Review of compliance

Warmest Welcome Limited Cymar House	
Region:	Yorkshire & Humberside
Location address:	113 Pontefract Road Glass Houghton Castleford West Yorkshire WF10 4BW
Type of service:	Care home service without nursing
Date of Publication:	August 2012
Overview of the service:	Cymar House accommodates up to 25 older people, the majority having either dementia or mental health problems. The service does not accommodate people who have nursing needs. The service is owned by Warmest Welcome Ltd and is located in Glasshoughton in Castleford.

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

Our current overall judgement

Cymar House was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 13 - Staffing
Outcome 14 - Supporting workers
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider and carried out a visit on 31 July 2012.

What people told us

We carried out this inspection visit earlier than planned after receiving information alleging that staff did not inform the person's GP when they were unwell, there was a lack of activities and choice of foods at mealtimes, moving and handling practices were poor and management arrangements were inadequate.

Because the majority of people who were living in the home had some form of dementia, we had difficulty in being able to communicate effectively with them. However, we were able to speak to one person living there, two relatives and a friend of one person who was at the home.

A person who was living in the home told us they were encouraged to make their own decisions but needed support to do this. They said staff were kind and helpful but always seemed busy. However, they did say staff were always available if they needed any kind of support.

Relatives said they did not know about care plans and had not had any involvement in developing these or in any subsequent reviews and discussion about their relative's care. People had little understanding how care was planned, monitored and recorded.

Relatives told us they could visit at any time. Another commented that their relative had regular baths and liked the food provided. They also told us staff always kept them informed about any incidents."

Relatives said they were given information about the home including how to raise any concerns and details about what to do if they wish to make a complaint.

What we found about the standards we reviewed and how well Cymar House was meeting them

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

People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.

The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard

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

People did not experience care, treatment and support that met their needs and protected their rights.

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.

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

People are protected from abuse, the risk of abuse and their human rights are respected and upheld.

The provider was meeting this standard.

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

People who use services have their care and welfare needs met by sufficient numbers of staff.

The provider was meeting this standard.

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

People were cared for by staff who were not properly supported to deliver care and treatment safely and to an appropriate standard.

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard.

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

People were not protected from the risks of unsafe or inappropriate care and treatment.

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.

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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
A person who was using the service told us they were encouraged to make their own decisions but needed support to do this.

A relative spoken with said; "I was given some information about the home when my relative first came here." Relatives said they did not know about care plans and had not had any involvement in developing these or in any subsequent reviews and discussions about their relative's care.

Other evidence
We found that people had opportunity to express their views but had little involvement in making decisions about their care and treatment.

We observed interactions between the staff team and people who were living at the home. Staff mostly explained their intended actions to people before offering them support. They were respectful and polite to people and any personal support was given in private.

Before our visit to the service we received information alleging that people did not have

choices at mealtimes. We observed the lunch time meal and saw there was a choice of menu. One person did not want their meal and staff offered to make them a sandwich later if they changed their mind. One person had to eat a soft diet because of swallowing difficulties and was asked about their food preferences. We saw a member of staff explaining what one type of food was when asking the person for their menu choice. Drinks were offered with the meals and people were asked if they would like further drinks.

Most people had family to act on their behalf. Where this was not possible information was available to people about independent advocacy services and this was on display near the entrance to the home.

We saw little evidence that people and/or their relatives were encouraged to have involvement in their care and treatment. When we looked at people's care records we saw that when initially assessed there was very basic information. The information did not include anything about what was important to the person about how they were cared for or their interests and preferences in relation to such things as food, activities and lifestyle choices. The information contained within different people's care records were very similar and were not individualised to suit the person's specific needs. We did not see any written evidence that people were encouraged to maintain their independence or make their own choices or that their care was planned in a person centred way to accommodate their preferences and wishes.

Our judgement
People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care.

The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
A person who was living in the home said staff were kind and helpful but always seemed to be busy.

Relatives told us they could visit at any time. One relative said they were sometimes asked if they wanted a drink during their visit. Another comment was "I think my relative has a regular bath and she seems to like the food here. Staff always let us know if there have been any incidents."

The person using the service and relatives spoken with had little understanding about how care was planned, monitored and recorded.

Other evidence
Prior to our visit we received information alleging that staff do not inform people's GP when they were unwell, carry out unsafe moving and handling practices and do not provide enough activities.

At this visit we found care and treatment was not planned and delivered in a way that ensured people's safety and welfare.

Risks were assessed in relation to such things as falls, pressure sores and nutrition. However, these were not updated and reviewed to provide up to date information. For example, we saw that one person was at medium risk of weight loss and needed to

have their weight monitored on a monthly basis. When we looked at the weight records we saw that the person had lost 8.15kgs since April 2012. We then looked at the person's care plan to see how this was being managed and found that the care plan in relation to the person's eating and drinking had been discontinued in March 2012. The daily records showed that the person had since been admitted into hospital because of concerns about their nutrition and hydration.

We looked at three peoples' care records. We saw that an initial assessment was undertaken when people were first admitted into the service. This contained very basic information about people's identified needs and it was difficult to link some of the information to that contained within the person's care plan.

Peoples' care plans were not person centred and contained very little information that was individual to the person although one of the three care records had information about the person's life history. The care plans contained a lot of information that was very similar and focused almost entirely on the person's physical needs. We saw no evidence that the person or their relatives had any involvement in planning the care plan.

None of the care plans seen had been reviewed within the last six months and in some cases this was longer. This meant the information within the care plans was inaccurate and not up to date to reflect each person's current needs.

When we looked at incident records we did see that where people had sustained injuries that needed attention, they were supported to attend the hospital. Within people's care records we saw that health care professional visits were documented. In one case a GP had been asked to visit the home because a person was experiencing some pain. District nurses were involved in some people's care and dieticians were contacted to help manage people's weight loss and nutritional needs. There was little information within care plans and risk assessments about the role of other professionals. It was also unclear about at which stage staff should refer concerns to specialist health professionals so that any health needs could be addressed.

Because the information within people's care records was out of date and not reviewed, we had concerns that staff would need to rely on verbal information from each other to be able to provide appropriate care. This was not a reliable way of communicating and could lead to people's health needs not being properly monitored and acted on.

Regular reviews of each person's support needs should be periodically undertaken and involve meetings between the person using the service, their relatives and others involved in the person's care. We found these reviews had been taking place so information about the person's progress and any changes to their care was not discussed.

A person who was using the service told us their needs were being met. Relatives' made comments that the care was good. We observed staff attending to peoples' needs in a caring and sensitive manner. Staff told us people had regular baths and could have additional ones whenever they wanted. We observed people enjoying their food during our visit and they were offered a regular choice of drinks. However, the care being provided was not accurately documented within people's care records.

The company's Care Director was present throughout the duration of our visit. She acknowledged that some of the documentation was poor. She had started updating some care plans onto a new care planning format. We saw an example of this which contained much more meaningful and person centred information about the person's needs and staff actions to meet these.

Throughout our visit we observed that for most of the time a lot of people were asleep. We were told that the previous activity co-ordinator had recently left their post and an advertisement had gone out for a replacement. The previous activity co-ordinator worked six hours a week. The person appointed into the new post will be working 20 hours a week so there will be more emphasis on providing people with more stimulation and opportunity to take part in things they enjoy doing and to spend time away from the home.

One member of staff was carrying out activities in the interim period although it was not clear from people's care records this was happening. Although people had care plans about their social needs, this provided very little information about the person's interests and hobbies and how these were to be met.

Our judgement
People did not experience care, treatment and support that met their needs and protected their rights.

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Relatives said they were given information about the home including how to raise any concerns and details about what to do if they wished to make a complaint.

Other evidence
There was staff guidance within policies and procedures about protecting people from abuse so that staff were familiar with the procedure to follow and their responsibilities if abuse was suspected. They also knew about the whistle blowing policy and where this could be accessed.

When we looked at the staffing matrix we found that 11 out of 26 staff had not received training about safeguarding people from abuse, and some of the other staff needed updates. Despite this, when we spoke with staff they demonstrated a good understanding about the different forms of abuse, their responsibilities if abuse was suspected, and how they would respond to it. The Care Director had arranged for those staff who have not had safeguarding training and for those in need of updates to receive training in August 2012.

We found that the provider responded appropriately to any allegation of abuse. The service had not had many incidents whereby referrals needed to be passed on to local safeguarding agencies. However, we were told there had been a recent incident between two people who were using the service which had been passed onto the local safeguarding team so that appropriate actions could be put in place to keep people

safe.

We spoke with the Care Director about the staff team's understanding of the Mental Capacity Act 2005 and how their care practices could be affected by this. She agreed that staff should develop more awareness about the impact of this legislation, so that staff maintain and protect the rights of people who lack capacity to make their own decisions and who may be restricted by actions that are being taken to keep them safe.

Our judgement
People are protected from abuse, the risk of abuse and their human rights are respected and upheld.

The provider was meeting this standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
A person using the service told us that staff were always available if they needed any kind of support.

Relatives told us staff were usually available if they needed to speak to anyone.

Other evidence
At the time of our visit there were 22 people using the service. Throughout the morning period and early afternoon there were four staff on duty, three in the afternoon and two staff during the night. We were told five people needed two staff to support them with their personal care.

The Care Director explained that the registered manager had been absent from work for around four months. The previous deputy manager had been recently dismissed. In the interim period a senior carer was running the service with support from the Care Director. In addition to the care staff there were domestic staff, a laundry worker, catering staff and a maintenance person. The activity co-ordinator's role was vacant and an advertisement had gone out for recruitment into this post.

During our visit we observed staff to be very caring and supportive towards the people in their care. We saw they were able to spend individual time with people. People were generally sat within the lounge areas and we saw that there was always a staff member around to observe what was happening.

Whilst visiting we saw that call bell requests for staff support were promptly answered. Staff told us that although most people had a bath at least every week, they could ask for additional bathing times whenever they wanted and this would be accommodated.

Staff did say there was a need for more activities and for people to spend time away from the home. The expectation was that the increase in the number of activity hours for the person who is to be recruited into the vacant activity co-ordinator post will enable this to be achieved.

Our judgement
People who use services have their care and welfare needs met by sufficient numbers of staff.

The provider was meeting this standard.

Outcome 14:
Supporting workers

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 non-compliant with Outcome 14: Supporting workers. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
Relatives commented "Staff appear to know what they are doing."

Other evidence
Prior to our visit we received information alleging concerns about unsafe moving and handling practices,

We looked at the staff training matrix that provided a summary of all the training that staff had undertaken. We saw that half of the staff had completed the (National Vocational Qualification) NVQ to enhance their knowledge and skills in care. However, the records showed that in some aspects of health and safety, mainly fire safety, moving and handling, COSHH and safeguarding adults from abuse, some staff had either never received training or were due updates. Because of this there were potential risks that staff may not be able to deliver care and treatment safely and to an appropriate standard.

During our visit we observed staff performing moving and handling techniques with two individuals in the lounge area. Proper techniques were used and the people were transferred safely to where they wanted to go. The Care Director did say that a member of staff had recently been dismissed because of unsafe moving and handling practices.

In a previous incident we saw that a member of staff had administered some medication to the wrong person whilst still undergoing medication training and this resulted in disciplinary action being taken against them. We were given assurances this was an isolated incident and not standard practice and staff spoken with also confirmed that

staff do not administer medication unless they have completed the necessary training.

The Care Director had increased her involvement with the service following the manager's absence and had already identified areas of concern around the lack of staff training before we visited. As a result of this she had booked a range of training for August 2012 in areas where staff had not had training or were due for updates. We saw a copy of the booked training programme and this confirmed all the outstanding training issues had been covered. The provider may find it useful to note that although the majority of people who were using the service had dementia care needs, no arrangements had been put in place to develop the staff team's knowledge and understanding of dementia.

When we looked at staff files we found that supervision arrangements were in place, however, annual appraisals had not been carried out. Because of this and the lack of staff training, it was evident that staff had not been receiving the proper support to provide the care and treatment to people who used the service.

Our judgement
People were cared for by staff who were not properly supported to deliver care and treatment safely and to an appropriate standard.

The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People made no comments about this outcome.

Other evidence
Prior to our visit we received information alleging concerns about the management arrangements within the service.

We found that the provider did not have an effective system in place to identify, assess and manage risks to health, safety and welfare of people using the service and others.

We spoke with the Care Director, who is the person appointed to supervise the management of the regulated activities within the service. She was managing the service along with a senior carer during the registered manager's absence. It was not known how much longer the manager would be absent from work for.

When we spoke with staff they told us how recent changes to the management of the home have had a positive effect. One staff member said; "The new management team are a lot more approachable and you can go to them with any issues." Another member of staff talked about a previous "bullying culture" towards staff but said the culture had changed since new management arrangements had been put in place. Another comment was "Training is getting better now."

The Care Director described a system of satisfaction questionnaires for people living in

the home, relatives and professionals who visited the service. Findings and actions taken from these were on display in the home. As a result of peoples' comments a patio had been built in the rear garden area so that people could sit out. Re-decoration work had been completed on the ground floor premises and new carpets and furniture had been purchased. Further plans were underway to re-decorate all the bedrooms and to refurbish other parts of the service.

A number of internal audit systems have either been introduced or will be in the near future. A recent visit from an external infection control team scored the service 93% for their infection control practices and procedures. A recent fire safety visit found the premises to be satisfactory. Environmental health had given the service five stars (excellent rating) for their hygiene and food standards.

Since the new management arrangements had been put in place staff meetings were taking place. Staff told us they were encouraged to voice their views and opinions and to make any suggestions on how the service could be improved. There had been no meetings held with people who used the service and their relatives although we saw that one had been arranged for the following month.

We also found that poor care practices had been addressed and that disciplinary procedures and actions had been taken against the members of staff concerned.

Despite the quality assurance systems that were in place and as mentioned within this report, we had a number of concerns about a lack of a person centred approach to care, poor record keeping, inadequate staff training, the lack of supervision arrangements and recruitment procedures not being followed. The Care Director had also identified some of these issues prior to our visit and had taken some actions to prioritise the outstanding work. However, a lot more further work needed to be completed to address our areas of concern. The provider may find it useful to note these issues were only identified because of them having more involvement in the daily running of the service in the registered manager's absence, and this will need closer monitoring in the future so that any management shortfalls can be more quickly identified and acted on.

Our judgement
The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 21: Records. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People made no comments about this outcome.

Other evidence
People's personal records including medical records were not accurate or fit for purpose.

During our visit we saw that records were not completed accurately and kept up to date. This included dating and signing records and ensuring people's care records accurately reflected the care and support they needed.

When we looked at the staff files, in five cases we could not find any evidence to show that a Criminal Record Bureau (CRB) check had been undertaken. This indicated that recruitment procedures had not been followed to protect people from unsuitable workers. The Care Director was taking immediate action to verify this information was accurate so that where necessary CRB checks could be undertaken and measures could be put in place in the interim period to ensure peoples' safety.

Our judgement
People were not protected from the risks of unsafe or inappropriate care and treatment.

The provider was not meeting this standard. We judged this had a moderate impact on

people using the service and action was needed for this essential standard.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People's views and experiences were not taken into account in the way the service was provided and delivered in relation to their care. The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard.	
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: People did not experience care, treatment and support that met their needs and protected their rights. The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers

	How the regulation is not being met: People were cared for by staff who were not properly supported to deliver care and treatment safely and to an appropriate standard. The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider did not have an effective system to regularly assess and monitor the quality of service that people receive. The provider was not meeting this standard. We judged this had a minor impact on people using the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People were not protected from the risks of unsafe or inappropriate care and treatment. The provider was not meeting this standard. We judged this had a moderate impact on people using the service and action was needed for this essential standard.	

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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

Document purpose	Review of compliance report
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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