Review of compliance

Sharnbrook Care Home Limited Sharnbrook Care Home Limited	
Region:	East
Location address:	17a Park Road North Houghton Regis Dunstable Bedfordshire LU5 5LD
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Sharnbrook Care Home Limited is registered to provide accommodation for persons who require nursing or personal care, to a maximum of 24 people. Currently no nursing care is provided.

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

Our current overall judgement

Sharnbrook Care Home Limited 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 7 February 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

During our inspection of Sharnbrook Care Home Limited on 07 February 2012 we spoke with some of the people living there, some of their relatives and some of the staff. People we spoke with were generally happy with the care they received at Sharnbrook Care Home Limited. People said they were given help when they needed it and we observed that care was given in a caring, kind and sensitive way. People told us they felt safe and they were very positive about the staff.

Our inspection identified that there were a number of issues about the service provided at this home, relating to assessments, care planning and risk assessments; safeguarding; staff training and support; and quality assurance. These are detailed in the report. The inspection also identified that improvements required following our previous inspection in March 2011 had not been sustained.

What we found about the standards we reviewed and how well Sharnbrook Care Home Limited was meeting them

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

The provider is not compliant with this outcome. Staff provided care in a dignified way. However, people were not sufficiently involved in making decisions about the care they received, or given adequate choices about how they lived their lives.

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. Care plans, risk assessments and daily records of care provided were not detailed enough and were not kept up to date, so that people's current needs were not clear. This meant that staff did not have clear guidance about how to meet each person's needs consistently, which put people at risk of not being given safe and effective care.

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

The provider is not compliant with this outcome. People were not given a sufficient choice of food and drinks to ensure their nutritional needs were met. Guidelines for staff were inadequate.

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

The provider is not compliant with this outcome. The provider did not have the appropriate policies, procedures and protocols in place to give staff sufficient guidance. Although staff had received training in this area, they were not all clear enough about their responsibilities regarding incidents of alleged abuse to ensure that people would be safeguarded from abuse and harm.

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

The provider is not compliant with this outcome. There was a sufficient number of staff on duty. However, records were not clear enough to confirm that all staff had received all the required training, training was not always being put into practice, and staff were not currently receiving supervision. The managerial arrangements were not adequate to ensure that people were receiving safe and effective care.

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. The systems in place were not robust enough to ensure that a quality service was provided to the people living at this home.

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

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
During our visit to Sharnbrook Care Home Limited on 07 February 2012 we spoke with a number of people living at this home, and some of their relatives. We also spoke with some relatives on the telephone following the inspection. Generally people were happy with the care they received. One relative told us, "Our relative is very happy at this home. They always have a smile when they go back [after a trip out]". We observed the care being given to people, and saw that staff were respectful in the way they spoke to people. A visiting health professional told us that staff treat people with respect and dignity, and people who are dying are "cared for beautifully".

People we spoke with told us that they were able to make choices about some aspects of their lives, such as when they went to bed and which lounge they sat in. However, people had limited opportunity for activities and community involvement. People we spoke with told us there was not much to do. One person said, "They could do more activities – I get bored". One relative we spoke with said that they had only seen one activity being offered in all the months they had been visiting the home. Another said they wished their relative could be given more to do.

Other evidence
We looked at care records held for four of the people living at Sharnbrook Care Home

Limited. There was little evidence that people or their relatives had been involved in the development of their plan of care. We saw consent forms on some of the files but these had not been signed.

Staff confirmed that people chose what time they got up in the morning. This was an improvement on our previous inspection when we had found that people were being woken and got up very early, which had not been their choice. Night staff said that in the evenings people went to bed when they wanted to. They said that some people liked to get ready for bed and sit in the lounge.

People were given little opportunity for activity or community involvement. Staff we spoke with told us that they tried to do some activities with people in the mornings and in the afternoons. They quoted a number of activities, such as dominoes, colouring, playing music, bingo and doing exercises. However, on the day we visited the home there were no organised activities taking place, and the daily records of the care provided to each individual gave no indication that any activities had taken place. One member of staff said they had been chatting with people on a one-to-one basis.

Our judgement
The provider is not compliant with this outcome. Staff provided care in a dignified way. However, people were not sufficiently involved in making decisions about the care they received, or given adequate choices about how they lived their lives.

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 minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People we spoke with said they were given help when they needed it. During our visit on 07 February 2012 we noted that staff offered personal care to people in a discreet and sensitive way.

Other evidence
Each person had a care plan on file but the quality of the information was inconsistent, as was the quality of assessments of people's needs, and of assessments of risk. We looked at care records for four people. Some of the records gave staff guidance on how to meet the person's needs for a particular aspect of their care, and some of the records had been reviewed monthly. However we found a number of issues which gave us cause for concern about the service's apparent lack of understanding of the whole assessment, care planning, risk assessment and review process.

For example, one person had been admitted to the home about eight weeks before our visit. There was a very brief assessment in the records. This was not dated or signed and gave very little information. Forms in the file entitled 'pre-admission' had not been completed at all, but there was an assessment from the hospital which gave staff some information. This meant that the home had not had sufficient information about this person before they were admitted, to be sure that Sharnbrook Care Home Limited could meet their individual needs.

This person's care records included care plans which gave staff guidelines regarding a number of aspects of the care the person needed. These were 'personal care'; eyes,

hearing, oral and foot care; communication and social care needs; medication assistance; and night care needs. However, care plans for some crucial aspects of care, such as pressure area care, were missing.

In this person's care records we found that risk assessments had been completed relating to four areas of risk. In the area relating to pressure area care, the records showed that this person had been assessed as 'at risk' of getting pressure sores. However, there was no risk management plan or care plan in place relating to pressure area care, so there were no guidelines for staff on how to manage and reduce the risk. There was a risk assessment in place, with detailed guidelines for staff, on how to 'transfer into car safely'. We asked staff why this was in place, as the person's moving and handling risk assessment had not identified any risks in this area, and had stated the person was 'independent'. Staff could not explain this.

Staff told us that an 'initial care plan' was put in place when each person was admitted to the home. A more detailed care plan was then written when the person had lived at the home for a few weeks and staff had got to know the person and their needs better. This 'initial care plan' was in place for one person who had been admitted in early December 2011, and the more detailed version started in early January 2012. For another person, admitted on 08 October 2011, the care plans were all dated 20 December 2011. There was no evidence in the records of any care plans being written prior to the December date. Staff searched the archived records and could not find any previous care plans. We asked for these records as the person had been admitted to hospital in November 2011 following a fall. They returned to the home seven days later, in mid-November. The care plans written in December referred briefly to keeping the person safe as they were 'prone to falling'. However, staff confirmed there was no risk assessment or care plan in place regarding falls, so no clear guidance for staff on how to manage and reduce the person's risk of falling.

Within another person's records we found a 'resident handling assessment' and a 'falls risk assessment'. These indicated the person needed some assistance with their mobility, and there was a risk of falling. There was no evidence of when these records were last reviewed. Discussion with staff and daily care records we read showed us that this person's care needs had changed considerably and the person was now cared for in bed. Staff confirmed that the risk assessments had not been updated to reflect the person's current care needs.

We found some records on some of the files we looked at which indicated that people had seen other healthcare professionals such as chiropodist, optician, dentist and doctor, so that their healthcare needs could be met. However, there was no clear audit trail to show how staff would know, for example, how often an individual would need to visit the optician, when the last visit had been and when the next visit was due. Staff explained that all the healthcare professionals kept their own records and would let the home know when they needed to see people.

The daily records of care provided were very brief and gave little information other than whether the person was up or in bed, whether there had been any continence issues and whether they'd eaten.

We spoke with a healthcare professional who works closely with this home. They told us they had no concerns about the care that was being offered. Staff contacted them

whenever they needed advice, and their advice was followed.

We acknowledge that most staff have worked at the home for a long time, know people well and know how to meet their needs. However, staff told us they read the care plans, risk assessments and daily notes to learn about any changes in people's care. The inconsistencies and anomalies in the recording and documentation put people at risk of not being given suitable care.

The failings we found were of even greater concern as we had identified similar issues at our previous inspection in March 2011.

Our judgement
The provider is not compliant with this outcome. Care plans, risk assessments and daily records of care provided were not detailed enough and were not kept up to date, so that people's current needs were not clear. This meant that staff did not have clear guidance about how to meet each person's needs consistently, which put people at risk of not being given safe and effective care.

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 we spoke with told us the food was good. One person said they would be offered an alternative meal if they did not like what was on the menu. However, another person said, "We don't really get a choice". This was demonstrated on the day we visited. We saw that people were offered choices about what they wanted to eat, but the choices were somewhat limited. For example, for breakfast the choice was porridge or cornflakes, which arrived at the table with the milk and sugar already in the bowl. We spoke briefly with the cook, who was making shepherd's pie for lunch. When we asked what the alternative was, they said that everyone liked shepherd's pie. They then added that they would make something else if someone did not want the main choice. At lunchtime we did not observe any choices being offered.

In the morning we noticed that some people were sitting at the breakfast table or in armchairs for quite some time before they were offered a drink. Staff confirmed that drinks were not routinely offered to people when they woke up, or when they first arrived in the lounge. Some people, especially those with dementia, were unable to ask if they wanted a drink. This meant that some people did not have a drink for up to two hours after getting up. At lunchtime we observed that people who needed support to eat were assisted in a relaxed, calm way. Staff sat with each person and enabled the person to eat at their own pace.

Other evidence
One person's records included a nutritional risk assessment which identified that this person was at risk of malnourishment. Their weight had been recorded regularly. In November 2011 staff had recognised that this person had lost weight and had

requested a visit from a dietician. In January staff recorded that they were still waiting for the dietician. The care plan gave no details about what was being done for this person in the meantime to ensure they were receiving a high calorie, nutritious diet. There were no guidelines for staff on what this person liked to eat or drink, nor on what staff could do to enhance the person's nutritional intake.

Our judgement
The provider is not compliant with this outcome. People were not given a sufficient choice of food and drinks to ensure their nutritional needs were met. Guidelines for staff were inadequate.

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

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People we spoke with during our visit to this home on 07 February 2012 told us they feel safe here, and that staff treat them well. We observed how staff treated people and met their care needs. Staff were kind, caring and attentive.

Other evidence
During our visit we found that this service did not have satisfactory or up to date policies and procedures in place to guide staff on what to do if they suspected abuse had taken place. We spoke with the provider who, after quite a search, found the home's policy in one of two huge policy folders. The provider also took some time to find the telephone number for the local authority's safeguarding team, which was in a long list of telephone numbers in the back of the diary. The local authority's protocol could not be found and the provider told us they could not recall ever having seen it. All care homes have to sign up to the local authority's protocol, which should have been easily accessible to staff. This meant that staff did not have the information or guidance to ensure they followed the protocols and kept people living at the home safe.

CQC had been made aware of two referrals made by the manager to the local authority's safeguarding team. However, during our inspection we met one person who had a large bruise under her eye. The bruise had been sustained following an unwitnessed fall about two weeks before our visit, which the person themselves had not been able to explain. This incident had not been referred to the safeguarding team, who confirmed with us that they would have expected the home to at least have had a discussion with them about the incident. The provider told us that a social worker had

visited this person and had criticised the staff for not reporting the incident.

Within the records we looked at relating to another person living at the home we found a completed safeguarding referral form relating to another unwitnessed fall: there was no evidence to show whether or not this had been sent to the safeguarding team, who later confirmed it had not. Regulations require that any incidents of abuse or allegations of abuse are reported to CQC, which had not been done on any of the above occasions.

The provider demonstrated they had little understanding about safeguarding. They confirmed they did not have any way of keeping track of whether or not referrals had been made, or what the outcome was. They did not know the local authority's safeguarding procedures and protocols and were unable to support staff to deal with issues correctly and keep people safe. For instance, since the issue referred to above where the person sustained a large bruise, the provider said they had told staff to report everything. This included a fall which had been witnessed and where no injury was sustained, so there was no indication of abuse.

Staff we spoke with told us they had received training on safeguarding vulnerable adults, and training records confirmed this. They said they would report any issues to senior staff or to the manager. However, they were not clear about their responsibilities when we asked what they would do if it were the manager who was the alleged perpetrator. This indicates that the provider had not checked whether staff were competent in this area following their training.

Our judgement
The provider is not compliant with this outcome. The provider did not have the appropriate policies, procedures and protocols in place to give staff sufficient guidance. Although staff had received training in this area, they were not all clear enough about their responsibilities regarding incidents of alleged abuse to ensure that people would be safeguarded from abuse and harm.

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 we spoke with were positive about the staff. Their comments included, "The staff are very pleasant, nice people", "The staff treat me well" and, "The staff are alright – couldn't have better". Our observations confirmed that staff carried out their work calmly and efficiently in a caring, friendly way.

Other evidence
On the day we visited Sharnbrook Care Home Limited we observed that there were enough staff on duty to meet people's needs. Staff we spoke with confirmed that there were always enough staff and that it was a very stable staff team. Most staff had worked at the home for a number of years so they felt staff knew the people living there very well. Staff made comments which included, "I love the job – it's satisfying and rewarding", "I like working here, it's nice" and "If I wasn't happy I wouldn't be here". During our visit we spoke with a visiting health professional who told us, "The manager is passionate about the residents, and cares about the staff. The staff are good – I've no concerns".

Relatives we spoke with were generally positive about the staff, although one said they could sometimes be a bit 'lackadaisical' and felt the home ran better when the manager was around. Another said, "The girls treat people lovely". The provider told us, "They are fantastic workers here".

Staff we spoke with told us they had received training in a range of topics which included moving and handling, fire safety, medication, infection control, equality and

diversity and care of people with dementia. All of which they said assisted them to do their job properly and improve the care they offered to people. Training records for each staff member were kept, with certificates on file to show what training each member of staff had attended, and when. The home also kept a chart (matrix) to give an overview of the training that had been done, but this was not up to date, so neither we nor the provider were able to confirm that all staff were up to date with all the required training. The provider had not taken steps to check that staff were competent following their training.

Staff said the manager was very supportive and, when she was around, they received regular supervision. However, they could not remember when their last session had taken place as the manager had not been around much. Staff told us that staff meetings were held monthly and they were able to put forward their views which they felt would be listened to. They also told us they could 'go to the office' at any time, where the provider, acting manager or senior staff would be happy to listen.

In the manager's absence, a senior care worker had been promoted to take on some management responsibility. The provider told us they were also there every day. However, the issues we found, especially with the assessments, care planning and risk assessment documentation, as well as the lack of robust safeguarding suggested that the arrangements for managerial oversight of the service were not robust enough to ensure people living there were receiving a safe and quality service.

Our judgement
The provider is not compliant with this outcome. There was a sufficient number of staff on duty. However, records were not clear enough to confirm that all staff had received all the required training, training was not always being put into practice, and staff were not currently receiving supervision. The managerial arrangements were not adequate to ensure that people were receiving safe and effective care.

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

Our findings

What people who use the service experienced and told us
When we visited Sharnbrook Care Home Limited on 07 February 2012 we did not ask people directly whether they had the opportunity to formally comment on the quality of the service provided. The provider told us that a written survey was sent each year to the people living at the home, their families and the staff. The provider said that in all the recent ones people had said they were happy: if not, they came to the office to complain. We did not see these.

Other evidence
The provider told us that there were a number of ways in which they ensured a quality service was being provided. They said they were always in the home and spoke with the people living there and with the staff about the people living there. They bought quality equipment to make people's lives better. They said they "leave the care side to the experts". By this they meant that the manager was responsible for monitoring the care records, and a consultant was employed at least three times a year to help ensure good quality care was provided, including training the staff. Two senior staff carried out audits of the medication.

However, there were no systems in place for the provider to have an overview of the service, and the provider did not appear to understand their responsibilities in this area. This was especially concerning as the registered manager, due to personal issues, had not been in regular day to day charge of the service for some time, working only a couple of days every other week.

The issues we found during this inspection, and discussed in outcomes one, four, seven and thirteen of this report indicate that the quality assurance systems are not robust enough to ensure a quality service is provided.

Our judgement
The provider is not compliant with this outcome. The systems in place were not robust enough to ensure that a quality service was provided to the people living at this home.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Staff provided care in a dignified way. However, people were not sufficiently involved in making decisions about the care they received, or given adequate choices about how they lived their lives.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Care plans, risk assessments and daily records of care provided were not detailed enough and were not kept up to date, so that people's current needs were not clear. This meant that staff did not have clear guidance about how to meet each person's needs consistently, which put people at risk of not being given safe and effective care.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were not given a sufficient choice of food and drinks to ensure their nutritional	

	needs were met. Guidelines for staff were inadequate.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: The provider did not have the appropriate policies, procedures and protocols in place to give staff sufficient guidance. Although staff had received training in this area, they were not all clear enough about their responsibilities regarding incidents of alleged abuse to ensure that people would be safeguarded from abuse and harm.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There was a sufficient number of staff on duty. However, records were not clear enough to confirm that all staff had received all the required training, training was not always being put into practice, and staff were not currently receiving supervision. The managerial arrangements were not adequate to ensure that people were receiving safe and effective care.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The systems in place were not robust enough to ensure that a quality service was provided to the people living at this home.	

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

Document purpose	Review of compliance report
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