Review of compliance

Disabilities Trust Dysons Wood House	
Region:	South East
Location address:	Tokers Green Reading Berkshire RG4 9EY
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Dysons Wood House is a residential home providing personal care and support for up to fifteen male adults with autism. The home specialises in managing challenging behaviour. The home is operated by The Disabilities Trust.

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

Our current overall judgement

Dysons Wood House 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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

We spoke to two of the people living at Dysons Wood House. One person told us that the home had changed for the better and he was happy with the support he received. He was aware of the new behaviour management systems and was happy that staff would be able to restrain people where necessary. He told us that under the previous management staff were not allowed to do this. He told us that he felt safe in the home but that one person tended to dominate the staff attention. He liked the new catering arrangements although he was worried his meal might get cold before he received it. The other person told us they enjoyed the meal they had on the day of our visit. Both were aware of the plans for changes to the physical environment and had been involved in discussions with staff about the changes. One was very well informed about the plans. He also told us the staff were very good but did say that some were 'a bit quick tempered and tended to raise their voices too much'.

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

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

Although detailed care plans, risk assessments and behaviour plans were in place, these

were not being consistently put into practice by the staff. People living in the home did not always experience effective, safe and appropriate personalised care, treatment and support. There was little interaction by staff with the people living in the home and what there was did not always follow written support plans or promote individual choice and decision making. There were limited opportunities for participation in constructive activity for people who lived in the home.

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

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

People living in the home were not sufficiently protected from abuse or the risk of abuse. Staff were not always following prescribed behaviour plans and one to one support requirements were not consistently being met. Until recently, reporting of safeguarding incidents to the local authority safeguarding team and the Care Quality Commission had been inconsistent.

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

Although the buildings were broadly safe and accessible, they did not sufficiently promote the well being of people living in the home. Standards of décor in the communal areas were plain and they were in need of redecoration. Plans for full redecoration were provided but have yet to be completed.

Overall we found that Dysons Wood House was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

Although staffing levels had recently improved, the staff were not yet being effectively deployed or managed by senior staff to meet the needs of the people in the home. There remained shortfalls in the permanent staff team, including at senior and team leader level. The home was still using significant numbers of bank and agency staff.

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

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 not always safe and their health and welfare needs were not consistently met by competent staff. There were shortfalls in the mandatory training provided for staff. Staff had not received regular support through supervision, appraisal or regular team meetings.

Overall we found that improvements were 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 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. Any regulatory decision that CQC takes 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 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
One person living in the home told us that the home had changed for the better while he was living there. He said he liked the food but wasn't sure the new serving system would work. He was worried his food might get cold on the way from the kitchen. He told us he found the other people living in the home quite challenging but always reminded himself that "they couldn't help it". He said that one person took up all the staff time and other people couldn't get their attention. He said he was happy living at Dysons Wood House and that it was much better than the last home he was in. He felt his behaviour was getting better because of the support he received from the psychologist and the staff.

Other evidence
We examined four care plans and associated records. Each person had three files containing different elements of the records relating to their care. The "working file" contained risk assessments, assessments of mental capacity, support plans and related guidelines and person centred plans. There were recent minutes of annual reviews and multi-disciplinary meetings as well as clinical reports and details of family contact. A second file contained daily notes, records of personal care, behaviour monitoring reports and night reports. The third file contained detailed health records which indicated regular appointments and information on diet and nutrition. The files contained individual risk assessments and behavioural guidelines relevant to each person. Files contained information on the individual's methods of communication and guidelines on how to respond to them.

The support plans were very detailed and included details of individual likes and dislikes, achievements and progress. However, the recorded achievements/progress were not reflected in the risk assessments and behaviour support plans. In one case relating to an inappropriate behaviour, this was stated to have 'mostly stopped' in the support plan, but the risk assessments/behaviour plans still reflected that this behaviour was a major problem. We saw some instances where behaviour plans were not being followed by the staff. For example, one person began to display a particular inappropriate behaviour and staff did not follow the written guidelines to manage this. The brief attempt to address the behaviour by one staff member was ineffective and was not followed through. The behaviour escalated and staff did not intervene until instructed to do so by the senior manager. Their intervention was not in accordance with the guidelines. Another person's guidelines specifically identified the importance of staff using a calm, even, but firm tone of voice when speaking to him. Yet we saw staff using raised voices and sounding agitated when responding to him. Some of the behaviour plans were undated. In one file some of the risk assessments were hand written and difficult to read. Clinical support was available with members of the psychology team regularly on site to observe behaviours and devise detailed behaviour plans for staff to follow. However, members of the psychology team reported that the degree to which staff followed the behaviour plans was variable.

We observed that staff spent time with people living in the home. However, we saw very little conversation or engagement initiated by staff. Often the staff were seen just talking amongst themselves. One person was waiting for lunch and was repeatedly told by three different staff "to sit and wait". It took about half an hour before he was served. During that time none of the staff spoke to him except to say "come here, sit and wait" if he moved from the settee. Another person sat down to wait for lunch some time before it was ready. There was very little interaction with him by staff, aside from a comment that it would only be another five minutes.

An agency chef had been brought in on the day of our visit to develop improved menus and improve the food ordering system. This was to enable the care staff to spend more time with people living in the home rather than in the kitchen. Senior staff told us that the food served that day was a significant improvement on previous meals. We saw several of the people in the home enjoying their lunch, two of whom went back for second helpings. One person decided to make his own sandwich for lunch and he was supported to do this.

Lunch was being served individually to people, from the kitchen, based on their personal choices rather than from a heated trolley in the dining room. This was said to better enable personal choice and be less institutional. We saw individuals being offered a choice of drinks at lunchtime and also being offered sauce with their meal. However, this was put on for them. The table mat, cutlery, plastic beaker and ketchup were brought individually to the table for the person eating there at that time. When one person finished his lunch he wiped his mouth on his T shirt rather than the paper serviette provided. None of the staff were seen to encourage him to use the serviette. Another person returned from a dental appointment and sat in the dining room waiting for his lunch. One of the senior staff suggested he go to collect his lunch from the kitchen and he did this. One staff member asked him if he was enjoying his meal and he replied yes and went to get a second helping. We saw some staff talking between themselves and the purpose of their presence was unclear.

During the lunchtime period people ate their lunches in various places including their bedrooms, the hallway and the dining rooms. They did this largely individually. At times we saw as many as three or four staff with an individual, they did not engage with the person just talked among themselves. This was especially noticeable with the agency staff of whom there were several working on the day of our visit. They did not appear to be effectively managed by the senior staff or have clear roles or duties. When two permanent staff arrived for the afternoon shift there was some interaction with people living in the home around finding out what they would like to do. When one person later ate his lunch in the dining room the staff encouraged him to put things back on the tray to return them to the kitchen, although he chose not to do so.

The records of activities within the daily notes indicated differing levels of involvement in activities and in some cases these were not very varied. For example, there were a lot of "drives out" with no specific destination or purpose. One person had a person centred plan that stated that he should be given a wider range of activities including identifying a specific activity to be developed. There was no evidence that any action had been taken to develop this activity. One staff member told us that activities had often not taken place because some people needed a 2:1 staffing ratio when going out in the community and there had not been enough staff to do this. They went on to say that although staffing had been increased in the past three weeks, the staff were new or from an agency and did not have the skills or training to carry out some of the behaviour guidelines. Staff told us that the level of activities was beginning to improve but we saw that some people did not have any significant positive activity or engagement during our visit.

At several points during the day one person living at the home came to the new staff office seeking clarification about the changes in the home. This was given each time by the senior staff who tried to explain the changes that had been made. Staff told us that people had been involved in different ways and to varying levels in the changes and the future plans for the home.

Staff told us that communication with families had improved recently. A letter had been sent to them outlining the proposed changes.

Our judgement
Although detailed care plans, risk assessments and behaviour plans were in place, these were not being consistently put into practice by the staff. People living in the home did not always experience effective, safe and appropriate personalised care, treatment and support. There was little interaction by staff with the people living in the home and what there was did not always follow written support plans or promote individual choice and decision making. There were limited opportunities for participation in constructive activity for people who lived in the home.

Overall, we found that improvements were 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

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
One of the people living in the home told us he had not seen staff using physical restraint "because they are not allowed to". He described the new behaviour management system which had recently been introduced, which was called Crisis Aggression Limitation and Management (CALM) and said he thought it would be a good thing when people can be restrained, but only as a last resort. He said he feels safe with the staff and people he lives with but this was because he could "look after himself" and people "wouldn't dare pick on him". He said he had never seen any excessive force used and had not yet seen staff using CALM.

Other evidence
We saw various individual risk assessments in the files we examined. Some of these were accompanied by behaviour plans and detailed guidelines to identify how staff should act to address the specified behaviour, or minimise the risk of harm to the individual or others. These documents had been reviewed recently. Some of the information on file was incomplete. For example, in one case there was a statement that the person was on a supervision order but there was no paperwork to support this.

In some cases staff were failing to safeguard the people in the home by not following the specified behaviour plans. Some people living in the home were not being supported 1:1 by staff in accordance with their risk assessments or behaviour plans. On one file there were records of aggressive behaviour towards staff which detailed over 300 instances in July. The guidelines were clear about how staff should speak when interacting with him but, as noted in outcome 4, these were not being followed. At one

point a person began to behave in an aggressive fashion and no de-escalation techniques were seen to be used by staff to try to diffuse the situation.

One agency staff was not able to be specific in describing individual behaviour plans. She said she was always on duty with a permanent staff member who dealt with any behavioural issues. She said she had not seen anyone being restrained. When asked about how she would respond to a safeguarding issue, one new staff member was unclear and unable to describe the reporting process. She told us she had received a detailed induction before starting in the home. She said she had received instructions on residents, other staff, the building, risk assessments and challenging behaviour. Another staff member told us that the behaviour of people living in the home had deteriorated and behavioural guidelines were not followed because there were not enough staff to do so. She said that the behaviour plans themselves were very clear and hoped that staff would be more confident in using CALM. However, she added that some staff were still afraid to use the CALM physical restraint techniques.

Until recently staff in the home had been trained in techniques called Strategies for Crisis Intervention and Prevention (SCiP) for behaviour management. Staff told us that they had been told not to use the physical restraint techniques by the previous manager. In addition, one staff member said that this manager had not responded to staff concerns about the resulting escalation in peoples' behaviour and people in the home had not always been safeguarded as they should have been.

The local safeguarding team had raised concerns about inconsistent recording and reporting of incidents between people in the home, to the safeguarding team and the Care Quality Commission, with the provider. Concerns about the level of aggressive incidents between people in the home triggered this inspection by the Commission. An action plan was produced by the team brought in by the provider to address these concerns. All of the staff were due to have been trained in the new behaviour management system by the end of the week of our visit. The system includes quarterly reporting of the use and effectiveness of the specified techniques to the system's developers. In addition to this, experienced senior staff had been drafted into the home to develop staff awareness of the importance of consistency and of following behaviour plans. The staffing levels had also been increased to help enable this. The safeguarding team had asked that the home write to families informing them of issues and concerns that had arisen in the home and how they were being addressed. This had not been done at the time of our visit.

Our judgement
People living in the home were not sufficiently protected from abuse or the risk of abuse. Staff were not always following prescribed behaviour plans and one to one support requirements were not consistently being met. Until recently, reporting of safeguarding incidents to the local authority safeguarding team and the Care Quality Commission had been inconsistent.

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

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

There are minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
One person living in the home told us about the plans for refurbishing the buildings. He had been involved in discussions with staff about the proposed plans.

Other evidence
At the time of our visit the main house accommodated five people, with a further seven living in the newer building. Each building provided individual bedrooms. The bedroom we saw was personalised. The communal environment, particularly in the main house did not feel welcoming. There were no curtains at the large windows in the lounge and dining room. In the entrance hallway there was an orientation board indicating the day, date and weather. It was up to date and the staff told us that people living in the home help to update this board daily. One of the communal toilets in the newer building was soiled. The senior staff told us that care staff were responsible for cleaning as well as care, but there were plans to provide housekeeping and domestic support to enable the to focus on delivering care.

We were told about the plans to redecorate the newer building. The old building was also due to be redecorated and have other improvements, despite the long term plan for its demolition and replacement with two new bungalows. Plans were being developed for the people living there to provide for them during the building works. There were various notices around the buildings to help people understand the plans and informing them who they could discuss any issues with. Some were in accessible symbol formats. Some of the people living in the home were clearly aware of the changes and one was able to tell us about them in some detail. We saw senior staff explaining some of the changes to another person using appropriate communication.

During the morning and the lunch period we saw the lounge door wedged open by means of a chair. We were told that the approved door retainer was not working. We noted that the maintenance person spent some time attempting to repair it.

Our judgement
Although the buildings were broadly safe and accessible, they did not sufficiently promote the well being of people living in the home. Standards of décor in the communal areas were plain and they were in need of redecoration. Plans for full redecoration were provided but have yet to be completed.

Overall we found that Dysons Wood House was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One person living in the home said that the staff were all very good "although a few were a bit quick tempered, which means that they sometimes raised their voices too much".

Other evidence
There was a newly appointed acting manager in place who was on leave on the day we visited. However, we met most of the staff and managers who had been drafted in from elsewhere in the trust to oversee the establishment of the new management team and the completion of the trust's action plan. The senior team presented a lot of plans for the future development of the home. A copy of the new management team hierarchy was supplied to the inspectors after the visit, to clarify who was responsible for which aspects of the ongoing management of the home. Some staff we spoke to appeared confused about who to refer to about different aspects of the home's operation.

We examined the new staff rotas which were clear and easy to understand. They identified key roles such as those who could give medication and which staff were designated drivers for the home's vehicle. They clearly identified who was working in each building, although they did not identify the shift leader. The assistant manager told us that they planned to have a team leader/senior leading each shift once all the team leader and senior posts were filled. The assistant manager was covering some shifts in the role of shift leader. The rotas included an overlap between shifts to enable staff to handover relevant information to support continuity of care.

We were told by staff that in the past the staffing levels, especially in the newer building, had been insufficient to meet the needs of the people living at Dysons Wood House. This was acknowledged by senior management and staffing levels had now been increased. Recruitment was in progress to fill vacancies, but considerable numbers of agency and bank staff were being used in the interim. We were told that the bank staff were familiar with the people in the home. Although the staffing levels had recently been increased we observed that staff were not being managed or utilised effectively. We saw staff talking to each other and not engaging with people or encouraging constructive activity.

One staff member told us there had not been enough staff last year and staff had to do the care, be cooks and cleaners and do daily activities. She told us this had improved in the last three weeks but said that it was still hard for the long-term staff as there were a lot of new and agency staff. She told us she was working a thirteen and a half hour day and this was not unusual.

Our judgement
Although staffing levels had recently improved, the staff were not yet being effectively deployed or managed by senior staff to meet the needs of the people in the home. There remained shortfalls in the permanent staff team, including at senior and team leader level. The home was still using significant numbers of bank and agency staff.

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

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

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not ask people living in the home about this outcome.

Other evidence
One staff member told us that training had improved recently with lots of courses provided or planned. However, they told us there had been hardly any training provided over the previous two years. Staff told us that the Trust had sent in a lot of senior staff from elsewhere within the organisation to address issues, but this had led to some confusion over management and reporting responsibilities. We were told by staff that there were not clear lines of accountability in place. One staff member also said that it felt as though "any good work that might have been done over the years", was not being valued.

Senior staff told us that there had been a culture change towards supporting and enabling people to do things for themselves and make decisions and choices. However, we saw limited evidence of this. In addition, we were told that some staff were now more positive and motivated and were engaging better with people in the home. We saw limited evidence of this during our visit. The staff did not appear to have fully adopted the new approach and from what they told us, needed more training and greater understanding of their role and the expectations of them in order to develop a sense of team working. At times we saw that the people living in the home were more engaged with the senior managers than the care staff. Care staff told us that the permanent staff team were committed.

The assistant manager said that weekly practice sessions on the new behaviour

management system were to start once all staff had completed the training. He said that the new system provided staff with a range of techniques to prevent negative behaviours escalating to the point where physical restraint might be necessary. Regular team meetings were planned, but had not yet been established. The staff had been interviewed individually to identify support and training needs. We were told that some staff were still concerned about using the new techniques having been instructed previously not to use physical restraint. The overall training spreadsheet for the team could not be accessed due to the absence of the administrator. However, a review of some individual training records found significant gaps in mandatory training. Full training records were provided following the inspection. They indicated significant shortfalls in staff training including health and safety, fire awareness, the Mental Capacity Act, food hygiene, autism awareness and epilepsy. There were also gaps in the training on basic first aid, medication and safeguarding, although 17 staff had recently received safeguarding training.

Staff told us that supervision had been infrequent. One staff member told us that he had one personal supervision in June but no others this year. He also told us that there had been two team meetings in the previous three weeks. He said the new changes were positive but some staff and some of the people living in the home were finding them difficult or confusing at times. Senior managers acknowledged that regular team meetings and supervisions needed to be established.

Our judgement
People living in the home were not always safe and their health and welfare needs were not consistently met by competent staff. There were shortfalls in the mandatory training provided for staff. Staff had not received regular support through supervision, appraisal or regular team meetings.

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

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: Although the buildings were broadly safe and accessible, they did not sufficiently promote the well being of people living in the home. Standards of décor in the communal areas were plain and they were in need of redecoration. Plans for full redecoration were provided but have yet to be completed.	

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 within 14 days of this report being received.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Although detailed care plans, risk assessments and behaviour plans were in place, these were not being consistently put into practice by the staff. People living in the home did not always experience effective, safe and appropriate personalised care, treatment and support. There was little interaction by staff with the people living in the home and what there was did not always follow written support plans or promote individual choice and decision making. There were limited opportunities for participation in constructive activity for people who lived in the home.	
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
	How the regulation is not being met: People living in the home were not sufficiently protected from abuse or the risk of abuse. Staff were not always following prescribed behaviour plans and one to one support requirements were not consistently being met. Until recently, reporting of safeguarding incidents to the local authority safeguarding team and the Care Quality Commission had been inconsistent.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated	Outcome 13: Staffing

	Activities) Regulations 2010	
	How the regulation is not being met: Although staffing levels had recently improved, the staff were not yet being effectively deployed or managed by senior staff to meet the needs of the people in the home. There remained shortfalls in the permanent staff team, including at senior and team leader level. The home was still using significant numbers of bank and agency staff.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People living in the home were not always safe and their health and welfare needs were not consistently met by competent staff. There were shortfalls in the mandatory training provided for staff. Staff had not received regular support through supervision, appraisal or regular team meetings.	

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 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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