Review of compliance

TAS CareLimited Rose Cottage Nursing Home	
Region:	South West
Location address:	47 High Street Haydon Wick Swindon Wiltshire SN25 1HU
Type of service:	Care home service with nursing
Date of Publication:	October 2011
Overview of the service:	Rose Cottage Nursing Home provides care and accommodation to up to 18 older people. There are 16 single rooms and one shared room.

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

Our current overall judgement

Rose Cottage 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 21 September 2011, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People appreciated the care they received and said they were treated with respect. Some people were cared for in bed and they were less able to express their views. Staff were friendly and they spoke to people appropriately.

People had individual care plans which helped to ensure that staff were aware of each person's needs and the care they required. However, the plans lacked the detail which would help staff to support people in a person centred way.

People enjoyed the individual attention they received from the home's activities co-ordinator. However not everybody experienced the same level of engagement. Staff said that they would like to be able to spend more time with people who stayed in their bedrooms during the day.

Staff told us they were meeting people's needs, but said that changes in the staffing arrangements had affected the quality of service they were able to provide. At lunchtime, we saw that people would benefit from more individual support and attention.

People told us that they felt safe in the home. Arrangements were being made which helped to maintain people's health and well being. However, some areas such as the bathrooms were not being well checked, which meant that there was a risk to people's safety.

What we found about the standards we reviewed and how well Rose Cottage 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 treated with dignity and respect. There are given opportunities to make choices and to be involved in decision making. However there is limited information about people's individual circumstances. This makes it difficult to provide support in a person centred way which is consistent with people's best interests.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People appreciate the support that they receive from staff. Their health and care needs are being met. However, people's care is not always clearly documented in their records. This makes it difficult to assess whether a person has received the correct support in accordance with their care plan.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard.

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

People are protected from abuse and can be confident that staff know what to do if they have any concerns.

The home's recruitment procedure helps to ensure that people are protected from unsuitable staff. However the records do not always provide good evidence of the actions that have been taken. This is important so that there can be no misunderstandings about what information has been received, and how any concerns have been followed up.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard.

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

People's needs are being met although the way in which staff are deployed is affecting the quality of the support that people receive.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

People receive a service that is meeting their needs. Procedures are in place, which help to ensure that people are safe although there are aspects of the environment which are not being well monitored.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People who use the service cannot be confident that records are being well maintained. Regulation 20 is not being complied with, in that appropriate information is not being recorded to ensure that people's rights and interests are protected.

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

Actions we have asked the service to take

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

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

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

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

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

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

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

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

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

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

Outcome 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

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People's privacy, dignity and independence were being respected. One person told us that staff knocked on the door before entering their bedroom. The doors had been fitted with mechanisms which enabled them to be kept open during the day if people preferred this. The staff who came to see people in their rooms were friendly and spoke to people appropriately.

Several of the bedrooms we saw had been well personalised. One person, for example, had a lot of pictures and family photographs around their room. Other rooms looked plainer, but people had items with them which were important to them. All except two people had their own rooms where personal care could take place in private. There was a mobile screen which could be used to provide some privacy to the two people who shared a room.

People were offered a choice of two main courses at lunchtime. The cook had asked people before the meal what they would like. People had drinks taken to them during the morning. In one bedroom, the staff member explained to the person that they had brought them their favourite type of drink. The relationships we observed between staff and the people who used the service were informal, but respectful. Staff usually called people by their first names. However, we heard the term 'feeds' being used to describe

those people who needed support with eating. This sounded impersonal and did not reflect a person centred approach.

People received individual attention from a staff member who was in the role of activities co-ordinator. The staff member said that information was obtained about people's backgrounds and interests. Relatives helped to provide this information when a person moved into the home. This was important, as some people who used the service were not able to express their own views and make informed decisions.

People were engaged in different activities during our visit. A number of people watched television in the lounge or in their own rooms. Some people were asked if they would like to go out to a concert which had been arranged for the afternoon. We heard about other activities which took place in the home, such as flower arranging and crafts. Most activities were arranged in the lounge, but the activities co-ordinator told us that they tried to spend at least five minutes a day with those people who were in bed. Another staff member said that people using the lounge were well catered for, but they felt that more time could be spent with the more dependant people who were in bed.

People's relatives were actively involved in the home and encouraged to participate in activities. We met with relatives and also with someone who was visiting in a legal capacity concerning one person's financial affairs. They spoke positively about their experience of the home.

Other evidence
Mental capacity assessments had been undertaken to identify people who were not able to make informed decisions. However, it was not clear from people's records how their lack of capacity was being followed up. The manager said that relatives were involved whenever possible, but they recognised that the decision making process was not formally documented to show how people's best interests were being determined.

People's individual records included information about their care needs and the support that staff would provide. The plans did not reflect people's own views and there was limited information about people's abilities and their preferred routines. In one person's record, for example, the section about their night time routine and getting up time only included the comment 'very confused and disorientated'.

We spoke to the home's manager after our visit. They told us that the same format for care plans had been used for about ten years. They acknowledged that the format did not promote a person centred approach.

Information was displayed in the home concerning a survey that had taken place in 2009. This was to obtain people's views of the home. There were also minutes of a recent meeting, which had been attended by a number of people who used the service, and their relatives. These meetings were an opportunity for people to receive information and to pass on their views about the home.

Our judgement
People are treated with dignity and respect. There are given opportunities to make choices and to be involved in decision making. However there is limited information about people's individual circumstances. This makes it difficult to provide support in a person centred way which is consistent with people's best interests.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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
People appreciated the support that they received and felt that their care needs were being met. Their comments included 'I'm looked after well' and 'they treat us as best they can'. One person told us they were independent in some areas of personal care, but had help with the things they found difficult, such as having a bath. They said they used a hoist when having a bath and felt confident in the way that staff assisted them with this.

A number of people were being cared for in bed and some people were not able to express their own views. Care assistants said that the nurses kept them up to date with people's care needs and they were aware of the support that people required. This included, for example, providing pressure area care, in order to treat or prevent ulcers. Care assistants told us that the nurses did the dressings, and they helped people with changing position in bed to reduce the risk of skin damage. A nurse told us that the home had a good record of treating people's pressures ulcers. As an example of this, they talked about the care provided to a person who had moved in with a pressure ulcer which had healed up after being treated in the home.

We saw people being offered drinks regularly when in their bedrooms and in the communal areas. This was important as inadequate fluid intake is a risk factor in the development of pressure ulcers.

People received support with managing continence. There were no unpleasant odours in the bedrooms or in the communal areas. However some personal items, such as

used combs and toiletries, had been left out in the bathrooms which gave these areas an institutional feel. It also meant that there was a risk that items would be shared, and cross-infection could occur.

People looked well supported with their dress and personal appearance. The laundry person told us that they regularly ironed people's clothes. One person enjoyed a manicure from the home's activities co-ordinator during the afternoon of our visit. They described this as 'really, really lovely'.

Other evidence
We looked at examples of people's care records. They included assessment forms and individual plans, which had been completed as part of a system of care planning. People's personal care needs were being assessed. Other assessments had been undertaken to identify people who might be at risk, for example because of falls or due to poor nutrition. People's weight was being checked regularly, which helped to identify any changes which could be a cause for concern and would need to be followed up. Other records were kept, which showed that health care professionals such as GPs and specialist nurses were visiting people at the home.

People had a main care plan which was kept in the office. These highlighted people's needs in areas such as personal care, mobility, continence, and pressure area care. The plans included guidance for staff, for example about the frequency of 'turns' in connection with people's pressure area care. The plans were being reviewed every month, with a brief comment recorded in an evaluation section. The format of the plans meant that only limited information could be recorded and they did not reflect a person centred approach.

People had daily care plans which were kept in their rooms where they were readily accessible to staff. Monitoring charts were not being used; staff recorded the different tasks they carried out on a single report form. One outcome of this was that details, for example in relation to people's pressure area care (changes of position) and fluid intake, were not being recorded consistently. This raises questions about whether a person has received the support that they need, and the timing of this throughout the day.

The manager told us that people were registered as patients at a local GP practice. Other services, such as a pharmacy and specialist nurses, were also based at the practice. The manager said that people received a good service and benefited from a co-ordinated approach between health care professionals.

We spoke to the tissue viability nurse who had visited people at the home. They told us that staff followed their instructions well, and in their experience the home was meeting people's needs in relation to pressure area care.

Our judgement
People appreciate the support that they receive from staff. Their health and care needs are being met. However, people's care is not always clearly documented in their records. This makes it difficult to assess whether a person has received the correct support in accordance with their care plan.

Overall, we found that Rose Cottage Nursing Home was meeting this essential

standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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
People who used the service told us that they felt safe at the home. One person said they would 'speak their mind' if needed, and talk to one of the nurses if they had a concern. A care assistant also said they would raise any concerns with one of the nurses. Another told us that they would speak to the home's manager. We observed people speaking up when they were not happy about things or wanted something changed.

The staff we spoke to had received training so that they would recognise signs of abuse and know what to do if abuse was suspected. They did not raise any concerns with us at the time. Staff were familiar with the 'No Secrets' booklet. This provided guidance for staff about abuse and summarised the procedures that should be followed for reporting allegations. Copies of 'No Secrets' were available for people to look at in the home's front hall.

Bedrails were being used with a number of people. Staff told us that these were in place for the purpose of preventing people falling from their bed. We did not see evidence of any items being used in a way that could constitute restraint.

A relative told us that they thought there was an open and friendly atmosphere in the home.

Other evidence
We looked at the employment files for three staff members. There was evidence of a

range of checks, including Criminal Records Bureau (CRB) disclosures, being carried out as part of a robust recruitment process. These checks helped to ensure that applicants were suitable for the work and did not present a risk to vulnerable people.

One staff member's record showed that they had started working at the home several months after their recruitment process had begun. The manager explained the delay and told us they had assessed the need to carry out further checks on the applicant. As a result, some further information had been obtained. However, the recruitment record did not include this information, and the record had not been updated to reflect the change in the person's circumstances since they had completed their application form.

The manager told us about the system in place for safekeeping people's money and recording expenditure. This included obtaining receipts for any items bought, which were then numbered and cross-referenced to the records. The manager said that the records of transactions were signed by two people, to help ensure that they were an accurate account.

Our judgement
People are protected from abuse and can be confident that staff know what to do if they have any concerns.

The home's recruitment procedure helps to ensure that people are protected from unsuitable staff. However the records do not always provide good evidence of the actions that have been taken. This is important so that there can be no misunderstandings about what information has been received, and how any concerns have been followed up.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People received support from nurses, care assistants and a number of ancillary staff who carried out non-care tasks, such as cooking and cleaning. Some staff, such as the activities co-ordinator, also helped out with people's care on occasions. Staff said that they worked well as a team.

People who used the service spoke positively about their dealings with staff. They saw staff regularly during the day. People who spent time in their bedrooms had call points close to them which they could use to contact staff.

There was at least one nurse working throughout the day, alongside care assistants. The number of staff deployed during the day had remained at a consistent level over a number of years. However, staff said that people's dependency levels had generally increased over this time. We were told about recent changes involving the staffing arrangements, which staff said had affected the service that people received. These included restrictions on the use of agency staff, and on the deployment of care staff in addition to the usual minimum.

Staff said that they were able to meet people's care needs, but they now felt rushed and there was sometimes a delay in people receiving support. We were told for example that people might now get up later in the morning, as they needed to wait longer for support. Staff also said that they would like to have more time to spend talking to people who were in bed, and who were less able to occupy themselves.

We saw staff going about their work in a busy but friendly manner as they responded to people's needs and the demands made on their time. This was evident at lunchtime, when we observed the meal arrangements in the dining room. We focused on the support being given to three people who needed encouragement with eating, or practical assistance with their meals.

One of our main observations of the meal was that people did not receive continuity of support from staff. Staff tended to provide support to people 'in passing' while doing other things, and needing to be in different rooms. The outcome of this was that people were assisted by a number of staff, and they were left waiting until one of the staff saw that they needed support. People became distracted whilst waiting, and started to lose interest in their meals.

When staff assisted people with their meals, they did so in a sensitive and friendly manner. Staff talked to people and encouraged them to eat. One person found it difficult to settle at the dining table and staff tried different approaches to help them.

Other evidence
As reported under outcome 1, the home's activities co-ordinator spent varying amounts of time with people in the lounge and in their own rooms. Records were kept which showed how the activities co-ordinator had spent their time and the different activities that had taken place with each person. We read that people who stayed in their own rooms had enjoyed 'a good chat'. A lot of their activities related to care and support tasks, such as 'assisted with meals' and 'helped with a cup of tea'. This was in contrast to other people who received more support with social and therapeutic type activities.

Our judgement
People's needs are being met although the way in which staff are deployed is affecting the quality of the support that people receive.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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 minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People received a service that was generally safe and meeting their needs. A maintenance person dealt with day to day repairs and they were doing jobs in the home at the time of our visit. They told us that they checked the fire precaution systems, which included a weekly test of the alarm system.

The maintenance person said that they were qualified to undertake the safety testing of the electrical appliances. Other items, such as fire extinguishers and hoists, had been serviced by specialist companies. Although the hoists in the bathrooms had been serviced, they were not clean around the base. Other items in the bathrooms looked stained and the floor covering around a toilet had discoloured.

The staff we spoke to were aware of risks to people, such as electric leads in bedrooms, and the need to check for other items that could be a hazard. However, we saw that spray sanitisers had been left out in the bathrooms, which could present a risk to the people who used the service.

Some people's beds were fitted with bedrails. We checked the rails on one bed and there was some movement because the rails were not firmly secured. The maintenance person told us that they were aware of this problem and said the bedrails were checked regularly to ensure that they worked correctly. The use of bedrails and floor mattresses was referred to in people's care plans. However people's records did not include individual risk assessments for the use of these items. These assessments help to ensure that the items are safe for people to use and an appropriate means of

managing risks relating to people having falls.

People who used the service, and their relatives, were being given opportunities to pass on their views. Surveys have been used to get feedback from relatives and from people outside the home. Meetings were taking place when people could suggest improvements and changes they would like to see. At the most recent meeting, people had talked about the choice of meals and one person had said they would like to have jellied eels. This suggestion had been passed on the cook, who said that they were following it up.

Other evidence
Information available in the hall included copies of inspection reports and details of outside agencies who could be contacted for advice and support. The certificate of insurance cover was displayed appropriately.

The home had been awarded four stars when inspected by the local authority's food safety department in August 2011. Although four stars meant 'very good', the home had achieved five stars ('excellent') at the previous inspection.

The home changed ownership earlier in the year and a new provider was registered in June 2011. An initial business plan had been produced which included a programme of refurbishment. Some work had already taken place, including changes in the facilities for the manager and staff. A number of bedrooms were due to be redecorated and carpeted.

The provider's business plan also set out the action that would be taken in relation to quality assurance and obtaining feedback from people. This included the consolidation of residents meetings, with the involvement of relatives, and the development of new questionnaires for relatives and professionals. We were told that this would 'ensure a high standard of cleanliness for the whole environment and delivery of a high standard of care and attention to all residents'.

Our judgement
People receive a service that is meeting their needs. Procedures are in place, which help to ensure that people are safe although there are aspects of the environment which are not being well monitored.

Overall, we found that Rose Cottage Nursing Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
People's personal records plans did not reflect their own views and there was limited information about people's abilities and preferred routines. As reported under outcome 1, this information is important as it helps to ensure that staff support people in a consistent and person centred way.

Some people were assessed as lacking the capacity to make informed decisions. It was not clear from their records who was authorised to act on their behalf, and how decisions were being made which were in people's best interests.

Other evidence
People's care was not being systematically recorded. Daily report forms were used, however these did not provide a good record of the care that people received. In particular, the details of people's pressure area care and fluid intake were not being recorded consistently. This meant that the records could not be relied upon to show that people had been provided with the right support in accordance with their care plans.

As reported under outcome 7, there were shortcomings in the recording of the staff recruitment process. The records did not always provide good evidence of the actions taken to ensure that people who used the service were protected from unsuitable staff.

Our judgement
People who use the service cannot be confident that records are being well maintained. Regulation 20 is not being complied with, in that appropriate information is not being recorded to ensure that people's rights and interests are protected.

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

Action
we have asked the provider to take

Improvement actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People are treated with dignity and respect. There are given opportunities to make choices and to be involved in decision making. However there is limited information about people's individual circumstances. This makes it difficult to provide support in a person centred way which is consistent with people's best interests.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: People's needs are being met although the way in which staff are deployed is affecting the quality of the support that people receive.	
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
	Why we have concerns: People receive a service that is meeting their needs. Procedures are in place, which help to ensure that people are safe although there are aspects of the environment which are not being well monitored.	

The provider must send CQC a report about how they are going to maintain compliance

with these essential standards.

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

The provider's report should be sent within 14 days of this report being received.

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

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: People who use the service cannot be confident that records are being well maintained. Regulation 20 is not being complied with, in that appropriate information is not being recorded to ensure that people's rights and interests are protected.	

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

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

The provider's report should be sent to us within 14 days of this report being received.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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