# Review of compliance

## Bupa Care Homes (CFHCare) Limited
### Oak Lodge Nursing Home

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<th>Region:</th>
<th>South East</th>
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| **Location address:** | 45 Freemantle Common Road  
Southampton  
Hampshire  
SO19 7NG |
| **Type of service:** | Care home service with nursing |
| **Date of Publication:** | March 2012 |
| **Overview of the service:** | Oak Lodge Nursing Home is registered with the Care Quality Commission to provide care and support to a maximum of 71 service users. The service is registered to provide the regulated activity of accommodation for persons who require nursing or personal care; treatment of disease, disorder or injury and diagnostic or screening procedures. |
Our current overall judgement

Oak Lodge Nursing Home was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review to check whether Oak Lodge Nursing Home had made improvements in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 22 February 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 spoke to some people, their relatives and the staff. Most people were not able to tell us about their care and support due to their mental frailty. People told us that they were treated with respect and that the staff were very kind and friendly. People were offered choices and there was no restriction to the time when they got up or went to bed. Relatives commented that the staff were available although they were ‘very busy’.

They said that they could approach the staff and the manager with any concerns and were confident these would be addressed. One person said that the staff always wave to them when passing their rooms and she liked that.

People told us that the food was ‘very good.’ They said the home was ‘always very nice and clean’ and well maintained. Relatives told us that they visited several times a week and found that people ‘always looked well dressed and clean.’

Relatives told us that there were a lot of staff changes and this was not good for people.
with dementia. They felt that people needed familiar faces in order 'to build trust.' We were
told that there was an issue with personal belongings such as spectacles going missing
and not available for 'four to five days' at times.

Visiting professionals said they attended the home regularly and the staff sought help and
advice for the residents as appropriate. They said that staff did not always follow through
when they identified any problems that may affect the care of people.

**What we found about the standards we reviewed and how well Oak Lodge Nursing 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**

People are involved in decisions about the care and support they received through care
planning, individual support and choices.

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

There are systems to assess people's needs and individualised care plans are in place to
demonstrate how these needs will be met.

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

People are provided with wholesome and nutritious diets to meet their needs. Dietary
assessments are not consistently followed and completed to inform plans of care to ensure
that needs are met.

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

People who use the service are protected from abuse, or the risk of abuse, and people's
rights are respected.

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

There are systems in place for the safe use and management of medicines. Though, these
are not consistently being applied to ensure people receive their medicines as prescribed.

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

The service has systems in place to ensure staff receive the necessary training to care for
people. There is a lack of supervision and appraisal to monitor and develop staff.

**Outcome 16: The service should have quality checking systems to manage risks
and assure the health, welfare and safety of people who receive care**
There are systems in place to monitor the quality of the service provided.

**Actions we have asked the service to take**

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

**Other information**

In a previous review, we found that improvements were needed for the following essential standards:

- Outcome 12: People should be cared for by staff who are properly qualified and able to do their job
- Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

In a previous review, we suggested that some improvements were made for the following essential standards:

- Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
- Outcome 06: People should get safe and coordinated care when they move between different services
- Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
- Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Please see previous reports for more information about previous reviews.
What we found for each essential standard of quality and safety we reviewed
The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*
Outcome 01:
Respecting and involving people who use services

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
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 told us that they were treated with respect and their privacy and dignity was respected. They confirmed that staff respected their wishes when providing care. People commented that their relatives were consulted about care and support that they needed. People told us that the staff were good. One person told us that they had recently attended a meeting and discussed the care of their relatives.

People said that they were treated with respect and that the staff were very kind and helpful. They said that they liked their bedrooms and the staff kept their room very clean.

Other evidence
We looked at six care plans which contained information about the individual's needs and wishes of the residents. Evidence from the daily record sheets showed that these were adhered to.

Care records showed that people had been consulted about their care. The staff said that family members were involved for those people who were less able to take part. A relative confirmed to us that they were aware of their relative's care plans and the staff had discussed this with them. The manager told us that the current records did not have a space for people to sign their care plans. This was being looked into in order to
evidence people had been consulted and agreed with their plan of care.

People were encouraged to make decisions about the care that they received. We saw that life histories and information about people's likes and dislikes were included in care plans. We observed the staff offering choices to people and respecting their responses.

One person's care plan showed that they could be verbally aggressive and refused care. Their care plans contained information for staff to gain their consent prior to any intervention. We observed this person had refused care that morning and staff were dealing with them in a sensitive manner.

People's bedrooms were highly personalised. They said that they had been able to bring in items of personal belongings. We observed the staff knocking and waiting for a response prior to entering people's bedrooms.

At the time of our visit we observed a visiting professional providing personal care to people in the communal lounge. This did not respect the privacy and dignity of people. A senior staff told us that this had been a common practice and it was evident that no action had been previously taken.

Our judgement
People are involved in decisions about the care and support they received through care planning, individual support and choices.
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 compliant with Outcome 04: Care and welfare of people who use services

Our findings
What people who use the service experienced and told us
We were unable to speak to the majority of the residents due to their cognitive problems and mental frailty. Some people said that they were happy living at the home and they received help and support from the staff as needed. The relatives told us that the staff were kind and helpful. They felt that people were 'looked after well'. Relatives were complimentary about the care and the staff.

Relatives also commented that there was a problem with personal belongings going missing and not available to them such as glasses. They felt that the attention to details was often overlooked as staff did not understand the importance of people having their hearing aids and glasses.

Other evidence
We looked at six sets of care plans, assessments and found that they provided information about people's wishes and the way they wanted to be supported. This included a 'map of life' with information about their previous jobs, type of music they liked and things that they disliked.

Care plans and assessments contained information to inform staff practices. These included personal care, moving and handling, continence management, pressure risk and equipment, falls and bed rails.

There was some evidence that regular reviews were undertaken to ensure that the plans of care remained current and up to date. Where people were not able to
participate, their relatives were involved. We observed that five care plans had been updated on a monthly basis as per the home's procedure. One care plan had not been updated and the senior nurse agreed that this had lapsed and action would be taken to address this.

Risk assessments had been developed and actions had been taken to reduce risks such as falls without impairing people's quality of life. We found that falls' assessments had been completed and the care records described the measures that staff needed to take. These included regular monitoring of the person's movements.

We observed that in three bedrooms people who were at risk of falls had an extra mattress put next to their beds at night. Staff told us that this was one of their measures of reducing injury to the residents.

The records for three people showed that they had been identified as high risk following an assessment for their pressure risk. Equipment such as pressure relieving mattresses and cushions were in use. Staff described how the correct mattress setting was assessed for each person. We randomly checked two of these and found they were as per their assessments. There was a procedure in place for the daily checks on pressure mattresses to ensure that they were in working order and set correctly.

A person's record showed that they had a pressure ulcer. A wound care plan had been developed and contained details of wound management and the type of dressings to be used.

The record for an insulin dependant diabetic showed that the staff were monitoring their blood sugar levels on a daily basis and records were kept. There was a clear procedure for the staff to follow if that person's blood sugar fell below the normal range. We found in two separate days their blood sugar levels had fallen below their accepted level. There was no evidence or record to indicate that staff had followed their procedure such as giving them a milky drink and re checking their blood sugar levels prior to administering their insulin.

We were told that although staff identified risks and concerns as part of their assessments; these were not always followed through. Any action taken could not be clearly evidenced as this was not recorded.

Moving and handling assessments had been completed and care plans developed to demonstrate how those needs would be met. Details of safe moving and handling included the type of hoist and slings to be used. We observed two people being moved from the wheelchairs to an easy chair in the lounge. This indicated that the staff were aware of people's needs and were following their care plans when assisting them to mobilise.

There were adaptations such as assisted baths, showers and hoists that were available to maintain and support people's needs. A passenger lift provided access to all the floors.

People were supported to access external healthcare professionals as required. The staff reported that the GP from the local practice visited the home twice weekly and held 'in house surgery.' They said that this worked very well and they can also access
the GP at other times as needed. The home had introduced six monthly advanced care planning meetings for the residents. This was a multi disciplinary meeting and involved the residents and their relatives in the decision making process.

The home had activities' coordinators and we found that weekly activities were planned and this information was displayed in the entrance hall. A variety of activities took place either in small groups or one to one. Recent events included exotic animals' visit, craft workshop and poetry reading.

**Our judgement**
There are systems to assess people's needs and individualised care plans are in place to demonstrate how these needs will be met.
Outcome 05: Meeting nutritional needs

What the outcome says
This is what people who use services should expect.

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

What we found

Our judgement
There are minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People said that they liked the food and 'food was very nice.' Relatives told us that they often came and assisted their relatives with their lunch. They said that food was varied and their relative was not a 'fussy eater' and food was very good. They said that choices were available and the staff were very good 'if you ask for anything.'

Other evidence
People were assessed for their nutritional risk and care plans developed to manage this. People’s weights were monitored monthly and records of these were kept in their care plans. The care plans contained detailed information about people's dietary likes and dislikes.

Staff told us that people were unable to make choices in advance due to their mental frailty. They would offer them a choice by showing them plated meals and allowing them to choose in that way. We observed the lunchtime meal and found this did not occur. Staff had a list that indicated whether people required pureed diets and meals were served according to that list. At the previous visits we noted that the chef served the lunchtime meals and staff told us that this did not happen any longer. We heard staff ordering a salad for one resident, staff said that they had not eaten the cooked meal provided.

We found that food was well presented and there were two choices for the main course at lunch. People were assisted with their food and fluids in a sensitive manner. The residents were provided with adapted equipment to support their independence at mealtimes.
We found inconsistency in the recording of food and fluid intakes, with records for a whole day that had one to two entries. One record showed that their last meal was at 12:30 pm and between 12:00 and 20:00 hrs they had taken only 150 mls of fluid. Another person’s record indicated that their last drink was at 12:20 and no other fluid was recorded until the following day. Staff confirmed that these people were on fluid and food record charts as they needed monitoring to ensure that they received an adequate diet. It was not clear how staff ensured that people’s dietary needs were met.

There were a number of people who were on pureed diets and thickened fluids as they were at risk of choking and aspiration. The record for one person showed that they had been assessed by the speech and language therapist. A detailed care plan was in place in relation to food, fluids and the positioning when supported with their meals.

We found inconsistency in the way that thickened fluids was managed. The records showed that care plans and records on food and fluid charts gave conflicting information. For two people the assessments and cares plan showed they were assessed as needing one type of thickened fluid. The food and fluid charts and staff confirmed that they were receiving different consistency of thickened fluids. This may put people at risk of not having their care needs met in a safe manner.

There was no evidence that new assessments had been carried or how the decision to alter the thickening agent used in fluids had been reached. Staff told us that sometimes the nurses did not inform them of changes and this was due to a lack of communication.

**Our judgement**
People are provided with wholesome and nutritious diets to meet their needs. Dietary assessments are not consistently followed and completed to inform plans of care to ensure that needs are met.
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

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<tr>
<td>The provider is compliant with Outcome 07: Safeguarding people who use services from abuse</td>
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<th>Our findings</th>
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What people who use the service experienced and told us
We did not speak to people using the service about this. Relatives told us that they felt people were safe and staff treated them with respect.

Other evidence
The home had in place a safeguarding policy and procedure which included the local authority safeguarding procedures. The manager described the procedure that they would follow and alert the safeguarding team as needed. The manager had informed us and the safeguarding team when a recent concern was raised with them.

There was a whistle blowing procedure in place and staff spoken with were aware of this. Staff told us of the internal process and said they would be confident to refer any safeguarding concerns to the local authority.

Staff we spoke with were able to describe the types of abuse that could occur and the action they would take if abuse was suspected. They were confident that they could approach the manager or the provider and actions would be taken to protect people. They told us that they had recently completed training in safeguarding adults. This training also formed part of the induction process for all staff and a new staff member confirmed this.

Our judgement
People who use the service are protected from abuse, or the risk of abuse, and people's rights are respected
Outcome 09: Management of medicines

What the outcome says
This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement
There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
People using the service were not able to tell us about this due to their mental frailty. A relative told us that the staff administered the resident's medicines and they were happy with this arrangement.

Other evidence
We looked at the process that the home had in place for managing the residents' medicines. The staff confirmed that none of the residents were administering their own medication at the time of our visit.

Medicines were all stored safely and there were procedures in place for receipt and disposal of medicines. We saw that the staff maintained records of medicines that had been discarded and those received. The home was using a monitored dosage system that operated over a 28 days period. The policy at the home was that registered nurses were responsible for the management of people's medicines. Medication training and competency assessments in medicines' management had been undertaken by staff.

Since the last visit a protocol for the administration of 'as required' medicines had been developed. Care records contained individualised care plans for the use of 'as required' medicines. We found that these care plans were detailed and informative. Staff said that this ensured that people received their medicines in a consistent manner.

We found that the medications administration records (MAR) were completed and there
were no gaps. A random sample of the remaining stock medicines showed that there were some missing tablets that the staff could not account for.

At the time of our visit we found two medicines that had not been administered and were recorded as 'out of stock'. One person had not received a newly prescribed medicine for seven days. There was no documented evidence of what action had been taken by staff to obtain this medicine. Staff told us that the normal procedure was for the prescription to be sent to the pharmacy from the surgery. Staff had not followed up when the medicines had not been received and continued to record them as out of stock.

There was a daily medicine audit in place. A senior staff told us that they looked at one record on each of the two floors. The audit had not been robust enough to identify when medicines had been out of stock for a number of days or when tablets had been missing.

**Our judgement**

There are systems in place for the safe use and management of medicines. Though, these are not consistently being applied to ensure people receive their medicines as prescribed.
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 minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People living at the home were unable to tell us about staff training.

Other evidence
The service had a learning and development plan in place. The staff told us that they had completed an induction programme and that training was good.

Records showed that the staff had also achieved national vocational qualifications at levels two and three in care. We saw training records that were up to date and staff said that these were updated regularly and monitored.

Five staff told us that they did not receive regular supervision or appraisal. Some of them told us that they had only one face to face meeting in the last year. The manager said that they were aware that this had lapsed. We were told that a supervision and appraisal training was planned for 29 February 2012 for managers and senior staff.

Our judgement
The service has systems in place to ensure staff receive the necessary training to care for people. There is a lack of supervision and appraisal to monitor and develop staff.
Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says
This is what people who use services should expect.

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

What we found

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<th>Our judgement</th>
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<tr>
<td>The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision</td>
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<th>Our findings</th>
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<tr>
<td><strong>What people who use the service experienced and told us</strong></td>
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<tr>
<td>People told us that they were happy to talk to the manager if they had any concerns about their relatives' care. People said they were satisfied with the care their relatives were receiving. We were told that they would be happy to 'speak up' if they had any concerns. They were confident that management would listen to them.</td>
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<th>Other evidence</th>
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<td>The home had an internal auditing system in place. This included regular assessments from the provider that looked at the overall management of the service. The service had a weekly quality audit from their internal quality consultant. These had identified shortfalls in food, fluid and bowel records.</td>
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<tr>
<th>Other evidence</th>
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<tr>
<td>There was a system for reporting and recording any accidents or incidents and action plans were developed to manage these.</td>
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<th>Other evidence</th>
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<td>There was an annual customer satisfaction survey that was also sent to healthcare professionals. We saw that a customer satisfaction survey was completed in October 2011. This indicated that people were positive about the care that was provided.</td>
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<th>Other evidence</th>
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<td>There was a monthly relatives and residents' meeting to seek people's views and involvements in the service. The manager said that any issues that were raised from these would be responded to and addressed.</td>
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<tr>
<td>There was a complaint log of any concerns raised and action taken and responses. The</td>
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manager told us that this was looked at in order to monitor any trends and developed action plans as needed.

**Our judgement**
There are systems in place to monitor the quality of the service provided.
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.

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<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 05: Meeting nutritional needs</td>
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<tr>
<td></td>
<td><em>Why we have concerns:</em></td>
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<td></td>
<td>People are provided with wholesome and nutritious diets to meet their needs. Dietary assessments are not consistently followed and completed to inform plans of care to ensure that needs are met.</td>
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<tr>
<td>Accommodation for persons who require nursing or personal care</td>
<td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 14: Supporting staff</td>
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<td><em>Why we have concerns:</em></td>
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<td></td>
<td>The service has systems in place to ensure staff receive the necessary training to care for people. There is a lack of supervision and support to monitor and develop staff.</td>
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The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider’s report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.
Compliance actions

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

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<tr>
<th>Regulated activity</th>
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<tbody>
<tr>
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<td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td>
<td>Outcome 09: Management of medicines</td>
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**How the regulation is not being met:**
There are systems in place for the safe use and management of medicines. Though, these are not consistently being applied to ensure people receive their medicines as prescribed.

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

CQC should be informed in writing when these compliance actions are complete.
What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

**Improvement actions:** These are actions a provider should take so that they maintain continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

**Compliance actions:** These are actions a provider must take so that they achieve compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

**Enforcement action:** These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.
## Information for the reader

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<td>Author</td>
<td>Care Quality Commission</td>
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## Care Quality Commission

<table>
<thead>
<tr>
<th>Website</th>
<th><a href="http://www.cqc.org.uk">www.cqc.org.uk</a></th>
</tr>
</thead>
<tbody>
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<td><a href="mailto:enquiries@cqc.org.uk">enquiries@cqc.org.uk</a></td>
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</tbody>
</table>
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