Review of compliance

Walton Care Limited The Grove Care Home	
Region:	North West
Location address:	40 Owen Street Rosegrove Burnley Lancashire BB12 6HW
Type of service:	Care home service with nursing
Date of Publication:	November 2011
Overview of the service:	The Grove is owned by Walton Care Limited. It is a purpose built single storey home with surrounding garden areas, an internal patio area and car parking to the front. The care home is suitably adapted for people with physical disabilities. Shops, pubs, churches and other amenities are within walking distance.

	The home can accommodate up to thirty eight people, either men or women who require nursing or personal care, and includes older frail people and younger people with disabilities.

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

Our current overall judgement

The Grove Care Home was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review 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 29 September 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People living in the home told us that they were happy in the home and that they felt well looked after. We were told that, "Staff are wonderful" and that, "They'll do anything for you, we are never made to feel a nuisance". We were also told that the meals served were generally "very good" and that there was sufficient choice. People living in the Grove were involved in the running and development of the service and told us there were residents' meetings and service quality questionnaire surveys. However some of our observations raised concerns about some aspects of care such as medication management.

Staff told us that they felt there were good training opportunities and that they felt well supported. They said that there was always senior staff on duty for supervision and support.

What we found about the standards we reviewed and how well The Grove Care Home was meeting them

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

Residents felt that staff generally showed them respect and treated them well. They felt able to express their views and make some choices in some aspects of their lives and the routines of the home. However some practices did not uphold residents' rights to privacy and dignity.

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

People were provided with care and support that met their needs and preferences, but some moving and handling techniques used were not always safe.

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

People were provided with appropriate choices of food and drink to meet their nutritional needs and preferences.

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

People were protected from unsuitable staff, care practices and treatment, but not always from the behaviour of other residents and this could put people at risk.

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

Thorough infection control procedures helped to ensure that people benefit from a clean and safe environment.

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

Some systems and practices, including record keeping, that did not demonstrate safe management of medication or show that people were always receiving the correct medicines.

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

There were sufficient qualified and skilled staff working in the home to meet the needs of the residents.

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

People living in the home were looked after by a well supported team of staff

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 were systems in place to monitor the quality of the service provided in the home, and that involved and took into account the views of the people living there.

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.

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
People we spoke with at our inspection visit to the home told us that they felt staff showed them respect and consideration, including when carrying out personal care. One said, "The staff will do anything for you" and, "They don't make me feel a nuisance". People also told us that they were involved in making some decisions about their lives and about the home. They had some choices in their every day lives such as in the food served and activities. People recalled regular residents' meetings where they were able to express their views and preferences.

At the site visit we generally observed care staff treating people respectfully and talking to them appropriately. However we observed two procedures that did not respect the privacy and dignity of the people concerned.

Other evidence
Information supplied to us before the inspection stated that the provider considered the Grove to be compliant with this Outcome, and gave examples to illustrate this. We were told that the residents were fully involved in their admission and assessment of need, and that their views were taken account of in meetings and in survey questionnaires. These views had, for example, influenced the decor and refurbishment of the home and the activity options.

Though people felt that staff treated them appropriately and with respect, we saw some procedures that could be seen as not respecting people's rights to privacy and dignity. Some nursing procedures were undertaken in communal areas in view of other residents and this could have been uncomfortable for those undergoing the procedures and those near by. This was discussed fully with the manager who subsequently informed us that she had taken action to ensure this will not happen again.

Our judgement
Residents felt that staff generally showed them respect and treated them well. They felt able to express their views and make some choices in some aspects of their lives and the routines of the home. However some practices did not uphold residents' rights to privacy and dignity.

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
Prior to the site visit the home had notified us of some incidents that involved residents being at risk in various ways. Two notifications were incidents between residents, and involved the police and social services. These incidents raised concerns about how the home was meeting the needs of some residents.

At the site visit people we spoke with told us that they felt they were well looked after and that staff were attentive and caring. One person said, "They're all wonderful". Another said, "They're grand and we have a laugh". Someone else said, "I like it here". People also felt sufficiently involved in the planning of their care and support. However we observed poor moving and handling practice that could have put the resident at risk from injury.

Other evidence
The information provided to us prior to the inspection stated that the home was fully compliant with this Outcome. We were told that all residents had a care plan, the development of which they had been fully involved in. This information also told us that care was planned according to people's individual and diverse needs and human rights.

The records that we looked at at the site visit confirmed some of this information. All residents had up to date care plans, some of which showed that people's preferences had been discussed and included. There was also evidence that people's needs were reviewed and the care plans up dated accordingly.

We discussed the incidents of concern (referred to above) with the manager and whether or not the home could meet the needs of some residents admitted to the home. She told us that some emergency admissions can result in people being admitted without sufficient, or with misleading, information but that all was done to meet unexpected needs that arose. If need be the Grove would request further assessments and/or transfer to another service (see Outcome 7).

However some of the care plans were not as detailed or as accurate as they could be. One resident had a nutrition assessment that did not reflect their circumstances, and there was no associated care plan. We also saw a person being transferred from chair to chair in an inappropriate way and there were no written instructions for staff on the care plan to help them move this person safely. We discussed these matters fully with the manager who subsequently told us that she had taken appropriate action.

Our judgement
People were provided with care and support that met their needs and preferences, but some moving and handling techniques used were not always safe.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
At the inspection site visit we saw that people had choices for their meals and that the food served appeared appetising and of suitable proportions. People received assistance if needed. One person told us, "Breakfast is the best meal of the day and you can have anything that you want". We were told this included cooked options. Several people said, "The food is very good", though another said, "The food is alright but a bit monotonous".

However we also saw that the presentation of the meals could be improved to enhance the experience for people, and also to assist their independence. For example there were no teaspoons on the table so people could not help themselves to sugar, and milk was poured directly from the plastic bottle into cups by a member of staff.

Other evidence
We saw that the food served met people's tastes and preferences and that there was suitable and sufficient choices.

Records showed that people's nutritional needs were assessed but that accurate records were not always kept. This was discussed with the manager who subsequently indicated this was rectified (see Outcome 4).

However as stated above we observed that some aspects of the presentation of meals could be improved. There were no table cloths or mats on the table, cups were served without saucers, there were no teaspoons and no milk jugs - a member of staff served milk directly from the plastic bottle. This did not assist people to be independent or

acknowledge their preferences. We discussed this fully with the manager, and were told in an action plan received soon after the visit that action had been taken, including the purchasing of crockery and cutlery. We are confident that improvements will be implemented.

Our judgement
People were provided with appropriate choices of food and drink to meet their nutritional needs and preferences.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Prior to the site visit the home had notified us of some incidents that involved residents being at risk in various ways. Two were serious incidents between residents and involved the police. One involved a serious medication error (see Outcome 9). Social services had also been involved in these incidents.

At the time of the site visit we found that the home was in the process of managing another serious incident and that the resident concerned had been transferred to another service.

People that we spoke with had no concerns about their care or about the staff who looked after them. They felt staff cared for them properly and safely.

Other evidence
The home had suitable policies and procedures, including a whistleblowing procedure, to guide staff on what to do in the event of a suspicion or allegation of abuse. The staff we spoke with knew what to do in these circumstances and the manager had followed the correct reporting procedures following the incidents referred to in the report. Staff had also undertaken relevant training on safeguarding.

However staff had not undertaken training on managing challenging behaviour and this could mean that staff did not have the necessary skills and knowledge to protect residents from the behaviour of other residents. Also staff had not undertaken training in the Deprivation of Liberty Safeguards under the Mental Capacity Act, which could

further assist them to understand difficult behaviour and how to manage situations that could put people at risk.

Our judgement
People were protected from unsuitable staff, care practices and treatment, but not always from the behaviour of other residents and this could put people at risk.

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
At the time of the inspection visit all parts of the home that we saw were clean and free from offensive odours. A cleaner and a laundry assistant were working in the home. There had been a recent outbreak of an infectious disease which had been managed efficiently and correctly to control the spread, and to minimise people's discomfort.

Other evidence
The manager was aware of what the home needed to do to comply with this regulation, and which involves working with the Department of Health Code of Practice on the Prevention and Control of Infections. There was a copy of this code of practice in the home and the manager was working through what needed to be done. A lead for "infection control" was appointed in the home and staff were undertaking relevant training. We saw staff using appropriate protective clothing including gloves and aprons.

The home had recently taken all the correct action in a recent outbreak of an infectious disease which showed that the correct procedures were in place and that staff knew how to implement them.

Our judgement
Thorough infection control procedures helped to ensure that people benefit from a clean and safe environment.

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 discuss this Outcome directly with people living in the home but there were concerns from other evidence that medicines were not always managed safely. There had been a previous incident when a resident had taken medicines belonging to someone else and at the inspection visit we observed some unsafe practices.

Other evidence
Although we were told that the manager undertook regular audits on medication systems and procedures we found a number of concerns on the site visit that had not been identified through this process. Through our own observation and looking at records we found some areas of poor practice.

On arrival at the home we found two medication trolleys in the dining room that were open and with medication accessible to residents and staff. There had been a previous incident reported to us involving medication being left unattended and as a result a resident had taken some medication that was not theirs.

We observed medication being administered at lunch time and found some practices of concern. The person administering medication signed the medication administration records (MARs) before medication had been given/taken and took medication from the trolley to people in their rooms leaving the trolley unattended. Signing the MARs prior to people taking medicines can mean that these are not true records of the medicines taken or not taken. We also saw that an insulin injection was given to a resident whilst

the resident was sat at the table at lunch time and in the presence of other residents. This practice does not uphold people's privacy and dignity (see Outcome 1).

The MARs we looked at had gaps where there was no entry for medication that should have been given. In some cases the medication had been given but not signed for, and in others the medicines had not been given. The MAR for one resident indicated that no medication had been given on one day recently. But we could not tell whether or not this was the case, as correct records of the number of tablets brought into the home had not been made. This meant that we could not tell how many tablets had been taken and there was no audit trail to check whether or not this person was receiving the correct medication. We also saw that for this person there was contradictory information about when anti nausea medication should be given and whether or not this was "when required".

We also saw that some medication prescribed specifically for individuals such as pain relief, laxatives and calcium tablets were being used communally. This meant there was no audit trail for these medicines to show whether or not people were taking the correct medication. Also this practice carries the risk of administering the wrong medication and/ or dose to people. We were told that this practice was adopted because there was not enough room in the trolleys for everyone's medicines. We were also told that there was only one person on every shift trained to administer medicines and that this was too much for one person given the amount of medication in use.

We discussed these matters with the manager who subsequently informed us through an action plan that some matters had been addressed, and that steps were being taken to address others, such as purchasing another trolley.

Our judgement
Some systems and practices, including record keeping, that did not demonstrate safe management of medication or show that people were always receiving the correct 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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People that we spoke to on the visit to the home felt that staff treated them well, and they said they got on well with them. Comments were made such as, "They're wonderful", "They're all grand and we have a laugh" and "They'll do anything for you".

We observed that there appeared to be enough staff on duty to meet the needs of the residents but two people said that they thought the home was short of staff in the evening and when people had to wait for attention.

Staff that we spoke to felt that they had the right qualifications and skills for their roles and we saw that most staff had undertaken essential training such as moving and handling, food hygiene and relevant national vocational qualifications.

Other evidence
Discussions with the manager indicated that staffing levels were adjusted to meet the needs of the residents. After talking to the residents about staffing levels in the evening (see above) the manager told us that the comments made by two residents referred to the recent past before an extra member of staff had been employed to assist with the suppers.

We saw that there was a suitable staffing structure in the home to ensure management and supervision of staff at all times.

Staff felt sufficiently trained and competent in their roles and we saw training records

that confirmed a rolling programme of essential training including moving and handling, first aid, food hygiene and fire training. Records also showed that almost all the staff had completed the relevant national vocational qualifications and that some staff had undertaken training in dementia care. In addition we were told that specialist nurses would deliver training to staff such as for huntington's chorea and diabetes. However some gaps in training have been referred to in the relevant part of the report.

Our judgement
There were sufficient qualified and skilled staff working in the home to meet the needs of the residents.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not discuss this directly with the people living in the home, but staff that we spoke to felt that they had satisfactory support and supervision. They spoke of having appraisals when they were given the opportunity to talk about their progress, any difficulties and training needs. They felt that there was suitable "management", that the manager was approachable and accessible and also that there was always a senior person around for advice and support. Staff also confirmed that staff meetings were held which gave them the opportunity to air their views and be listened to.

Other evidence
Discussion with the manager and staff, and the records viewed demonstrated that new members of staff undertook an induction suitable for their qualifications and experience and according to government guidance. This ensured they felt confident and competent to fulfill their roles.

Records also indicated that staff had one to one formal supervisions and appraisals with a "manager", which helped to encourage them and also identified training and support needs.

Our judgement
People living in the home were looked after by a well supported team of staff

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Some people living in the home told us that they attended residents' meetings, when their views were listened to. They therefore felt they could influence some decisions that were made about the routines and running of the home. Some people also recalled completing quality monitoring questionnaires. The people we spoke with felt sufficiently involved in their care, and decisions made about their daily lives such as the food served and the activities they took part in.

Other evidence
We saw that there were systems in place to monitor various aspects of the care and service quality in the home. These included audits of health and safety, accidents and incidents, care plans and medication (see Outcome 9).

There were records of a service quality monitoring survey in February this year when questionnaires had been completed by residents and relatives. The analysis of these concluded that there was high level of satisfaction with The Grove, and that matters concerning refurbishments and improved seating areas outside had been addressed.

The provider also undertakes monthly unannounced visits to the home with a view to ensuring the home complies with all standards and regulations. However these visits and the audit systems should identify and address the same issues that were highlighted at this inspection. This was discussed with the manager and we are confident that an improvement in the internal quality monitoring systems will be made.

Our judgement
There were systems in place to monitor the quality of the service provided in the home, and that involved and took into account the views of the people living there.

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
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: Some nursing procedures did not uphold residents' rights to privacy and dignity.	
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
	Why we have concerns: Some nursing procedures did not uphold residents' rights to privacy and dignity.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: Some nursing procedures did not uphold residents' rights to privacy and dignity.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Some moving and handling techniques used were not always safe and in accordance with correct methods.	
Accommodation for persons who require nursing or personal	Regulation 9 HSCA	Outcome 04: Care and

care	2008 (Regulated Activities) Regulations 2010	welfare of people who use services
	Why we have concerns: Some moving and handling techniques used were not always safe and in accordance with correct methods.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Some moving and handling techniques used were not always safe and in accordance with correct methods.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Residents were not always protected from the behaviour of other residents and staff had not undertaken relevant training to help them manage difficult behaviour.	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Residents were not always protected from the behaviour of other residents and staff had not undertaken relevant training to help them manage difficult behaviour.	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Residents were not always protected from the behaviour of other residents and staff had not undertaken relevant training to help them manage difficult behaviour.	

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 14 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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The systems and practices, including record keeping, that we saw did not demonstrate safe management of medication or show that people were always receiving the correct 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: The systems and practices, including record keeping, that we saw did not demonstrate safe management of medication or show that people were always receiving the correct 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: The systems and practices, including record keeping, that we saw did not demonstrate safe management of medication or show that people were always receiving the correct medicines.	

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.

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