Review of compliance

Kimbolton Lodge Ltd

Kimbolton Lodge

Region:	Eastern
Location address:	1 Kimbolton Road Bedford Bedfordshire MK40 2NT
Type of service:	Care Home with Nursing
Publication date:	May 2011
Overview of the service:	Kimbolton Lodge is a care home with nursing in the town centre of Bedford. The home is registered to care for 36 people who will be cared for in individual bedrooms. Three bedrooms could be used as double rooms on request. Kimbolton Lodge registered at transition to the Health and Social Care Act for accommodation for persons who require nursing or personal care, diagnostic and screening and treatment of disease, disorder or injury. At the time of registration the service declared compliance

	with all 16 essential outcome areas. Because of historic information CQC had minor concerns with two outcome areas. A compliance condition was imposed for a registered manager to be in post by 01 April 2011.

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

What we found overall

We found that Kimbolton Lodge was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 20 April 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

We made a visit to the service on 20 April 2011, during which we spoke with eight people living at Kimbolton Lodge and observed the care provided to most.

People told us that the staff treated them with respect and asked them about how they wanted their care to be provided. They also confirmed that they were able to make decisions about their care and how they spend their time.

The people that we spoke with during our visit were positive about the support they received from the staff team and confirmed that the staff providing care did so in a caring way. For example, we were told that the staff looked after resident's medication and made it available as and when they wanted it. One person told us how grateful they were for this, as in the past they had often forgotten to take their medication. No one suggested that they had to wait for medication when they needed it.

People told us that the food provided was good and plentiful and, although some people made comments about preferring stronger flavours or different ways of preparing a certain dish, all were confident that if they had any real requests these would be granted. One person said, “I am sure if I asked for spicy food I would get it but you have to consider the other people living here.” People told us that the cook regularly asked them about the meal they wanted or if they had enjoyed the meal that had been served. In addition, people told us how they were able to influence changes in the home by either voicing concerns at residents’ meeting or completing the satisfaction surveys they were given.

Although the bedrooms were all very different, everyone we spoke with was happy with the room they had. We saw that they had been able to personalise their bedrooms with belongings, and even small items of furniture, from home.

What we found about the standards we reviewed and how well Kimbolton Lodge was meeting them.

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People living at Kimbolton Lodge were involved in the decisions that affected their lives and the care that they were given.

People were treated positively and their dignity was valued and upheld at all times.

Overall, we found that Kimbolton Lodge was meeting this essential standard.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

A care planning system was in place; this recorded all activities of daily living and aimed to ensure regular reviews. However, records at times lacked sufficient detail about how care was to be delivered or to evidence that care had been delivered as prescribed. This meant that staff were not provided with the information that was required to ensure that care was consistently provided. This was exposing people to the risk of receiving inappropriate care.

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

Outcome 5: Food and drink should meet people’s individual dietary needs

People were provided with a variety of nutritious meals that they enjoyed. Wherever necessary, they were supported by staff to maintain their individual nutritional needs.

Overall, we found that Kimbolton Lodge was meeting this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services

People could be confident that the staff team at Kimbolton Lodge worked with a variety of health and social care professionals to promote their rights and well-being.

Overall, we found that Kimbolton Lodge was meeting this essential standard.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

Records made when medications were given to people were inaccurate and did not always indicate that medicines were given as prescribed or consistently detail the reason why some medicines had not been given. Records of the receipt of medicines were not always completed and did not allow the use of medicines to be fully accounted for. Therefore, stock control, administration and storage systems were not being effectively managed and existing audit processes within the home had failed to achieve the required improvements.

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

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

People were able to live in comfortable surroundings that were kept clean and tidy and refurbished as the need arose.

Overall, we found that Kimbolton Lodge 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

There was evidence of some effective audits in place but people were not protected from the risk of harm associated with the unsafe use and management of medicines through the quality audit systems.

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

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

There were systems in place to make sure people's records were accurate and fit for purpose. However, some records were not easy for staff to access and personal information was not kept in a manner which protects confidentiality.

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

The home had a compliance condition imposed at transition that required a registered manager to be in post by 01 April 2011. This has not been achieved but the interim processes for managing the home have ensured that people are kept safe.

Action 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.

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 1:
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

Our findings

What people who use the service experienced and told us

We made a visit to the service on 20 April 2011, during which we spoke with eight people living at Kimbolton Lodge and observed the care provided to most. All of the people using the service told us that the staff treated them with respect and asked them about how they wanted their care to be provided. One individual said, “it is up to me when I go to bed, if I want to watch TV until late it is never a problem.” Another individual said to us, “I prefer to be on my own so I stay in my bedroom, but I join in with the organised activities in the main lounge.”

Other evidence

Throughout our visit to the home on 20 April 2011, we saw that the staff team treated people with respect and dignity when they addressed them. People using the service chose the term they wished to be addressed by and this was adhered to. We did not hear any inappropriate endearments, such as ‘dear’ and ‘lovey’, being

used when addressing individuals. We also noted that people were dressed appropriately and looked fresh, with clean hair and nails.

People told us that they received any personal care in the privacy of their bedroom or a bathroom. During our visit we observed that doors were shut when personal care was provided and staff were discreet in their management of individual's care needs.

The plans of care that recorded how an individual wished to be cared for were stored in the individual's bedrooms and could therefore be viewed by this person, or a person acting on their behalf, in addition to the care and support staff. One person told us about their plan of care and how it was to be used by the staff. It was apparent that this person had been asked about preferences and could make decisions about how their care was provided. They confirmed that they agreed with what was written in their plans.

Our judgement

People living at Kimbolton Lodge were involved in the decisions that affected their lives and the care that they were given.

People were treated positively and their dignity was valued and upheld at all times.

Outcome 4:
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

Our findings

What people who use the service experienced and told us

During our visit to the home on 20 April 2011, we spoke with eight people living at Kimbolton Lodge and observed the care provided to most. The people that we spoke with during our visit were positive about the support they received from the staff team and confirmed that the staff providing care did so in a caring way. One person said to us, “All of the staff are good and know how to look after us. It takes a certain type of person to do it.”

Other evidence

Each of the people using the service had a plan of care for the different aspects of care that the staff team provided. Each plan of care was kept in a ring binder in the individual’s bedroom. The plans were generated from a commercially sourced package and were individualised as necessary. On the whole, the plans included sufficient detail and had been regularly reviewed and updated as care needs changed. They were, however, not always stored in order, so the reader had to take time to look through the whole folder to find all the relevant information. It was noted that some of the end of life care plans lacked the detail needed to ensure that the person’s end of life wishes would be addressed. Staff told us that in their view this was a sensitive area to talk about with people using the service and/or their

relatives and that some people had told them that it was inappropriate to ask questions about end of life care.

Regular care plan audits were being carried out by the deputy manager. These had been undertaken to ensure that the required information was available to support people's care and assist staff to carry out their roles. Where the audit had identified the need to include additional information or make changes to the plan, it was clear that this had been done in a timely fashion. We were informed that the deputy manager was leaving and it is expected that this task would be allocated to the new deputy.

We looked in detail at the plan for one individual who had multiple pressure ulcers that needed dressing. There was a plan for each ulcer that described how it should be dressed and how often. However, it was not clear from the information recorded in the daily log or the care plan exactly what had been done in relation to dressing each of the wounds. For example, the entries in the daily log stated 'dressing done', but did not identify which ulcer had been dressed. This was important, as the care plan identified that each ulcer required a different regime of wound changes i.e. daily attention, every other day or every three days. Staff showed us that, at handover, they recorded that the dressing had been completed but these records also failed to identify which ulcer had been dressed. From talking with the nurses and looking at the photographs of the ulcers, we had evidence that the dressings were being changed but we were concerned that if staff were less vigilant, or did not work regular shifts, dressings could be missed.

The deputy manager showed us former documents that had been designed to indicate when dressings had been carried out and to record the state of the wound. These had ceased to be used in November 2010 but staff could not tell us why. Staff agreed they were a useful tool for recording dressings and the current state of a wound.

We noted during our visit that there were clear records of the interventions required for those people being nursed in bed. These include information regarding the frequency at which each individual needed repositioning. Food and fluid charts were completed accurately and used appropriately to plan care. In addition to plans of care, people had risk assessments in place for tissue viability, moving and handling, nutritional management and other areas of risk. These had been accurately completed and kept up-to-date.

People were weighed regularly, either monthly or weekly. We did note that the weekly recordings did not always happen. There was also some confusion over one of the plans of care that we looked at, as the care plan stated the weight should be recorded on a Sunday while a note in the office stated Wednesday.

Our judgement

A care planning system was in place; this recorded all activities of daily living and aimed to ensure regular reviews. However, records at times lacked sufficient detail about how care was to be delivered or to evidence that care had been delivered as prescribed. This meant that staff were not provided with the information that was

required to ensure that care was consistently provided. This was exposing people to the risk of receiving inappropriate care.

Outcome 5:
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

Our findings

What people who use the service experienced and told us

We made a visit to the service on 20 April 2011, during which we spoke with eight people living at Kimbolton Lodge and observed the care provided to most. All of the people with whom we spoke told us that the food was good and plentiful. One person said to us, when asked about the food, "It is good but not what I am used to." Another said, "Sometimes I would like something with more flavour, but they have to cater for the majority so I don't make a fuss."

Other evidence

During our visit, people talked positively about the food provided. People told us, and we witnessed, that if a person did not like the main meal on the menu it could be substituted with a variety of different meals, such as omelettes, salads and jacket potatoes.
On the day of our visit, lunch was beef stew, mashed potatoes and vegetables and the evening meal was poached haddock. We spoke to the cook who told us that she met regularly with the people using the service and asked them about their likes and dislikes, so that she had this information when preparing menus. She told us that the majority of the people enjoyed meat and vegetables for their main meal and that, where possible, fresh vegetables were used. On the day of our visit, the menu stated beef stew and dumplings. The dumplings had been taken off the menu as

the weather had turned unseasonably hot and the cook felt they were not appropriate. She told us that the menus would be altered to reflect the season at the end of the month but meals could always be changed. Special meals were prepared for special occasions and the cook told us of her plans for the forthcoming events of St George's day, Easter and the Royal Wedding.

We saw that, where it was required, the amount of food a person ate at each meal was recorded. Staff confirmed that they recorded the proportion of the meal eaten. Fluid intake was also appropriately recorded by writing down the amount that was drunk and not the amount provided in the glass or cup.

Staff told us they were able to refer people to a dietician through the individual's GP where required. The care records we reviewed confirmed that, when necessary, people were referred to the dietician and food supplements were provided. Charts confirmed that food supplements were given and one person told us that she looked forward to her milk shake.

Kimbolton Lodge had a dining room and, where possible, people were encouraged to take their meals there to promote social interaction. During mealtimes, staff were observed to appropriately support people who needed help. We also observed hot and cold drinks available throughout the day and fruit, biscuits and homemade cake served with drinks.

Our judgement

People were provided with a variety of nutritious meals that they enjoyed. Wherever necessary, they were supported by staff to maintain their individual nutritional needs.

Outcome 6:
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

Our findings

What people who use the service experienced and told us

We did not speak with people using the service about this outcome.

Other evidence

Health professionals regularly visit the service to provide care and advice. The care plans we reviewed, during our visit on the 20 April 2011, confirmed people had access to additional health and social care services. We saw entries in care plans we reviewed from GPs, community nurses, dentist, opticians and dieticians. We also heard staff speaking on the telephone with social and health care staff.

The deputy manager told us that the service had good relationship with a GP practice that was close to the home. A GP from this practice would visit regularly in addition to as and when required.

Our judgement

People could be confident that the staff team at Kimbolton Lodge worked with a variety of health and social care professionals to promote their rights and well-being.

Outcome 9:
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

Our findings

What people who use the service experienced and told us

We made a visit to the service on 20 April 2011 during which we spoke with eight people living at Kimbolton Lodge and observed the care provided to most. People told us that the staff held their medication and would give it to them at the correct time. One person said, “The staff having my medication is such a weight off my mind. They always remember if they have given it to me or not. I used to forget if I had taken it.”

Other evidence

There were two medication trolleys in use at Kimbolton Lodge. During our visit on 20 April 2011 we looked at the records and stocks in both trolleys and identified similar shortfalls in both.

Records of medication received into the home, given to people, and no longer required were incomplete and inaccurate.

We looked at the records for six people living in the first floor and two people living in the ground floor areas of the service. There were gaps in the administration of medication (MAR) records that made it difficult to confirm if the medications had been correctly given. Reconciliation (the counting of the tablets left in stock and the signatures on the MAR charts) could not be used, as staff did not record on the MAR chart any medication carried forward from the previous month. By looking at the dates on the medication boxes and talking with staff, it was evident that unused medications were routinely added to the new stock being received into the home. We also noted that, although many staff recorded variable doses, some did not, which made reconciliation impossible as the exact number of tablets given could not be confirmed.

The home had introduced an audit system that required the staff to complete the number of tablets or amount of medication in stock following each medication round. These records had not been consistently kept and did not accurately reflect the number/amount in stock. This audit was therefore meaningless and did not identify potential problems.

There were gaps in the MAR charts, which could either indicate that a medication had been given and the nurse or care worker had failed to complete the record or that a prescribed medication had been refused or not given. On the whole, staff used codes to record when a medication was not given. However, the reverse of the MAR charts were not consistently completed to record the reason why a medication was refused or why an 'as required' medication was given.

The acting manager told us that a new pharmacy would be providing the medications to the home at the beginning of the next cycle. Staff would be having additional training and the pharmacy would carry out their own audits as a support to staff.

We looked at the records and the stocks for those people requiring controlled drugs. We found that the systems for ordering, storing, administering, recording and disposing of these medication were well managed

Our judgement

Records made when medications were given to people were inaccurate and did not always indicate that medicines were given as prescribed or consistently detail the reason why some medicines had not been given. Records of the receipt of medicines were not always completed and did not allow for the use of medicines to be fully accounted. Therefore, stock control, administration and storage systems were not being effectively managed and existing audit processes within the home had failed to identify problems and achieve the required improvements.

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

Our findings

What people who use the service experienced and told us

We made a visit to the service on 20 April 2011 during which we spoke with eight people living at Kimbolton Lodge and observed the care provided to most. All told us that they had chosen their bedroom and would not want to change it. One person told us that they liked to be able to open the door to the garden from their bedroom. Another person told us that they liked the en-suite toilet but went on to say that in an ideal world they would like an en-suite shower, rather than a bath, as they preferred a shower now.

Other evidence

The layout and design of the home did not meet the standards we would expect of a service currently applying for registration with CQC, as some bedrooms were located off a narrow corridor and not all of the bedrooms had en-suite facilities. However, the uniqueness of the bedrooms appealed to some of the people using the service. The home had a large lounge and a separate dining room, in addition to smaller lounge areas that could be used as quiet rooms.

During our visit, we confirmed that, when necessary, suitable levels of heating were provided to keep people warm and comfortable and that during the warm weather the home could be well ventilated. We saw that window restrictors were fitted to

windows above ground level to reduce the risk of accidents.

There was information on display in the office about whom to contact in the event of a service failure, for example, electrical failures. Staff told us that for day to day maintenance issues there was a maintenance person.

Kimbolton Lodge had a planned programme for maintenance, refurbishment and redecoration. We were told that bedrooms were redecorated and carpets replaced, as necessary, when a room was vacated.

Our judgement

People were able to live in comfortable surroundings that were kept clean and tidy and refurbished as the need arose.

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

Our findings

What people who use the service experienced and told us

The people we have spoken with during this review have told us that they were asked about how their care was provided and the way in which Kimbolton Lodge was run. People told us about meetings with the manager and the cook. One individual said, "I have filled in a questionnaire about living here and said I would like a shower rather than a bath in my en-suite."

Other evidence

Staff and residents told us that they were listened to and that their suggestions were considered

Information that we received from the provider told us that compliance in a variety of outcome areas was regularly checked and outlined what needed to be done to make improvements. This evidenced that provider has some quality assurance systems in place and that this highlighted outcomes for people. Regular audits included review of the care records by the deputy manager, to ensure that they were current and reflected the needs of people. However, as detailed previously, medication audits had failed to identify the development issues and practice

concerns identified by this review.

Our judgement

There was evidence of some effective audits in place but people were not protected from the risk of harm associated with the unsafe use and management of medicines through the quality audit systems.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are minor concerns

Our findings

What people who use the service experienced and told us

People were spoke were aware of their care records and what was written in them.

Other evidence

During our visit on the 20 April, we were shown examples of audits of care records. These were undertaken to ensure that the records were up to date, factual and accurately reflected the care and treatment being provided. Any gaps that had been identified had been followed up by the allocated named nurse. As a consequence, the records were accurate. However, by having care records in people's bedrooms confidentiality was compromised. The acting manager told us of her plan to split the records and store only the care information in people's rooms to ensure confidentiality.

As already detailed in Outcome 4 of this review, there was a need to review the manner in which records are kept and to ensure that information was easily available to staff. In addition, there was a need to ensure that records were kept of when individual wound dressings were changed and when they were next due.

The management were aware of the records that needed to be retained by the home. These included staff recruitment, off duty rotas and menus.

Our judgement

There were systems in place to make sure people's records were accurate and fit for purpose. However, some records were not easy for staff to access and personal information was not kept in a manner which protects confidentiality.

Outcome 24
Requirements relating to registered managers

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

● Their needs are met because the service is managed by an appropriate person

What we found

Our judgement

The provider is non compliant

Our findings

What people who use the service experienced and told us

We did not speak with any of the people living in the home about this outcome.

Other evidence

The registered manager for Kimbolton Lodge left their position in April 2011, during the time in which the service was transitioning to the Health and Social Care Act. A new manager was appointed in August 2011 and had applied to CQC to be registered. Two weeks before our visit, this manager had resigned.
To ensure continuity, an Operations Manager for Downing, another part of the business, had filled the role at these times.
We were told that an advertisement was to be placed for the post following the forthcoming Easter and Bank holiday.

Our judgement

The home had a compliance condition imposed at transition that required a registered manager to be in post by 01 April 2011. This has not been achieved but the interim processes for managing the home have ensured that people are kept safe.

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 requiring nursing or personal care, treatment of disease, disorder and injury and diagnostic and screening procedures	9	4
	How the regulation is not being met: Care plans were in place; however, the records of how and when individual dressings were changed were incomplete and did not accurately detail people's current needs. This was exposing people to the risk of receiving inconsistent or inappropriate care or not receiving the care they needed.	
Accommodation for persons requiring nursing or personal care, treatment of disease, disorder and injury and diagnostic and screening procedures	13	9
	How the regulation is not being met: Records made when medications were given to people were inaccurate and did not always indicate that medicines were given as prescribed and, if not given, the reason why. Records of the receipt of medicines were not always completed and did not allow the use of medicines to be fully accounted for. Therefore stock control, administration and storage systems were not being effectively managed and existing audit processes within the home had failed to achieve the required improvements.	
Accommodation for persons requiring nursing or personal care, treatment of disease, disorder and injury and diagnostic and screening procedures	10	16
	How the regulation is not being met: Although there were audit and quality management processes in place, the issues that we identified about inadequate medication processes and the lack of detail as to how and when individual dressings had been changed had not been identified by these	

	internal processes.

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 <XX> 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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