Review of compliance

Health & Care Services (NW) Limited Orchid Lawns	
Region:	East
Location address:	Steppingley Hospital Grounds Ampthill Road Steppingley Bedfordshire MK45 1AB
Type of service:	Care home service with nursing
Date of Publication:	February 2012
Overview of the service:	Orchid Lawns is registered with the Care Quality Commission as a Care Home with Nursing (CHN). It is registered to provide the Regulated Activities, Accommodation for persons who require nursing or personal care, Treatment of disease, disorder or injury, and Diagnostic and screening procedure. This home provides accommodation,

	care and support for up to 24 Older People.

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

Our current overall judgement

Orchid Lawns was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 Orchid Lawns had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 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 23 January 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

When we visited Orchid Lawns on 23 January 2012 we noted that everyone living at the home, had conditions which affected their cognitive functioning. This meant that their ability to communicate with, and understand us was very limited. However we observed that people looked content and comfortable, and where they required attention and support this was recognised and addressed swiftly by staff.
We observed periods of engagement and conversation between the staff and people who lived in the home, and noted that at meal times and when physical care was being delivered, communication was positive. Although we did not observe that anyone was left for long periods without some type of interaction with staff, we concluded that some people would benefit from more focused / meaningful activities which could improve their well being and quality of life.
People were appropriately dressed and looked clean and well cared for, and where people needed support or assistance with personal care this was done in the privacy of their bedroom or the bathroom to protect their dignity.

What we found about the standards we reviewed and how well Orchid

Lawns was meeting them

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

The provider is not compliant with this outcome. Improvements are needed.
People are at risk of not receiving the care they require, because care plans and associated documentation is not being completed accurately or reviewed to reflect people's needs as they change. Meaningful activities and social stimulation for some people in this home remains limited, which could potentially have a negative impact on their well being.

In view of the major concerns identified in this outcome area the Care Quality Commission issued a warning notice on the registered provider on 06 February 2012.

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

The Provider is compliant with this outcome.

People who live at Orchid Lawns are protected from abuse, because the staff have the appropriate knowledge and understanding of the safeguarding policy and protocols, and know how to raise alerts swiftly.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The Provider is compliant with this outcome, but to maintain this we have suggested some improvements are made.

The provider has taken action to improve the environment for the people who live there at Orchid Lawns, however further improvements are needed to ensure that the safety of the environment is monitored and maintained. CQC will continue to monitor these improvements until the ongoing redecoration and refurbishment programme is completed.

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

The Provider is compliant with this outcome, but to maintain this we have suggested some improvements are made.

There are sufficient staff on duty to safely meet the health and welfare needs of people in this home. The staff interact with people in a positive way that reflects their understanding of the needs of people with dementia. However further training for all staff with regards to more focused engagement / activities would potentially benefit people in this home.

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 is not compliant with this outcome. Improvements are needed

The internal quality assurance systems and monitoring process are ineffective and do not accurately reflect the situation within the home. They do not consistently drive the improvements that are required and secure compliance with essential standards of quality or safety.

In view of the major concerns identified in this outcome area the Care Quality Commission issued a warning notice on the registered provider on 06 February 2012.

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.

We have taken enforcement action against Health & Care Services (NW) Limited.

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.

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

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

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

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

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
During our last review of Orchid Lawns care home in October 2011, we identified moderate concerns with regards to the way in which care and support was being provided to people using the service.
We conducted a further review on 23 January 2012 to check what improvements had been made. People who lived this home had a range of conditions that affected their cognitive functioning. This meant that their ability to communicate with, and understand us was very limited. However we observed that staff were caring in their approach to people, and when they engaged with people verbally, this was done slowly and clearly to help people understand them more easily.

Other evidence
At our review in October 2011 we identified concerns in relation to inconsistencies identified in people's care documentation, lack of reviews and the lack of meaningful activities for people in this home. We made a compliance action advising the provider that swift improvements were required.
During this visit on the 23 January 2012, we looked in detail at the care documentation relating to three people who lived in this home. Following our last review the provider submitted an action plan telling us that the care files would be in order by the end of December 2011. Although each file that we looked at contained care plan documentation and related risk assessments, these had not all been reviewed to reflect people's needs as they changed, and in some cases documents were only partially completed.
This was specific to the Malnutrition Universal Screening Tool (MUST) in all of the files

that we looked at. In each case, the persons' weight and height had been entered on the form, however the process to fully complete this screening tool and subsequently identify their nutritional needs had not been carried out. This meant that it was unclear whether or not people were underweight, and there was no clear guidance for staff to follow.

We looked at the target weight chart for January 2012. This identified that eight people had lost weight over the last month, and we were told that, in line with the home's policy, these individuals had been commenced on daily fluid and food intake charts. We were unable to locate the fluid monitoring charts for all of these people. We found one person's chart had been completed in duplicate for the same period of time, however these copies did not correspond with each other. We looked at four people's food intake charts, and despite highlighting at our last review that information such as 'pudding', 'tea' or 'cereal' was insufficient to enable an accurate monitoring of nutritional intake, this practice had continued.

One person's care plan identified that they should have 2000mls of fluid each day, and they had been referred to the doctor regarding their hydration. Fluid charts had been commenced to monitor this individual's intake, however we found that these had been discontinued. Staff stated that this was because they had put on weight. We found that the related care plan had not been reviewed since November 2011, therefore we could not identify if this persons' current care was appropriate.

We noted that another file contained coloured 'post-it' notes, which appeared to have been written in December when the file was audited by the area manager. These notes identified tasks and documentation that needed to be completed. This had not been done.

The nurse in charge advised us that there were two people in the home who were on 24 hour bed rest every other day and that this was to promote pressure relief. We were advised that the tissue viability nurse had been involved in the decision for this care regime, however we could not find any evidence to support this, or to record the rationale for this approach. We noted that although these people had both had pressure wounds in 2011, one had been recorded as healed in October 2011 and the other as healed in November 2011. The staff were unable to show us a care plan detailing that this was the appropriate care regime for these people and the care plans did not reflect that their needs had changed. However the prolonged periods of bed rest had continued and this had subsequently impacted on their level of social interaction with other people in the home, and had increased risk factors for these individuals.

During this visit on the 23 January 2012 we observed that although interactions between the staff and people using the service were positive, the level of meaningful activities remained limited. The activity programme identified poetry reading in the morning and colouring in the afternoon on the day of our visit. We were present in the home between 11am and 4pm and did not observe either of these sessions taking place.

We looked at one person's file to identify the range of activities they had been involved in throughout January 2012. We noted that their personal profile identified that they enjoyed going out and joining in group activities, however their activity record did not show that these choices had been regularly considered. For example, between 01 and 19 January they had only participated in seven activities, which included a hairdresser appointment and a church service. There was no record to indicate that this person had either been unable to, or refused to participate in any activities for any reason.

The provider has clear legal responsibilities to ensure that, there is appropriate planning and delivery of care and treatment for people, to meet their needs and ensure their welfare and safety. These responsibilities were not being met.

Our judgement
The provider is not compliant with this outcome. Improvements are needed.
People are at risk of not receiving the care they require, because care plans and associated documentation is not being completed accurately or reviewed to reflect people's needs as they change. Meaningful activities and social stimulation for some people in this home remains limited, which could potentially have a negative impact on their well being.

In view of the major concerns identified in this outcome area the Care Quality Commission issued a warning notice on the registered provider on 06 February 2012.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
When we visited Orchid Lawns on the 23 January 2012 everyone who lived there had conditions that affected their cognitive functioning. This meant that their ability to communicate with, and understand us was very limited. However we observed that people looked content, comfortable and at ease in the company of the staff who cared for them.

Other evidence
At our review on 06 October 2011 we raised serious concerns in relation to safeguarding practice in the home, this was because there was an inconsistency in the level of understanding that the staff had with regard to this important aspect of care. We raised our concerns with the provider and asked them to take action to ensure that the required improvements were made.
When we visited Orchid Lawns on 23 January 2012, we spoke with six staff that were on duty about their understanding of safeguarding and their role in raising alerts.
All the staff that we spoke with were able to demonstrate a clear understanding of, and give us examples of incidents or concerns that should be raised with the safeguarding team. They were all aware that they could raise concerns directly with the local authority safeguarding team, if for any reason they were unable to make an alert through the homes' management. There were posters displayed around the home that advised staff of the numbers that they should call with concerns of this nature.
The two qualified staff that we spoke with were able to tell us exactly what action they would take if they were in charge when allegations of abuse were made. They were familiar with the documentation that they needed to complete and where to send it.

There was a file in the nursing office which contained the safeguarding policy and copies of the necessary forms which staff were required to complete. The staff that we interviewed knew who to contact if they required any advice regarding referrals.
Since our last review of this home in October 2011 there had been two safeguarding training sessions available, and we were told that the majority of staff had now attended. We requested a copy of the records of attendance for the safeguarding training, however at the time of writing this report we had not received this information and therefore could not confirm how many staff this training remained outstanding for.

Our judgement
The Provider is compliant with this outcome.

People who live at Orchid Lawns are protected from abuse, because the staff have the appropriate knowledge and understanding of the safeguarding policy and protocols, and know how to raise alerts swiftly.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

The provider is compliant with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
During our review in October 2011 we had serious concerns about the safety and cleanliness of the environment, and the lack of privacy it afforded to people in some areas.
We did not speak with people using this service about the environment, however we noted that it was clean and tidy when we conducted this review on the 23 January 2012.

Other evidence
During our visit to Orchid Lawns on 06 October 2011 we raised major concerns relating to the safety and suitability of these premises. This was because the home was in need of work in relation to fire safety, was poorly lit, had bathing facilities that did not promote people's privacy, and the provider was unable to evidence that maintenance and safety checks were being carried out regularly. We told the provider that urgent action was needed to make sure that the environment was safe and suitable for people in this home.
We conducted another review of this home the 23 January 2012 to check improvements. We found that the home was clean and free from offensive odours, and a programme of redecoration had commenced. The provider had advised us that the redecoration and refurbishment programme would be ongoing until August 2012.
We did not notice any areas of the home to be particularly dark and all the lighting appeared to be working.
We found that all the bathrooms were free from clutter and in regular use. Although the windows were frosted for privacy there were no blinds in place in two of these bathrooms. We discussed this matter directly with the area manager, who has since

confirmed that blinds had been fitted.
During our visit on 23 January 2011 we also found that other work, including the insulation of loft hatches to meet fire requirements had not been completed. As with the bathroom blinds, we addressed this matter with the area manager and subsequently received confirmation that the work had been completed.
The area manager advised us that the maintenance man had resigned from this service since our last visit, which had left some of the work in progress, but incomplete. We noted that the maintenance man from a local 'sister home' had now taken responsibility for the environmental health and safety checks at Orchid Lawns. There were records to confirm that a variety of weekly and monthly checks were being undertaken. This included fire safety checks, water temperature, emergency lighting and the nurse call system.
We looked at the maintenance records for the home, which clearly showed that portable appliance testing had been carried out.
CQC are concerned that prior to our follow up review that the provider had failed to identify that works which could impact on people safety had not been completed, or prioritised for attention through their internal audit processes.

Our judgement
The Provider is compliant with this outcome, but to maintain this we have suggested some improvements are made.

The provider has taken action to improve the environment for the people who live there at Orchid Lawns, however further improvements are needed to ensure that the safety of the environment is monitored and maintained. CQC will continue to monitor these improvements until the ongoing redecoration and refurbishment programme is completed.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Many of the people who live at Orchid Lawns are unable to communicate verbally, therefore we spent time observing how the staff interacted with people.
We noted that the staff interacted positively with people. They demonstrated patience and understanding in their approach to people and encouraged them to maintain independence where possible.

Other evidence
During our review in October 2011 we had concerns that the number of staff on duty was insufficient to ensure that meaningful activities were delivered effectively to people in this home. This meant that people lacked stimulation and were at risk of becoming socially isolated or withdrawn. We asked the provider to address this and they stated that they would increase the hours worked by the activity coordinator to full time. They also said that they would explore training and mentorship to enhance the delivery of activities to people with dementia.
We conducted this review on 23 January 2012 to assess what improvements had been made. We found that there was sufficient staff on duty. This included two qualified nurses, three care assistants, an interim manager, a new deputy manager and the activity coordinator. There were also kitchen and domestic staff on duty.
The activity coordinator hours had increased to full time since our last review and training had been sourced for them, however this had not yet taken place. We were told it had been arranged for March, although no specific date had been confirmed with staff at the time of this review.
We observed that staff interacted effectively with people in the home, and assisted

them in an unhurried way and encouraged independence where possible. We did not observe that anyone was left for long periods without some type of interaction with staff, however the needs of some people, who would benefit from more focused engagement / meaningful activities, were not always recognised and addressed effectively.

Our judgement
The Provider is compliant with this outcome, but to maintain this we have suggested some improvements are made.

There are sufficient staff on duty to safely meet the health and welfare needs of people in this home. The staff interact with people in a positive way that reflects their understanding of the needs of people with dementia. However further training for all staff with regards to more focused engagement / activities would potentially benefit people in this home.

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

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not speak with people who lived in Orchid Lawns about the monitoring of service provision; however we were told that people's relatives were encouraged to act as advocates and voice their opinions through regular meetings.
We noted a steady flow of relatives visiting the home throughout our visit on the 23 January 2012, and observed that communication between the staff and visitors was relaxed and positive.

Other evidence
In October 2011 we raised a number of concerns about the level of compliance with essential standards of quality and safety. We asked the provider to swiftly ensure that the required improvements were made. The provider submitted a detailed action plan on 16 November 2011 setting out how they intended to achieve this.
We conducted another review on 23 January 2011 and found there were a number of areas where the improvements had not been made and where non compliance with essential standards of quality and safety had not been achieved.
We found care documentation that was incomplete or out of date, and therefore was not reflecting the appropriate care for some people. The area manager gave us a copy of an updated action plan of compliance, which had been completed in the home on 18 January 2012. This had identified that care plans were out of date and risk assessments were not fully completed, however there was no indication of how this continued non compliance would be addressed. We also noted that although this action plan had detailed the general environment work that was needed, it had failed to identify that works related to fire safety in the home had not been completed.

This reflects a failure within the provider's internal quality assurances process to drive the required change and also highlights a number of inadequacies in the internal audit and monitoring processes.
The level of concerns that we have identified in some areas during this review was significant. Although the infrastructures in place had identified ongoing non compliance in key areas such as the care documentation, it had failed to identify that the fire safety issues had not been addressed.
This indicated that the leadership and managerial oversight of compliance with essential standards, and the services ability to ensure positive outcomes for people was ineffective.
The provider has clear legal responsibilities to monitor the quality of the service provided and to take action to address areas where standards are not being met. These responsibilities were not being met.

Our judgement
The provider is not compliant with this outcome. Improvements are needed
The internal quality assurance systems and monitoring process are ineffective and do not accurately reflect the situation within the home. They do not consistently drive the improvements that are required and secure compliance with essential standards of quality or safety.

In view of the major concerns identified in this outcome area the Care Quality Commission issued a warning notice on the registered provider on 06 February 2012.

Action
we have asked the provider to take

Improvement actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: The provider has taken action to improve the environment for the people who live there at Orchid Lawns, however further improvements are needed to ensure that the safety of the environment is monitored and maintained. CQC will continue to monitor these improvements until the ongoing redecoration and refurbishment programme is completed.	
Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: The provider has taken action to improve the environment for the people who live there at Orchid Lawns, however further improvements are needed to ensure that the safety of the environment is monitored and maintained. CQC will continue to monitor these improvements until the ongoing redecoration and refurbishment programme is completed.	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: The provider has taken action to improve the environment for the people who live there at Orchid Lawns, however further improvements are needed to	

	ensure that the safety of the environment is monitored and maintained. CQC will continue to monitor these improvements until the ongoing redecoration and refurbishment programme is completed.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: There are sufficient staff on duty to safely meet the health and welfare needs of people in this home. The staff interact with people in a positive way that reflects their understanding of the needs of people with dementia. However further training for all staff with regards to more focused engagement / activities would potentially benefit people in this home.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: There are sufficient staff on duty to safely meet the health and welfare needs of people in this home. The staff interact with people in a positive way that reflects their understanding of the needs of people with dementia. However further training for all staff with regards to more focused engagement / activities would potentially benefit people in this home.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: There are sufficient staff on duty to safely meet the health and welfare needs of people in this home. The staff interact with people in a positive way that reflects their understanding of the needs of people with dementia. However further training for all staff with regards to more focused engagement / activities would potentially benefit people in this home.	

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.

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**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 or section is not being met:	**Registered manager:**	**To be met by:**
	People are at risk of not receiving the care they require, because care plans and associated documentation is not being completed accurately or reviewed to reflect people's needs as they change. Meaningful activities and social stimulation for some people in this home remains limited, which could potentially have a negative impact on their well being.		12 March 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
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 or section is not being met:	**Registered manager:**	**To be met by:**

	People are at risk of not receiving the care they require, because care plans and associated documentation is not being completed accurately or reviewed to reflect people's needs as they change. Meaningful activities and social stimulation for some people in this home remains limited, which could potentially have a negative impact on their well being.		12 March 2012

Enforcement action taken

Warning notice

This action has been taken in relation to:

Regulated activity	**Regulation or section of the Act**	**Outcome**	
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 or section is not being met:	**Registered manager:**	**To be met by:**
	The internal quality assurance systems and monitoring process are ineffective and do not accurately reflect the situation within the home. They do not consistently drive the improvements that are required and secure compliance with essential standards of quality or safety.		12 March 2012
Regulated activity	**Regulation or section of the Act**	**Outcome**	
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 or section is not being met:	Registered manager:	To be met by:
	The internal quality assurance systems and monitoring process are ineffective and do not accurately reflect the situation within the home. They do not consistently drive the improvements that are required and secure compliance with essential standards of quality or safety.		12 March 2012

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

Document purpose	Review of compliance report
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