Review of compliance

Orders of St John Care Trust OSJCT Bartlett House	
Region:	South West
Location address:	Old Common Way Ludgershall Andover Hampshire SP11 9SA
Type of service:	Care home service without nursing
Date of Publication:	July 2012
Overview of the service:	Bartlett House is registered to care for 49 older people who have residential care needs, these may include dementia needs.

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

Our current overall judgement

OSJCT Bartlett 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 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 28 May 2012, checked the provider's records, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People told us they could chose how they spent their lives. One person told us "I like to get up very early every day have a cup of tea with the night staff " and another "they do what I ask". People told us they liked living at Bartlett House. One person said "I love it, everyone's nice here" and another "it's very comfortable, very nice here". People said they liked the staff, one describing them as "very good". People felt they could comment on the service. One person told us "I would mention something to them if I had concerns, no hesitation".

However we found people did not consistently experience care and support which met their needs and care provided did not routinely follow relevant guidance. The home's practice did not prevent risk of cross infection and ensure a hygienic home environment. The provider's systems to assess and monitor the quality of service people received were not effective in practice as they did not identify areas which needed to be addressed. Necessary records were not being maintained about all people.

What we found about the standards we reviewed and how well OSJCT Bartlett 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 privacy, dignity and independence were largely respected and their views and experiences generally taken into account in the way care was delivered.

The provider was meeting this standard

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

People did not consistently experience care and support that met their needs. Care was not always planned and delivered in a way that ensured people's safety and welfare and did not reflect relevant research and guidance. Relevant professional advice was not always sought when indicated by a person's condition.

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

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

The provider had not ensured that people were cared for in a hygienic environment and risk of infection was not prevented by their management systems.

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was 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 were cared for by staff who were generally supported to deliver care safely and to an appropriate standard.

The provider was meeting this 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 had systems to regularly assess and monitor the quality of service that people received but it was not effective in practice, as it did not enable the provider to assess, identify and manage all of the risks to people's health, safety and welfare.

The provider was not meeting this standard. We judged that this had a moderate 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 as the home was not maintaining appropriate and accurate records about them.

The provider was not meeting this standard. We judged that 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 compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People said they could express their views and were involved in making decisions about their care and treatment. One person told us "sometimes I eat my meals here, sometimes in the dining room, depends on how I feel", another, "I get a bath every week, I can change the day I have a bath if I want to" and another "I like to get up very early every day have a cup of tea with the night staff ". One person told us "I'm not aware I have a care plan but they do do what I ask" however another person told us "I don't have a care plan, I just take it as it comes".

People's dignity and rights were respected by some of the staff. We observed two care workers who always made sure they called a person by their preferred nickname. They were also very careful to explain all the actions they would be doing when assisting the person to move, using a hoist. The provider may find it useful to note that some of their staff needed support to ensure they respected people's dignity and rights. We observed a male member of the ancillary staff entering a female person's room without knocking on the door first. We observed a care worker put food on a person's fork at lunchtime without telling the person what they were doing, only saying "ok" when they had finished and were leaving the person.

Other evidence

We met with the laundry worker who told us all people's clothes were marked, including people's socks. This ensured all people had their own clothes returned to them and there were no un-named clothes stored in the laundry.

We were aware the provider had identified people's involvement in decision-making about their care was an area which needed further action, across their homes. This was because they had assessed some people needed additional support and advocacy to be involved in making decisions about their care. The provider had made us aware new systems were being piloted in another home and these would be spread out across the provider's homes, following this.

Our judgement
People's privacy, dignity and independence were largely respected and their views and experiences generally taken into account in the way care was delivered.

The provider was meeting this 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
People said they liked living in the home and they received the care they needed. One person told us "I love it, everyone's nice here", another "I'm quite content here" and another "it's very comfortable, very nice here".

A community nurse told us "the staff are lovely" and they do "a really good job considering what they do".

Other evidence
The provider met some people's needs. One person had diabetes. They had a very clear care plan, which informed staff of the actions they needed to take if their blood sugar levels became unstable. Another person was receiving continuous oxygen. They had a detailed care plan to inform staff of how to look after this person's breathing needs, including details of actions to take relating to their oxygen concentrator.

However the provider was not meeting people's care and welfare needs in a wide range of areas and was also not following research-based guidelines. The inspection took place during a heat wave. Department of Health guidelines advise frail elderly people are likely to be at risk from dehydration during heat waves. They advise people will need additional support from staff to drink fluids, and also staff need to be aware if a person is unduly drowsy; this can indicate they are becoming dehydrated. The staff were not following these guidelines. We observed while there were fluids available for people, they were not consistently supported to drink additional fluids. We looked in

detail at the needs of three people living in the home. All three of them were frail and remained asleep or drowsy between 9:30 and lunch time, whilst they had drinks available to them, we only observed one person being supported to take sips of fluid, on one occasion only. Two of the people had records which indicated they needed support to take in adequate fluids but records had not been completed to show this had taken place. The third person's records showed they had declined drinks and breakfast that morning and had not had a drink since the previous evening. We made safeguarding referrals in respect of these people as we considered they were at risk of dehydration, due to the home not meeting their needs during a heat wave.

We met with two people who were frail and assessed as being at high risk of pressure ulceration. Guidelines from the National Institute for Health and Clinical Excellence (NICE) state as pressure ulcers can take an extended period to heal, are painful and can present a source of infection, the emphasis needs to be on preventing them from happening. A key area in this is ensuring people have their positions changed regularly. Both people did not have records to show their positions were being changed. We observed both people during the morning, but their positions were not changed in accordance with the frequency stated in their care plans. Care workers staff we spoke with were not able to tell us about when these people's positions had last been changed.

The provider was not taking appropriate action when a person developed skin damage. We met with one person who told us they had sore areas on part of their body, we saw a dressing on another person and saw records relating to skin damage a third person's records. We spoke with care workers about these people and received different information from different members of staff. None of the people had care plans about how their changed skin care needs were to be met. The district nurse told us they had not been informed about two of these people's changed conditions, although they were seeing one of these people regularly.

Appropriate actions were not taken when people were nutritionally at risk. We met with two people who had changing nutritional needs. One person told us about recent changes in how they were able to eat their meals. Their care plan was brief and had not been up-dated to reflect the changes they told us about. We spoke with two care workers about this person, one of them knew about the changes but the other one did not. The other person's records showed their weight had gone down recently but their care plan had not been revised to show actions needed for them. This person was being cared for by an agency care worker who did not know what the person had eaten that day. The district nurse told us they had not been told about this change for the person, although they were seeing the person every day.

People who experienced falls did not consistently have their risk of falling reviewed and appropriate action was not taken where they hit their head. A person showed bruising to their face. A care worker told us the person had fallen recently. They told us, and the person's records showed, they had a history of falls, including four during the past four weeks. The person's care plan had not been reviewed when they fell to identify risk factors for the person and reduce their risk of falling. There were no records to show the person's condition had been observed after they hit their head to ensure appropriate medical assistance could be sought if their condition indicated they were becoming unwell, as can happen if a person sustains a head injury.

Our judgement
People did not consistently experience care and support that met their needs. Care was not always planned and delivered in a way that ensured people's safety and welfare and did not reflect relevant research and guidance. Relevant professional advice was not always sought when indicated by a person's condition.

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

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 non-compliant with Outcome 08: Cleanliness and infection control. 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
We spoke to people using the service but their feedback did not generally relate to this standard. One person did tell us "they keep the floors clean".

Other evidence
The provider did not have effective systems in place to ensure cleanliness and lack of odour. The home's quality audit stated they were to be free of offensive odours by 1 March 2012. We noticed an malodour when we came into the home and also noticed a mal odour in two of the six people's rooms we went into. We talked with a care worker about one of these rooms. They told us they were aware of the odour and had asked a domestic worker to shampoo the carpet. The room still had the odour after lunch. We asked a domestic worker about the other room. They told us they shampooed the carpet regularly but issues with odour and staining tended to return. The home manager told us the odour in the entrance area had been brought up with the provider and a new carpet was going to be ordered.

Effective systems for ensuring regular cleaning were not in place. We looked at the chairs in the sitting room. Seven of the ten chairs showed staining. The carpet in this room also showed staining. The dining room carpet was stained. Three of the six bedrooms we looked in showed staining to their carpet.

Systems to ensure decontamination were not effective in all areas of the home. We looked at two raised toilet seats, both showed yellow spots on their under surfaces at both 09:10 and 11:30. A communally used bathroom showed staining and limescale, particularly round the sink hole. A hand wash basin in a sluice room showed staining on and round the taps and in the bowl. In a different sluice room we saw a brush, which we

were told was used to clean sanitary items, had been left in a pool of water on the sink drainer. This showed deposits of dark coloured material at the base of the bristles.

The provider was not taking appropriate steps to meet people's sanitary needs. At 9:30 we met with a person who told us they stayed all the time in their room. They told us they had used their commode and it had not yet been emptied. At 11:30, we observed the person's commode remained in the same condition as at 9:30. There was also yellow/brown staining and debris on the chassis underneath the commode bucket. Another person's commode bucket in their room showed dried-on dark debris and stain in the base.

Laundry was not always being managed in a way to reduce risk of cross infection. The home had a colour-coding system for used laundry, which reduced the need for used laundry to be handled. At 09:20 we saw a red plastic bag which contained foul laundry. The bag had been left open and unsealed, balanced on top of a used linen trolley. There were several plastic bins in the laundry containing used items. We observed a member of staff taking items out of one bin, putting them in other bins and putting a red plastic bag for foul laundry in the first bin. We asked the laundry worker abut this. They told us they used these bins as they needed to re-sort the laundry before they washed it, as sometimes people's personal laundry was mixed up with sheets and towels. They told us they had two washing machines which could do sluice washes and they did the sluice washes as soon as the red bags for foul laundry came in, followed by other washes. They did not leave potentially contaminated laundry to be completed after non-infected laundry.

We spoke with a domestic worker. They told us "we are short staffed". They said they shampooed carpets "when we can, if it really needs it, it will get done". We observed this domestic worker was careful when they cleaned, making sure they did their work correctly, not rushing or missing areas because they felt they had a lot to do.

We met with the care worker who said they were going to be one of the designated leads for infection control for the home. They said they were booked on the provider's course but had not done it yet. We asked the care worker where the Department of Health's Code of Practice was kept but they could not find it. This Code advised homes on the Department of Health guidance on infection control and hygiene. The care worker was aware of the provider's own infection control policy.

Our judgement
The provider had not ensured that people were cared for in a hygienic environment and risk of infection was not prevented by their management systems.

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

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We spoke to people using the services but mostly their feedback did not relate to this standard. One person told us "the staff are very good". We observed staff moving three different people and saw they did this in a safe manner, correctly using relevant equipment.

Other evidence
We talked with staff about training. One care worker told us about their training, describing a range of different areas. They said they had recently attended fire training and said their first aid training had been "brilliant". They told us they received supervision from their line manager "regularly". Another care worker told us about the provider's "Back to Basics" training and how useful they had found it. The laundry worker told us they had been trained in their role and had also recently been trained in fire safety and infection control. They also said they had supervision with their manager. The activities worker described their training in caring for people with dementia and how this had helped them in their role. They also mentioned recent fire safety training.

We looked at the home's training records. There was no matrix for training so management could see at a glance which members of staff had attended which training. We were aware from information from the provider that this had been identified as an area for action and the provider was in the process of developing their systems. We were told one of the senior care workers led on training for the whole home and they liaised with the provider's central training department. The training department maintained records of training for employees and informed this senior care worker when individual members of staff were due to attend the provider's mandatory

training. These records were not kept in the home.

We looked at individual training records for three members of staff we had met with. One member of staff's records showed they had undertaken most of the company's mandatory training, including dementia training, managing challenging behaviour and falls. Their last infection control training was documented at taking place in 2009. Two care workers' records showed they had not undertaken either dementia awareness or managing challenging behaviours. One of the care worker's training records did not show they had undertaken infection control. The provider may find it useful to note that the home's training and supervision records do not show the home are meeting this outcome area, particularly records for training in infection control and caring for people with dementia.

We looked at records of supervision for staff. The provider may like to note twenty eight staff supervision files had no records of supervision for 2012. Some supervision files had minutes from a staff meeting included on the file. Where supervision was recorded the records were clear, demonstrating discussions about areas such as safeguarding and whistleblowing and where relevant they showed staff behaviours were challenged. The home manager told us some supervisions, for example catering staff, were kept by the staff member's supervisors, not on the home's main individual files. This was an area which they had asked the senior care worker who was leading on staff training and support to develop.

We looked at records for an agency care worker we met with. They had a completed induction checklist, which included fire safety.

Our judgement
People were cared for by staff who were generally supported to deliver care safely and to an appropriate standard.

The provider was meeting this 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 moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People who used the service told us they said they felt their views were taken into account. One person told us "there are several people in charge and I would mention something to them if I had concerns, no hesitation", another "we can complain if we don't like the food" and another "I'm the first one to say – it's easier that way".

Other evidence
The provider had an extensive quality audit system where reports were produced regularly and if the audit identified matters, actions plans were developed to address them. However the quality audit system did not identify many issues needing attention or action, including making sure people had their needs met, ensuring safe systems in infection control and correct record-keeping.

Other matters were not identified by the home's processes. This meant relevant action was not taken. We observed several areas relating to maintenance as we went round the home, these included two very loose toilet seats where a person who was frail might be at risk of falling, a radiator cover in a toilet which was chipped and no longer wipeable, a shower room with a very loose handle and damage to a bathroom wall. We asked a care worker about what happened when repairs were needed. They told us they would write them in the handyman's book or tell them personally. We looked in the handyman's book and none of the matters listed above were documented. We asked the handyman about them, but said they did not know about them.

One of the bathrooms had a first aid box in it. It was untidy, with items spilling out. These included a bandage with an expiry date of December 2009. The home's quality audit stated first aid boxes were to be checked monthly with a completion date of 8 May 2012.

The audit systems did not effectively monitor the home environment and staff performance. We asked if there was a system for spot checks on the quality of the home environment. The domestic manager told us they went round the rooms with the maintenance man. This had last been completed on 23 April12. The domestic manager told us they were in the process of developing documentation to audit the quality of cleaning of rooms, but they did not do spot checks on quality of cleaning. We asked the home manager about other spot checks, particularly monitoring the presence of odour. They said a system was not in place and matters were dealt with informally.

The provider had some systems for monitoring of infection control and hygiene. For example a senior manager was performing an audit of the catering department when we visited. These systems did not take all areas into account. We noted in records and in discussion with staff that urine infections could be an issue for some people. The home manager told us they did not monitor the rates of such infections as part of their audit process.

The home did seek the views of people, including holding regular meetings for residents and relatives, which were minuted. The minutes of staff meetings showed staff were informed of matters of relevance to the home. Minutes of the home's health and safety meetings showed actions were not taken in a timely manner. The minutes for March 2010 reported on the leaking roof in the entrance area. In 7 March11, it was noted to still be an area which needed addressing, and on 16 July 2011, was reported to be replaced "this year". We were told it had not yet been done and was at planning stage. A steam cleaner was noted and being needed for the kitchen on 2 September 2010 and was still identified on16 September 2011. There was no further information in further minutes about actions about this. The minutes of the meeting of 18 January 2012 did identify a high level of falls in the home had been identified and discussion about actions to be taken.

We looked at the fire log book. This was fully completed to show fire safety precautions were being maintained.

The home also had a system for monitoring any complaints made. Records showed three complaints had been received during 2012. They had been dealt with in accordance with the provider's policies.

Our judgement
The provider had systems to regularly assess and monitor the quality of service that people received but it was not effective in practice, as it did not enable the provider to assess, identify and manage all of the risks to people's health, safety and welfare.

The provider was not meeting this standard. We judged that this had a moderate 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
We spoke with people using the service but their feedback did not relate to this standard.

Other evidence
The home maintained records about services provided, however some records were not completed when appropriate.

We met with a person who had a skin tear injury on an arm. We asked two care workers about the injury, when the person had sustained it and what they were doing to meet the person's needs. The two care workers gave us different dates for when they thought the person had sustained the injury and were not sure of actions currently being taken about it. We looked at the person's records and the home's accident records but nothing had been documented in any of the records.

We met with a person who visibly needed attention to their toe-nails. We asked a care worker about this. They told us the person did receive chiropody and how they had responded to the chiropodist. We looked in both the chiropody book and the person's records but could not see any documentation about the person receiving chiropody.

A person's records stated a urine sample was needed from them on 12 April 2012. There were no records to state why this was needed, for example any symptoms the

person was showing or if it was a request from their GP or district nurse. The same person was documented on 18 May 2012 as "showing symptoms" of a urine infection and that their GP had prescribed antibiotics for this. There were no records before the date to show what these symptoms were or when they had started.

A person was documented as having four falls during the previous month, in their multidisciplinary records. We asked to see the accident records relating to these falls to find out more about them. However when we looked at the home's accident records (which were held on computer) with a care worker, records had not been made.

Our judgement
People were not protected from the risks of unsafe or inappropriate care as the home was not maintaining appropriate and accurate records about them.

The provider was not meeting this standard. We judged that 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 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 consistently experience care and support that met their needs. Care was not always planned and delivered in a way that ensured people's safety and welfare and did not reflect relevant research and guidance. Relevant professional advice was not always sought when indicated by a person's condition.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: The provider had not ensured that people were cared for in a hygienic environment and risk of infection was not prevented by their management systems.	
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 had systems to regularly assess and monitor the quality of service that people received but it was not effective in practice,	

	as it did not enable the provider to assess, identify and manage all of the risks to people's health, safety and welfare.	
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 as the home was not maintaining appropriate and accurate records about them.	

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

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