Care Quality Commission

Review of compliance

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust The Queen Elizabeth Hospital	
Region:	East
Location address:	Gayton Road King's Lynn Norfolk PE30 4ET
Type of service:	Acute services with overnight beds
Date of Publication:	December 2012
Overview of the service:	The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides a range of acute hospital services. The Queen Elizabeth Hospital is a 515-bed general hospital providing services to the people of West Norfolk and parts of Breckland, North East Cambridgeshire and South Lincolnshire.

	It provides a comprehensive range of specialist, acute, obstetrics and community-based services.

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

Our current overall judgement

The Queen Elizabeth Hospital was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review 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 14 August 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us what it was like to be a patient in The Queen Elizabeth Hospital. They described how they were treated by staff and their involvement in making choices about their care. They also told us about the quality and choice of food and drink available. This was because this inspection was part of a themed inspection programme to assess whether older people in hospitals were treated with dignity and respect and whether their nutritional needs were met.

The inspection team was led by a Care Quality Commission (CQC) inspector joined by a practising professional and an Expert by Experience, who has personal experience of using or caring for someone who uses this type of service.

We visited the medical admissions unit (MAU) and an acute medical ward. We spoke with 12 people who used the service and one relative. Overall people were very complimentary about the care and treatment they had experienced. One person said,"I've no complaints about the care," and another described staff as, "wonderful."

Most people seemed to have a good understanding of their condition and told us about their treatment in a way that suggested there had been good consultation with medical staff and some involvement with their treatment choices.

Two people we spoke with did not feel that their dignity had been respected. This was because one person had not been offered the opportunity to take a bath and the other felt staff had not respected their ability to walk to the bathroom.

In general people told us the food was sufficient and they could obtain additional food and

drink on request if necessary. However we found the level of support to people at mealtimes varied and was not always person centred to meet their individual needs.

One person told us they thought there could be more staff as the call bells sometimes rang for a long time. We did not witness this during our visit to the two wards as call bells were answered within five minutes.

We looked at people's records in relation to their nutritional needs and found they did not always include accurate information about their needs. However we also saw some good records of detailed medical discussions with relatives and observed that staff were careful to ensure that personal information was not easily visible to people passing by.

What we found about the standards we reviewed and how well The Queen Elizabeth Hospital was meeting them

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

The provider was not meeting this standard. We judged this had a minor impact on people who used the service. Some staff did not always respect people's individual needs or ensure that people's preferences were taken into account.

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

The provider was not meeting this standard. We judged this had a minor impact on people who used the service. People were not always supported to eat and drink sufficient amounts to meet their individual needs and preferences.

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

The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had reasonable steps in place to identify the possibility of abuse and prevent abuse from happening.

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

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

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

The provider was not meeting this standard. We judged this had a minor impact on people who used the service. Some people were not protected against the risks of unsafe care because the records did not always include accurate information in relation to their care and treatment.

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. We will check to make sure that this action has been taken.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
Overall people were very complimentary about the care and treatment they had experienced and told us that staff were respectful. They also said that, "Staff are wonderful here," and," I've no complaints about the care."

Most people seemed to have a good understanding of their condition and told us about their treatment in a way that suggested there had been good consultation with medical staff and some involvement with their treatment choices.

One person told us that their level of independence had not been respected when staff wheeled him to the toilet on a commode although he was able to walk with the aid of two walking sticks. Another person admitted to hospital the previous morning told us," I haven't been offered a bath or shower since I came in."

Another person that we spoke with told us they had waited for half an hour to have their call bell answered.

Other evidence
Are people's privacy & dignity respected?

There were posters around the wards that highlighted the importance of respecting the privacy and dignity of people using services and we also saw evidence that there are staff champions to promote it. The wards had separate male and female bays with single sex toilets and bathrooms. We noted that the trust had embroidered signs on the curtains around each bed that said, "Respect my privacy, do not enter, please ask permission before entering".

Overall we found that call bells were being answered by staff within five minutes.

Staff that we spoke with told us they received training on privacy and dignity as part of their annual refresher training. Most staff said that they were able to help people to maintain their privacy and dignity although this sometimes became more difficult if a person was confused and less aware of their surroundings. In this situation staff tried to be more attentive to that person's needs. Some staff said that some colleagues did not always ask permission to go behind curtains but we did not see this in practice.

We saw doctors and nurses approach patients by name, explain what needed to happen and seek permission from people before continuing. Most staff spoke in low tones to people but some conversations could be overheard. For example one doctor who was with a person behind the curtains had to raise his voice when discussing personal details as the person was hard of hearing. Then in lower tones two doctors continued to discuss plans for tests etc with each other while still behind curtains with the person without involving them.

We observed a patient sitting in a chair beside their bed. Their clothing finished at the knee and their catheter leg bag was clearly visible.

During lunchtime on a ward for older people, most staff who assisted people to eat and drink were speaking in conversational tones that could be overheard but without divulging any personal details. Staff members were polite, called people by their name and explained how they would help them. The staff who assisted with meals sat down so that they were at the same level as the person being helped but did not seem to continue in conversation with them for more then a few minutes. The ward meal time was completed within 30 minutes.

We observed two care workers on the ward for older people, talking over a patient who was being assisted with their lunch.

A member of staff who was helping people to prepare for lunch by offering them a hand wipe approached each person in turn saying, "Hiya, would you like a hand wipe before lunch?" She spoke in the same way to each person without changing her tone or respecting their individual need.

Are people involved in making decision about their care and treatment?

We did not see many people being given the opportunity to be actively engaged in their care although staff that we spoke with told us they did seek the views and preferences of people they cared for. A ward manager also informed us that this kind of information was collected and recorded in the nursing records to inform a prescription of care but sometimes people were too unwell to give the information when they first arrived in the hospital. One care worker told us that staff aimed to promote a culture of independence

and choice and if someone refused care staff accepted this and recorded it in their notes. They told us that when a person was unable to communicate their needs they checked what was recorded in their care plan or referred to the person's family or carers.

One person who had a learning disability also had a "This is Me" record which had been brought into hospital with them. This document, completed with the person and their carers in the community, aimed to provide detailed information about the person's needs and preferences so that care staff knew how to care for them more effectively. We found it contained basic information about the person but did not contain specific information to help support the person's communication. A member of staff confirmed they had not made contact with the person's regular carers to ensure they had the right information to meet the person's specific care needs.

Records indicated that people had been involved in their medical discussions and in one case there was a record that the person had given his consent for the doctor to speak with his family about his condition. We checked five sets of nursing records and found they did not always demonstrate that people were involved with their assessments and plans of care as they did not reflect their choice and preferences. However, the nursing records did include details of people's preferred names.

Records made by physiotherapists showed that consent to treatment was always obtained before the treatment was given.

Our judgement
The provider was not meeting this standard. We judged this had a minor impact on people who used the service. Some staff did not always respect people's individual needs or ensure that people's preferences were taken into account.

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

The provider is non-compliant with Outcome 05: Meeting nutritional needs. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
On one ward people told us that they were required to choose their meals the day before and on the second ward people chose their food that morning. In general people told us the food was sufficient and they could obtain additional food and drink on request if necessary. A few people, who had not been in hospital for very long, were unaware that food was available outside of the set mealtimes.

Other evidence
Are people given a choice of suitable food and drink to meet nutritional needs?

People were required to select their preferred meal one day in advance although on the Medical Assessment Unit (MAU) this was done each morning for the same day due to the shorter admission time. The menus provided sufficient choice and included a hot meal option at lunch and the evening meal. The meals were delivered to the wards already plated in accordance with each person's choice of meal. One patient was presented with a meal that she did not want to have and though she had to wait a little while, was offered an alternative from the trolley that she was happy with.

Staff informed us that there was some flexibility around meal timings so if someone was off the ward for an investigation a hot meal could still be ordered for them until 7pm. At other times snack boxes, containing sandwiches, yoghurts and fruit were available and this was promoted on posters displayed on the ward.

Meals were delivered to the wards already plated, looked appetising and portions were of a were sufficient size. Food was served promptly to ensure it was hot.

Milky drinks and supplement drinks were readily available on the wards for people who may require additional nutrition. Staff provided six beverage rounds each day with a choice of hot drinks. Jugs of water were also available for each person at all times.

Are people's religious or cultural backgrounds respected?

Staff told us that they were able to order halal or kosher diets from the catering department. One member of staff that we spoke with described an example of how staff had ensured this was done.

Are people supported to eat and drink sufficient amounts for their needs?

The hospital used a blue tray system to identify people who required support to eat and drink at mealtimes. People who required a level of assistance with drinking were given a red jug to alert staff to this need. There was a team of volunteer "meal mates" who attended the wards at meal times to assist people who were unable to feed themselves. The hospital also had a protected meal time policy. This aimed to ensure that all non emergency activity on the wards was stopped during mealtimes to ensure that people had adequate time to eat and drink.

Additionally, a member of staff on the ward was identified as the meal co-ordinator each day. This role ensured that the ward prepared for the arrival of the meal trolley, ensured that people were ready to eat their meal and people who required help received it.

On an acute medical ward, staff told us they usually had a number of people who required help with meals. They told us that it was often very difficult for them to ensure that people received their meal in a timely way. On the day of our visit the ward received additional support from staff who worked in other areas of the trust who were undertaking the role of a meal mate. We found that the meal was over quite quickly and everyone ate or was fed at their bedside. This meant there was little opportunity to use meal time as a social activity.

One person who did not have the use of their arms, was supported by a meal mate who was known to him from a previous ward and they had a good rapport. However this person had been left with a drink without a straw prior to the meal. If the drink had been correctly positioned the person may have been able to manage it without help and with a degree of independence.

Another person who was in need of some support to eat was given some assistance by staff to start their meal and were left to continue independently but their ability to continue quickly deteriorated. Some time later a different member of staff returned to help her to eat her dessert but the main meal was abandoned.

On the medical admissions unit we observed the meal co-ordinator preparing the ward for lunch time. Staff went around each bay to offer hand wipes and to help people sit in an appropriate position for eating their meal. Meal trays were given out to people promptly by ward staff and there were no meal mates to provide additional help.

One care worker helped prepare a bed bound patient to eat then said, "Eat what you can, alright?" The person tried to tell the care worker they did not have an appetite and the full meal tray was left in front of them. Several minutes later a nurse tried to

persuade the person to take a little food but was not successful. She then offered to get a hot drink but this was also declined. The meal remained on the table and was not covered up or removed.

Another person on the ward was helped by staff to sit more upright in bed for their meal. The person required a soft diet and this was provided along with appropriate cutlery and a hot drink. The person managed to feed them self a little but then appeared to struggle to get the food to their mouth. The person had been given a hot drink in an ordinary cup and their hand shook considerably when trying to drink it. On a couple of occasions staff asked if the person was alright and did not intervene when they said they were fine. However at the end of the meal very little had been eaten. The tray was taken away although the person was left with a spoon and a dessert. When we checked an hour later they had fallen asleep and only a little of the dessert had been eaten.

We looked at the records of five people to see if their nutritional needs had been assessed. We found that two people had not had their level of nutritional risk calculated at the time of admission. Each person had a current nutritional risk assessment although they had not all been weighed therefore the estimated level of risks may not have been accurate.

We checked the records for one person who had recently been admitted and was experiencing nausea. The symptoms of nausea were not detailed in his nutritional risk assessment which meant that the assessment was inaccurate. We noted that a nurse spent time with the person and their relative to discuss the management of their nausea and alternative diets. This indicated that his needs were still being assessed.

We looked at another person's nutritional records. We found that although the assessment of nutritional risk had not been completed on the day of their admission, it had been reviewed three times in an eight day period. Staff had identified the person required support and commenced a food monitoring chart. The food charts for the previous day were incomplete indicating that staff were not monitoring the person's food intake.

Overall we found the level of support to people at mealtimes varied and was not always person centred to meet their needs. Some people were given full supervision and others did not receive enough. There was no adapted cutlery available on MAU to enable some people with limited use of their hands to be independent.

Our judgement
The provider was not meeting this standard. We judged this had a minor impact on people who used the service. People were not always supported to eat and drink sufficient amounts to meet their individual needs and preferences.

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
We did not talk with people who used the service about this specific standard although people told us they knew how to raise a complaint if they had the need to do so.

Other evidence
Are steps taken to prevent abuse?

We spoke with seven staff who had all received training and most could demonstrate they had an awareness of the different types of abuse.

One deputy ward manager said she had used the safeguarding referral process on two occasions and felt confident that it worked well. Another member of staff described suspected financial abuse of a person by their relative and the action taken by ward staff. We saw posters that identified lead staff for safeguarding concerns and issues.

Do people know how to raise concerns?

Most people were dismissive of the need to complain, as they were happy with the care they had received. When asked, they were aware of how to raise a complaint if they had a need to do so.

Staff that we spoke with were able to describe how they would report safeguarding concerns.

Are Deprivation of Liberty Safeguards used appropriately?

Staff that we spoke with confirmed they had received training on the Deprivation of Liberty Safeguards and were aware the trust had a procedure to follow when issues were identified.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had reasonable steps in place to identify the possibility of abuse and prevent abuse from happening.

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
One person told us they thought there could be more staff as the call bells sometimes rang for a long time. During our visit to the two wards however, call bells were answered within five minutes.

Other evidence
Are there sufficient numbers of staff on duty?

On the older people's ward we found that there was a considerable number of staff present at lunchtime including "meal mates" helping to ensure that all patients had a chance to eat their meal. Additional support from the meal mates was valued by the staff although one member of staff said they had seen very few meal mates on the ward over the last five months.

On the medical admissions ward staff answered call bells in a timely way and met the needs of people on the wards even though several more patients arrived during the time that we visited. One member of staff told us that recent changes to staffing and the structure on the ward had made a difference in terms of supportive teamwork. At busy times, a member of staff said they found it was difficult to welcome people as they arrived although they tried to do this as soon as possible.

Do staff have the appropriate skills, knowledge and experience?

We spoke with trust staff who informed us that training for privacy and dignity issues

were provided at induction. The trust provided us with a programme for the annual training and induction programme for nurses and this included sessions for privacy and dignity and nutrition.

Dietitians that we spoke with informed us the trust had recently updated the training for staff in how to assess and manage the nutritional risks of people in hospital. This training was now part of the induction for new staff and provided as part of refresher training. It was unclear how many staff had received this update.

We observed that staff were respectful of people's privacy most of the time. We found that staff did not always provide people with the right level of support at mealtimes or monitor their food and fluid intake correctly.

Our judgement
The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We did not speak with people who used the service about their personal records.

Other evidence
Are accurate records of appropriate information kept?

We looked at the records of three older people on the medical assessment unit. (This unit is where people are often first admitted to hospital following a referral by their GP).

One person was experiencing nausea and had been prescribed medication for this before admission. The medical assessment had been completed but the nursing assessment was still in progress. The person had an intravenous fluid infusion (a drip inserted into a vein in the arm to administer fluids) and had a chart for staff to record all fluid input and output to monitor the person's level of hydration. We observed that the bag of fluid running immediately before lunch (approximately 12.15) had almost finished. When we checked the fluid balance chart two hours later it had been recorded that the bag of fluid had been started around midday. The record did not match our observation of the fluid given to the person during that time.

We found there were good records made of medical discussions with relatives for two people. In one case there was a record that the person gave his consent for the doctor to speak with his family about his condition. The second person was too unwell to give

their consent.

We found inaccurate or incomplete records for two people in terms of their nutritional needs. One person had a nutritional risk assessment completed on admission to the hospital with an estimated weight. Approximately six weeks later the person was well enough to be weighed and this was recorded as 45 kilograms less than the estimated weight on admission. There was no explanation recorded for the significant difference.

Another person was on a fluid balance chart which required all fluid input and output to be measured and recorded. They had a fluid infusion inserted into their arm to give additional hydration. When we checked the records we found the prescribed infusion fluid had been signed as given but there was no record of it being given on the fluid balance charts for the previous two days. We observed that the person drank from a glass of milk during the lunchtime period. A record of this had been written into the fluid intake section of the record as a measure of 20 millilitres. We observed that a larger amount had been taken.

The person's care rounds chart, completed by a nurse or care worker every two hours had been ticked against the activity of offering a drink but the fluid balance chart did not indicate what or how much had been taken, or whether the person had chosen not to accept a drink. This meant the records of the person's fluid intake were unclear.

Are records stored securely?

Nursing care records were kept in folders at the end of each person's bed. More detailed medical and multidisciplinary records were stored in trolleys outside the bays. We observed that staff accessed these to check information and to add to the records and placed them back in the files once they had finished. This meant that staff were careful to ensure that personal information was not easily visible to people passing by. Information files were closed after use and returned to the place of storage.

Our judgement
The provider was not meeting this standard. We judged this had a minor impact on people who used the service. Some people were not protected against the risks of unsafe care because the records did not always include accurate information in relation to their care and treatment.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Some staff did not always respect people's individual needs or ensure that people's preferences were taken into account.	
Surgical procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Some staff did not always respect people's individual needs or ensure that people's preferences were taken into account.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Some staff did not always respect people's individual needs or ensure that people's preferences were taken into account.	
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities)	Outcome 05: Meeting nutritional needs

	Regulations 2010	
	How the regulation is not being met: People were not always supported to eat and drink sufficient amounts to meet their individual needs and preferences	
Surgical procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were not always supported to eat and drink sufficient amounts to meet their individual needs and preferences	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: People were not always supported to eat and drink sufficient amounts to meet their individual needs and preferences	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Some people were not protected against the risks of unsafe care because the records did not always include accurate information in relation to their care and treatment.	
Surgical procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Some people were not protected against the risks of unsafe care because the records did not always include accurate information in	

	relation to their care and treatment.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Some people were not protected against the risks of unsafe care because the records did not always include accurate information in relation to their care and treatment.	

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

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

The provider's report should be sent to us within 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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
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