Review of compliance

Four Seasons (Bamford) Limited Holbeche House Care Home	
Region:	West Midlands
Location address:	Wolverhampton Road Wall Heath Kingswinford West Midlands DY6 7DA
Type of service:	Care home service with nursing
Date of Publication:	July 2012
Overview of the service:	The home can provide accommodation for up to 49 people who require personal and nursing care.

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

Our current overall judgement

Holbeche House Care Home 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 to check whether Holbeche House Care Home had taken action 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 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, carried out a visit on 28 June 2012, 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

We visited Holbeche House in May 2012 and identified concerns in a number of areas. The provider sent us an action plan and we carried out this inspection in June 2012 to review improvements that had been made.

The home had a nursing unit and a separate dementia care unit. We spoke to two people, five staff, the manager, and two health and social care professionals.

We found that opportunities for people and their relatives to be involved in the planning of care continued to be limited. However, the provider informed us that care-planning reviews would take place shortly. We found that although some improvements had been made, these were not consistent throughout the home and further improvements were required.

We found that there had been some improvements, particularly in the dementia unit. There was use of instruments, improved ways to stimulate people and the introduction of dolls, which was known to help with dementia. We saw that interactions between staff and people had improved. We found that healthcare professionals were not always involved in

people's care in a timely manner. This meant that concerns that we previously raised relating to care and welfare were not all met.

People at the home continued to be at risk of not being safeguarded appropriately. We found that staff were not appropriately escalating safeguarding concerns and any incidents to management. We found that we were not being notified of incidents, which the home has a duty to report to us. There was an ongoing risk that people's finances were not appropriately safeguarded.

We found that not all actions from the provider's action plan had been completed. We were not updated with the progress on a regular basis. We found similar concerns during this inspection that we had raised in May 2012. This meant that not all necessary changes had taken place.

What we found about the standards we reviewed and how well Holbeche House Care Home was meeting them

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

The provider was not meeting this regulation. We judged that this had a minor impact on people. The provider does not ensure that people's independence is promoted and their dignity maintained.

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The provider did not ensure that people experienced care, treatment, and support that met their needs and protected their rights.

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who use the service were not protected from the risk of abuse.

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. Staff were not able to access regular training, supervision and appraisals.

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 was not meeting this regulation. We judged that this had a moderate impact

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

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

The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service. People were not protected from the risks of unsafe or inappropriate care and treatment.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 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

In a previous review, we found that action was needed for the following essential standards:

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

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
When we visited Holbeche House in May 2012, we raised concerns about people and their relatives not being involved in making decisions about their care and treatment. We had found that people's views were not always taken seriously. We saw that people's dignity was not always respected and that people did not receive adequate support around the home. We had found that visual aids were limited to support people with dementia as they can often forget things.

On 28 June 2012, we visited Holbeche House to review improvements from the previous inspection.

We reviewed xx people's care records and found they had not been completed with people and their relatives. For example, two people in the dementia unit did not have any information in their care records about their choices and preferences. We were told that care plan reviews would be carried out by the home, which people and their relatives would be invited to attend. This meant that although there were limited opportunities, the provider had plans in place to involve people in their care planning.

We found that people were actively offered choices and their views were taken seriously. For example, we found that people were now offered a choice of whether they wanted to watch TV during lunch or not.

We saw that staff respected one person's dignity on one occasion in an appropriate and professional manner on the dementia unit. However, on the nursing unit we saw that before staff hoisted a person they discussed that the battery needed changing. However, the staff did not change the battery and continued to lift the person using the hoist. The staff had to replace the battery on the hoist on two occasions, which meant the person was left in mid-air whilst the battery was changed. This meant that staff were not consistently considering and respecting people's dignity.

We saw that there were improvements in the visual aids used in the dementia unit. We found that there was a use of dolls, which was accompanied with research about how this could help people with dementia. We found that new crockery was being used which was colourful and the peripheral manager told us that more items were being ordered to ensure that the dementia unit was more stimulating for people. We found that although food menus were not available in a visual format to enable people to associate food items with pictures, the home had plans to carry this out shortly.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a minor impact on people. The provider does not ensure that people's independence is promoted and their dignity maintained.

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
When we visited Holbeche House in May 2012, we had concerns about people's needs not always being assessed in a timely manner and that healthcare professionals were not contacted appropriately to attend to people's needs. We had also found that people's care records did not provide an overview of the care and treatment they might have received and that appropriate risk assessments were not carried out for all aspects of care.

On 28 June 2012, we visited Holbeche House to review improvements from the previous inspection.

We found that the home was in the process of transferring people's care information from current records, to a new set of records. We looked at three people's care records on the dementia unit and three people's care records on the nursing unit. We looked at three new care files and three files which had not yet been transferred over to the new format. We found that people whose care records we looked at had received timely assessments. This meant that staff could understand people's needs and deliver this in a consistent manner. We also found that people's care plans were being reviewed monthly since the previous inspection.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We saw that there were improvements in the way staff responded to people on both units. We observed how staff interacted with five people for over one hour. We found that staff had some positive interactions with two people, staff did not

interact with two other people during this time, and one person had to initiate contact with staff to ask for help. This meant that although some improvements had been made, staff should ensure that they consistently engage and interact with people. One person said, "Staff are fine."

We saw that people in the dementia unit were encouraged to play musical instruments. We saw that people enjoyed this activity and found it relaxing. This was an improvement since the previous inspection. However, we found that people on the nursing unit did not have any opportunities to take part in activities. This was raised with management during the previous inspection. This meant that the opportunities available for people were not consistent throughout the home.

We looked at the care records for one person who had a pressure sore. We were unable to tell what care was delivered, how it was delivered, and how often it was delivered. We found that records did not start from when the tissue viability nurse visited the home to assess the person's pressure sore. This meant that the home had not addressed these concerns to ensure all care related information was appropriately recorded. We found that the person was referred to see the tissue viability nurse in a timely manner.

We found that although there were pressure-relieving cushions available for people to sit on, some types of pressure relieving cushions need an electricity supply to keep them constantly inflated. The limited number of accessible plug sockets meant that people would not have a choice of where they sat in the lounge. The plug socket was only available near a door, which was permanently open. This meant that arrangements that were in place were not offering people a choice of where they wanted to sit if they wanted to use pressure relieving equipment as recommended by health professionals.

We found that people were offered choices during mealtimes, although the choice on the day of the inspection was limited to two different pork dishes. We were told that this was because two lots of pork had been ordered in error. People we spoke to were not happy with the food. One person said, "Dinner could be better, it does not look very appetising and tastes OK." We found that there was an improvement from the previous inspection where people were not offered choices. We spoke to the chef who told us that a new menu had been created with the involvement of people but this had not yet started to be used at the home. We saw that a new drinks machine had been placed in the lounge for people to try different flavoured drinks.

We found that a required referral to the podiatry service had not been made.. We had to raise this with the staff and management and a referral was then made for the person to receive appropriate care. In another instance, we found that it took the home over a month to arrange for a person to see an optician although the relative had expressed concern about the person's eyesight. This meant that the home did not ensure that people received expert advice about their healthcare needs in a timely manner.

We found that there were improvements since the last inspection for weighing people. Staff told us they had used alternative methods to assess people's weight who were bed bound. However, the action plan that was sent to us by the provider stated that all people would be weighed weekly for one month to monitor changes so that appropriate referrals could be made. We found that this had not taken place weekly.

We found that there were still risks associated to people's care and welfare that had not been identified, assessed, and managed. For example, staff told us that one person was bare foot as the person used to try to put their slippers in their mouth. We did not see any risk assessments in place to manage the risks of the person walking around the home bare foot. There was no information in the person's care plan to state the reason why the person should not wear anything on their feet.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. The provider did not ensure that people experienced care, treatment, and support that met their needs and protected their rights.

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 non-compliant with Outcome 07: Safeguarding people who use services from abuse. 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
When we visited Holbeche House in May 2012, we found that people who use the service were not protected from the risk of abuse and staff were not escalating safeguarding concerns appropriately.

On 28 June 2012, we visited Holbeche House to review improvements from the previous inspection.

We found that staff had not appropriately escalated incidents relating to safeguarding to managers or the local authority. This meant that safeguarding concerns continued to be unreported and unrecognised at the home.

We found continued discrepancies in people's monies. We were told that the home identified these discrepancies at the end of each month. We found that there was an over-reliance on the system to identify the discrepancies rather than having robust systems to minimise the discrepancies in the first place. We saw that following the previous inspection, the manager had started to check and sign money records weekly although this had not been completed recently. However, we were told that the manager only checked balances against paper records and did not look at receipts. We saw that another discrepancy had been identified by an internal audit that was carried out. However, this had not changed arrangements to ensure that the manager and provider were taking appropriate action.

We saw that there was an improvement in the training that staff had received on Deprivation of Liberty Safeguards (DoLS). We found that consent was being obtained

from people or their relatives for the use of bedrails. This would ensure that people understand the risks of using bedrails.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. People who use the service were not protected from the risk of abuse.

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
We were unable to see an updated training plan for staff on the day of the inspection. This was sent to us following the inspection. The planning of training reflected the needs of people living at the home. We found that most staff had not received training in key areas such as infection control, health and safety, pressure ulcer care, and nutrition. We had found that there were issues relating to pressure ulcer care and nutrition for people at the home, at our previous inspection. This meant that staff might not have the relevant knowledge and skills to ensure that they were meeting people's needs appropriately.

We found that most staff had not received regular supervision. Records showed that some staff who did have recent supervision did not have an opportunity to discuss performance, training and any other issues in detail. For example, we found that one senior staff told us that they were unaware of where to record information relating to people's care. This meant that staff were not always confident about working practice, and these were unaddressed.

We looked at two staff files and found that one staff last received an appraisal in 2008 and another staff had no record of appraisal. It was not clear how staff knew what was expected from their role and how they agreed training and development needs to improve their skills and knowledge.

We found that the majority of staff had also not had an induction following a change in the provider. Records showed that some staff, including the manager, had started this process. This would enable staff to familiarise themselves with expectations of working practice and work towards set objectives.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. Staff were not able to access regular training, supervision and appraisals.

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
When we visited Holbeche House in May 2012, we found that the arrangements in place to assess and monitor the safety and quality of care were not identifying the issues.. We were also concerned about the management of incidents and complaints within the home.

On 28 June 2012, we visited Holbeche House to review improvements from the previous inspection.

We saw that staff had access to a computer at all times to record any incidents and accidents at the home. However, we found that not all accidents and incidents had been recorded electronically. This meant that the information held could not provide an accurate overview of all the incidents relating to individual people. This is essential to appropriately manage people's care.

Records showed that staff had been informed about an item that was missing from a person's room. We found that there was no record of this in the complaints folder. Staff were unsure whether this was reported to the manager. This meant that complaints were not being managed efficiently within the home.

We saw records detailing discussions and meetings that had taken place following the previous inspection. We found that these meetings were held to share the inspection findings with staff. This meant that staff were involved in the processes to ensure they understood the importance of their role. Staff we spoke to told us they had seen the action plan that had been put together to address the concerns identified at the

previous inspection.

We found that a number of the issues raised from our previous visit had not been addressed. Although some improvements had been made, we identified continued failures in the home that the registered manager or registered provider had not addressed. .This included areas where the provider had advised that appropriate action had been taken and completed. For example, risk associated to people's care was still not consistently being identified and managed.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service. The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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
When we visited Holbeche House in May 2012, we found that records were not accurate, fit for purpose, and complete. On 28 June 2012, we visited Holbeche House to review improvements from the previous inspection.

We found that some people's care records had been transferred to a new format, which was more detailed and structured. The home was in the process of completing this for all people.

We found that although care plans and risk assessments were updated, these were not always completed accurately. For example, one person had a nutritional assessment, which had not been completed fully. This would have established whether the person was at risk of malnutrition or not. We found that the person's care records stated that the person was on a fortified diet, which should only be provided if the person was at high risk. However, when we spoke to staff, we were informed that the person was on a normal diet. This meant that records were contradictory and did not accurately reflect the people's care needs.

We found that information about individuals' preferences and needs was not being completed. The reasons stated for not completing the paperwork for two people were the same, which we found was not an accurate reflection of the two people. For example, for two people it stated that staff could not complete the paperwork as people could not communicate. However, other records for the same people stated that they communicated well with staff. We found that paperwork was incomplete even in instances where relatives could have been involved in completing this to understand

people's needs better.

We found that everyone at the home was on a food and fluid chart, without an assessment to see whether this was needed or not. Records for people's food and fluid intake was not completed everyday and was not accurate. For example, one person's records were missing for many days and some records that were completed stated that the person only had one drink during the day with no food. This meant that staff were not accurately completing the records as they should to reflect the care and treatment that was provided for people.

At the previous inspection, we identified that one person had not had an assessment of their needs at the home and that their care records were blank. We looked at this person's records during this inspection. We found that there were retrospective entries in the person's care records, which were dated even before our inspection in May. This meant that records had been completed with an inaccurate date.

Other evidence
There was no other evidence.

Our judgement
The provider was not meeting this regulation. We judged that this had a moderate impact on people using the service. People were not protected from the risks of unsafe or inappropriate care and treatment.

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: The provider does not ensure that people's independence is promoted and their dignity maintained.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider does not ensure that people's independence is promoted and their dignity maintained.	
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: The provider did not ensure that people experienced care, treatment, and support that met their needs and protected their rights.	
Diagnostic and screening procedures	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:	

	The provider did not ensure that people experienced care, treatment, and support that met their needs and protected their rights.	
Treatment of disease, disorder or injury	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: The provider did not ensure that people experienced care, treatment, and support that met their needs and protected their rights.	
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 who use the service were not protected from the risk of abuse.	
Diagnostic and screening procedures	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 who use the service were not protected from the risk of abuse.	
Treatment of disease, disorder or injury	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 who use the service were not protected from the risk of abuse.	
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:	

	Staff were not able to access regular training, supervision and appraisals.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met: Staff were not able to access regular training, supervision and appraisals.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met: Staff were not able to access regular training, supervision and appraisals.	
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.	
Diagnostic and screening procedures	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.	
Treatment of disease, disorder or injury	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.	
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.	
Diagnostic and screening procedures	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.	
Treatment of disease, disorder or injury	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 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 28 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
Author	Care Quality Commission
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