager''. This is acceptable practice so that people who lived in the home could be assured that all staff had the knowledge to keep them safe from harm.

Staff that we spoke with told us that they had received training to give them an awareness of the Mental Capacity Act 2008 (MCA) and the Deprivation of Liberty Safeguards (DOLS). This ensured staff had the knowledge to assist people who lived

in the home who may be unable to make their own decisions.

We found that there was a robust system in place for assisting people to manage their personal monies. We checked the monies of some people who lived in the home. All monies were correct and tallied with the recorded balances. We were told that the manager and administrator hold the key to the safe.

Other evidence
We found that there were policies and procedures in place for staff to follow if they had any concerns about possible neglect or abuse.

Our judgement
People are protected from the risk of abuse or harm.

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
When we visited the home on the 28 February 2012 we did not gain any direct views about the cleanliness of people's flats or communal areas of home from people who lived there during our visit.

We looked at parts of the home that people used including public areas, bedrooms, bathrooms and toilets. We found that there were unpleasant smells in some of the flats we looked at and some corridor areas. Staff that we spoke with told us this could be due to people's incontinence. We could not be confident that cleaning was being done effectively to ensure the home's environment was a clean, hygienic and pleasant place for people to live. Therefore we spoke with the manager about our concerns. We were informed that the manager was going to introduce peer audits to check that cleaning schedules were being followed by all staff. This should ensure that all staff were being diligent with the cleaning within some areas of the home.

Other evidence
The manager is going to have overall responsibility along with two other designated staff for infection control within the home. This should ensure that standards are maintained in cleanliness and hygiene for the benefit of people living in the home.

We saw that equipment and protective clothing was available which included disposable gloves and aprons. Staff we spoke with told us that they had received training to understand good hygiene, including good hand washing. This should ensure they had the knowledge to minimise the potential risks of spreading infections.

Our judgement

There are inconsistencies in staff practices and the systems that are in place to promote good standards of cleanliness and hygiene.

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
People who live at Carpenter Place have their own flat and also the benefit of a large communal area in the dining room on the ground floor and a smaller lounge area on the first floor. There was a lift so that all people would be able to access all parts of the home.

We found the home to be pleasantly decorated in some areas with improvements needed in others. During our visit we noticed some improvement work was being undertaken.

We observed throughout the day the safety of people who lived in the home and whether the environment met people's needs. People commented abut their flats and these included, "I like being in my flat" and "I have everything I want in my flat."

We saw people were able to move around the home safely as the corridor areas were wide and spacious with no unnecessary hazards. This helped people who required wheelchairs to move around the home giving individual's the chance to retain as much independence as possible. We saw that the environment also generally promoted people's independence within daily tasks such as making drinks and meals within their own flats as these had kitchens.

We observed that some of the flats we were invited into by people living in the home were filled with items that were important to them. We were told by some people that they were encouraged to bring in personal items to furnish their flats when they came to live in Carpenter Place as they chose. This was also promoted in the home's

information given to new people coming to live in the home.

We were concerned that some of the furniture in people's flats was broken and worn, such as, beds and a chest of drawers. A person told us that they would like their furniture repaired or replaced. We also observed that some of the net curtains did not fit the windows and were creased. There were also some uncertainties about what furniture was provided for people who lived at Carpenter Place. We found that the information given to people when they came to live at Carpenter Place stated, 'Carpenter Place provides carpets, curtains, a bed, a bedside table, a wardrobe, an armchair if required and lockable storage space.'

We found that a carpet area by a person's front door was worn and could be a potential tripping hazard which we pointed out to the manager during our visit We also found that this person's front door was wedged open which does not comply with fire regulations in relation to people remaining safe if there was a fire in the home. The manager closed this door once we had brought this to their attention.

Other evidence
There is no further evidence.

Our judgement
The premises are suitable to meet the range of needs of people who lived in Carpenter Place but repairs and improvements are required to provide a comfortable environment for people.

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
People that we spoke with did not express any concerns in relation to there being insufficient staff to meet their needs.

On the day of our visit, staffing levels appeared appropriate to meet the needs of people. Staff were observed undertaking care related activities with people and were also seen spending time sitting and talking with people.

Other evidence
There was a management team which consisted of the manager and a deputy manager who ensured that staffing levels were driven by the care needs for each person. The manager said they would move staff around the home and increase staffing where required to meet each person's needs.

We were shown the staffing rotas for a four week period which confirmed what the manager had told us about staffing levels in the home. Whilst speaking with staff, they also confirmed staffing levels with us and said that there were enough staff to meet each person's needs. In addition to care staff, cleaning, laundry, maintenance and administration staff were employed to make sure all aspects of people's needs were met.

Our judgement
Staffing arrangements ensure that people receive the right care, at the right time.

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 minor 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 that we spoke with did not express any concerns about the care and support they received.

We found that any complaints raised were investigated and responded to appropriately. During our visit, we observed that a person wanted to speak with a member of staff in private and this was responded to appropriately which showed that this person was listened to.

We were told that people who lived in the home and their relatives could always informally meet with the manager. As mentioned in outcome 1 we were informed and shown meetings had taken place with people who lived in the home. This should ensure that people could put forward their views about how the home could be improved. We were told that surveys will be another way in which people will be able to offer their contributions to aid improvements. These practices would assist people in sharing their views to shape the standard of care and treatment to people who lived at Carpenter Place.

Other evidence
We would expect the provider to identify where there were shortfalls in the home to ensure that improvements were made. During our visit, we met with the new manager who wanted to make improvements in the home to ensure people received quality care to meet their needs. This was positive as the manager had already identified some of the areas where improvements were needed. For example, care planning and cleaning

tasks and schedules.

Following our visit to the home we have received documentation from the manager detailing the audits that have now been carried out to reflect the areas of the home where improvements are needed. This included replacing people's furniture in their flats where required. Also ensuring that cleaning is undertaken in people's flats where there were unpleasant smells which we identified during our visit. This provides confidence and assurances that where shortfalls were identified improvements were being made.

Our judgement
Systems to monitor the quality of the service and facilities need to be developed further to ensure risks to the quality and safety of care provided are adequately managed and responded to.

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 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	Why we have concerns: There are inconsistencies in staff practices and the systems that are in place to promote good standards of cleanliness and hygiene.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: The premises are suitable to meet the range of needs of people who lived in Carpenter Place but repairs and improvements are required to provide a comfortable environment for people.	

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

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

The provider's report should be sent to us within 28 days of the date that the final review of compliance report is sent to them.

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

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People are treated with dignity and respect but suitable arrangements are not in place to ensure people's privacy is always maintained. There are some shortfalls in the way in which people are involved in making decisions about their care, treatment and support.	
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: Overall, we found that further improvements are needed in the assessment and planning of care to ensure people's needs are consistently 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: Systems to monitor the quality of the service and facilities need to be developed further to ensure risks to the quality and safety of care provided are adequately managed and responded to.	

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 28 days of the date that the final review of compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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