Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Mildenhall Lodge

St Johns Close, Mildenhall, IP28 7NX

Tel: 01638445036

Date of Inspection: 31 July 2014

Date of Publication: September 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Enforcement action taken
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed
Records	✖ Action needed

Details about this location

Registered Provider	Care UK Community Partnerships Limited
Registered Manager	Mrs Sally Shadbolt
Overview of the service	Mildenhall Lodge is a registered care service providing residential and nursing care for up to 60 people, including those living with Alzheimer's and other forms of dementia. The service opened in June 2014 and at the time of our inspection 30 people were accommodated there.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

During our inspection we spoke with eight people who used the service, three relatives, seven members of staff and the registered manager. We carried out a structured observation and observed staff providing care and support on all three units. Other records we reviewed included staff files and quality and monitoring records. We considered our inspection findings to answer questions we always ask; Is the service safe? Is the service effective? Is the service caring? Is the service responsive? Is the service well-led?

This is the summary of what we found:

Is the service safe?

Care records were not always updated to ensure that people received the care they needed to keep them safe. We found some records which were not completed appropriately and contained conflicting information which placed people at risk. Some records were not sufficiently detailed to ensure that staff had all the information they needed to keep people safe.

The service worked with other healthcare professionals to help meet people's healthcare needs.

We saw that regular checks were carried out on the fire equipment and systems. However we found that the call bell system was not operating correctly throughout the service and this posed a risk to people who used the service.

We observed how staff provided care and support and looked at staffing rotas. We found

that there were not always enough trained and experienced staff on duty to meet people's needs and ensure their safety.

We found that the service was aware of their responsibilities under the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and most staff had received training. We saw that the service had made a DoLS application for one person and was considering making two further applications. This meant that the service was taking steps to ensure that people were kept safe and not unlawfully deprived of their liberty.

Is the service effective?

People's care and support needs were assessed in consultation with either the person themselves or relatives. Most people's care plans reflected their care and support needs although we found that some plans did not identify in enough detail how their needs should be met.

We found that care plans to monitor and manage people's diabetes were not specific and management of people's diabetes was not effective.

We were concerned that a lot of people seemed to be spending the majority of their time in their rooms. One person told us, "There's not much to do. The food is very good. I eat my meals in my room".

Is the service caring?

People were supported by staff who were caring and respectful. We observed staff engaging positively and warmly with people.

People who used the service and their relatives told us that they found the staff very caring. One person told us, "I wasn't feeling very well yesterday and they looked after me lovely". Another person said, "[My relative] likes to look after [their] appearance. I find [they] always look nice".

Is the service responsive?

Low staffing levels on the day of our inspection meant that people did not always get the help and support they needed promptly. People who used the service told us that although they were happy with the staff they struggled to find them at times. One person who used the service told us, "The staff work hard but you have to be patient. It does take them some time to answer your call bell". We found that call bells were not always answered promptly.

Records showed that where concerns about an individual's wellbeing had been identified, staff had not always taken appropriate action to ensure that people were provided with the support they needed.

Is the service well led?

We were concerned that despite the fact that the service had only been operating for a number of weeks we were able to identify a number of issues which required improvement.

Systems to assess staffing levels and review and monitor care plans were not robust. We were concerned that the service had not identified yet how to audit the response times to the call bells. When they did learn how to gather this information following a request from us it highlighted that some call bells had not been answered within an acceptable timeframe.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 16 September 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Mildenhall Lodge to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We looked at seven care plans as part of this inspection. We saw that both paper and electronic records were kept. People who used the service had received an assessment of their needs before they started to use the service and this information had been incorporated into their care plan. Most of the people who used the service had transferred from other Care UK services which were closing and records were transferred from those services.

We looked at the care plans for four people with a diagnosis of diabetes. Although this diagnosis was noted in their care plan there was no clear information for staff regarding the management of their diabetes. We saw that one person's blood glucose level had been recorded as 18 on 17 June 2014 but we could find no record to show that their blood glucose level had been tested again. We also saw that information related to when they took medication to control their diabetes was unclear. Another person's plan stated that they were diabetic but did not include information as to whether their diabetes was tablet or diet controlled. Another person's care plan stated that they should ensure that, 'meals provided maintain their blood sugar'. There was no information as to what constituted an acceptable blood glucose level or what to do if the person's level exceeded a particular figure. We saw that there was no record of blood glucose levels for this person. We noted that their food and fluid charts were incomplete. Fluid charts from 17 to 30 July 2014 had not been completed on three days and on all other days the person had not achieved their target fluid intake. No action had been recorded when they failed to take adequate fluids. A member of staff told us that in these circumstances they would contact the GP but this had not happened for this person. This meant that care and treatment was not delivered in line with this person's care plan.

On 25 July 2014 this person's food chart recorded that they had received 'toast and marmalade, cake and jelly'. On 24 July the chart recorded that they had received '2 x toast, lunch (ate most), biscuits'. We could see no evidence of the service promoting a healthy diet or of the person receiving a 'good nutritional and fluid intake' as stated in the person's care plan.

During our inspection a person who used the service told us they were thirsty and hungry. As we were unable to locate a member of staff we pressed the call bell. The registered manager had previously told us that the call bell should default to a louder bell after three minutes and to an emergency bell after four minutes. The bell rang for 14 minutes before a member of staff came along. We were very concerned that this person might have been placed at serious risk of harm because they had to wait so long for assistance. We raised this issue with the registered manager who informed us that this call bell must be faulty. We noted that the service did not routinely audit or test call bells which meant that there was a risk that other call bells were also not working correctly.

Following our inspection the service sent us a record of response times to call bells. We looked at call bell records for 29, 30 and 31 July. We saw that on 20 occasions call bells rang for more than five minutes before being answered. On ten occasions call bells rang for more than ten minutes before being answered. We also noted that there were three night time call bells which were unanswered for period of 15, 22 and 23 minutes. This meant that the failure to respond promptly to call bells placed people at risk.

We spoke with people who used the service about the staffing. All the people we spoke with were positive about the care and support they received but all said they found there were not enough staff. One person said, "I never know where they are." A relative of a person who used the service told us, "The staff are very kind but rushed off their feet and can be difficult to find at times". During our inspection we observed a person walking along the corridor and looking for a member of staff. They became quite distressed and we attempted to find a member of staff to assist them but could not locate one within an acceptable amount of time.

On the dementia unit we saw that at 2.10 pm only one member of staff was on duty supporting 11 people. One member of staff had gone for their break and the team leader was not on the unit. We asked the member of staff who remained on the unit where the team leader was and they were unable to tell us. Their shift should have finished at 2pm but nobody had come to take over from them. Three people on the dementia unit required two members of staff to assist them with their mobility. This meant that they would not have been able to receive this support when only one member of staff was available to them.

Later in the day we saw that the same unit had only one member of staff working for a period of more than 10 minutes. At one point this member of staff was supporting a person in their room for a period of five minutes and during this time no member of staff had been asked to check that the other people were safe. People who used this part of the service were living with dementia and some had been assessed as at high risk of falling. One person's care plan stated, "They will attempt to leave, especially as unfamiliar." This lack of staff placed this person and others at risk.

On the nursing unit we saw that two members of staff were on duty to support and care for seven people. Each person needed considerable support with their meals and dietary intake. Three relatives of people on this unit had come in to support their relative to eat

their meal. One relative told us that they did this as they felt that staffing levels meant that they were not confident that their relative would receive their meal while it was still hot or receive all the help they needed to eat it. This meant that we were not assured that there were enough staff on this unit to meet the needs of the people who used the service.

We asked the registered manager how many people on the dementia unit required to support to eat their meals. The registered manager told us that most of the people on that unit needed active support. We observed one person eating their meal without staff support. Their care plan stated that their meal should be cut up but we noted that it had not been cut up. The plan also stated that they should be given encouragement to eat their meal. The person was struggling to eat their meal as they were unable to hold the cutlery correctly. They were attempting to eat peas and carrots by balancing them on their knife. They told us they liked the meal.

We went to look for a member of staff to support this person. On our return we noted that a member of staff had removed the meal from them and told us that they did not want it. We advised the member of staff that the person had struggled to eat their food but had been enjoying it. We suggested they provided different cutlery for this person. We observed later that the person had continued to eat their meal with staff support. We were concerned that this person's meal had been removed from them even though they were enjoying it. We noted from their care record that this person had sustained a 5% weight loss since 20 May 2014.

We saw from care records that one person had been admitted to hospital because they had aspirated food into their lungs because it had not been provided in the correct consistency for them. During our inspection a relative of a person who used the service told us that they were concerned as their relative had not been provided with pureed food, as was stated in their care plan, on two occasions. We spoke with the quality manager about this and they told us that they had believed this issue to have been addressed. They told us that the service recognised that the chefs came from a hotel background and required additional training. We were concerned that training for the chefs had been booked for September 2014 which meant that people who used the service might continue to be placed at risk from receiving nutrition which could harm them.

We saw that the new dementia wing had been designed to cater for people living with dementia. Bathroom lights were activated by body heat, motion sensor technology alerted staff if someone at risk of falling had left their bed, studded rails indicated where doorways were and colours suitable for people living with dementia had been used throughout. We saw that the memory boxes outside people's bedroom doors were empty. All the doors were the same colour and these boxes, which are designed to hold items important to the person, would help identify which is the person's bedroom. Whilst we were at the service the manager asked staff to begin discussing this with the people who used the service.

Throughout our inspection we noted that many people spent considerable time in their rooms. Although the day centre was having an open day on the day of our inspection, staff were unable to tell us what activities had been provided. Those who chose not to attend the day centre opening had no additional activities provided. On the dementia unit only one of the 11 people attended the day centre open day.

We saw that the service had appropriate policies and procedures in place in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA DoLS). The registered manager told us that one application had been made and the quality manager told us that

two others were being considered. During our inspection staff told us that two people who used the service were known to try and leave the building and told us, "They get blocked by doors and we steer them back". This constituted a deprivation of these people's liberty. We checked and found that the two people referred to were those the service was considering putting in a DoLS application for. This meant that the service was aware of the issue and had begun to address it to ensure that people would not continue to be unlawfully deprived of their liberty.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We saw that the service had a programme of training in place and had so far provided 29 members of staff with training in safeguarding people from abuse. This left a similar number of staff who were yet to receive training. The staff we spoke with were clear about their responsibilities to protect people from the risk of abuse and to report abuse if they suspected it was happening.

We saw that information was available to staff and the people who used the service to direct them how to raise a safeguarding issue. Local procedures were prominently displayed.

We saw that the service had responded appropriately to some recent allegations of abuse by making referrals to the appropriate authorities who had begun to carry out investigations.

We noted that the service was responsible for the safekeeping of money belonging to some people who used the service. We saw that there was a clear process in place and that an audit of these monies had last been carried out on 7 July 2014. We checked one person's money and found that the record was accurate. This meant we were assured that the service had systems in place to safeguard people from financial abuse. The provider may find it useful to note that since people had moved from other Care UK services a new inventory of their property had not been completed. We asked staff where such a record might be located and they were unable to provide one. This meant that people might not be sufficiently safeguarded from the risk of theft of their property.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Before we inspected on 31 July 2014 we had received information of concern which related to there being insufficient numbers of staff on duty to meet the needs of the people who used the service. At our inspection we spoke with the registered manager who told us that Care UK staffing guidelines assessed that one member of staff would be needed to support and care for five people during the day and 10 people at night. They told us that staffing levels at Mildenhall Lodge exceeded this guideline and that they aimed for 10 members of staff on duty in the day, nine in the evening and four at night.

On the day of our inspection the rota showed that there were 10 staff on duty in the day, six in the evening and four at night. We noted that one of the staff on the night shift was an agency staff member and no senior member of staff was due to work that particular shift. The day of our inspection was not a typical day as the next door day centre was having an open day. Two members of staff had been specifically delegated to support people to attend the open day when their caring and support duties were finished.

We saw that a nurse was on duty on each shift but a senior member of staff was not always on duty at night. In the week of our inspection a senior member of staff worked a night shift on only four occasions. This meant that there was a risk that people who used the service could be supported by staff who were not always sufficiently skilled and experienced.

When we examined the rotas the registered manager gave us we saw that the service rarely reached the stated staffing levels. In a two week period before our inspection the service had operated with their stated staffing levels on only seven occasions. On 28 July 2014 only six staff worked the day and evening shifts with an additional member of staff working 12- 6pm.

Some staff told us that they felt that there were not enough of them to carry out their roles safely and effectively, although two staff members felt this had improved recently. One member of staff told us that they felt there should be one additional staff member on each unit as people were being left in bed too long, often not getting up until lunchtime. They

also told us they were concerned that some people were not getting enough fluids as staff were too busy.

On a different unit we noted that one person was trying to find a member of staff to take them into the garden for a walk. After several minutes a member of staff arrived and produced a wheelchair for the person. This confused and upset the person as they did not need a wheelchair. The staff member intended to take them outside to sit in the wheelchair but this was not what they wanted. There were not enough staff available to enable this person to take a short walk around the garden. Ultimately a visiting member of the senior management team offered to do this but we were concerned that they would not normally be available to assist in this way which meant the person would not have been supported to go outside.

We looked at six staff files, including one for a team leader who had been recently appointed. We noted that four members of staff had received a supervision session since the service came into operation six weeks ago. The newest member of staff had no record of a structured induction, although they had received some training. We asked the registered manager to supply us with an updated record of training for all members of staff. We saw the newest member of staff, whose file we had viewed, had received training in a variety of subjects including nutrition, safeguarding people from abuse, infection control and dementia. We were concerned to see that records indicated that this person had not completed their medication training. We observed this person administering medication during our inspection.

According to the training records provided for us we saw that of the 10 members of staff on duty on the day of our inspection four had no record of training in nutrition, three had no record of safeguarding training, four had no record of training in dementia care and four had no record of practical moving and handling training. This meant that there we were not assured that enough skilled staff were available at all times to meet the needs of the people who used the service.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received or to identify, assess and manage risks to the health, safety and welfare of people who used the service and others.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The service had only been operating for a six weeks when we carried out our inspection. This meant that they had not yet sent out any questionnaires or surveys asking for feedback from people who used the service, their relatives or advocates and staff. We saw that regular meetings had been held with senior staff and one meeting had been held with the people who used the service. We saw that people who used the service had asked for the time lunch was served to be changed and that this had happened.

We saw that the service had a complaints policy and process in place. Since the service had opened two complaints had been received. Both had been responded to promptly by the registered manager and in accordance with the service's policy. Both were in the process of being investigated.

We found that although care plans were being reviewed regularly, those for people with diabetes did not ensure that they received care and treatment which met their needs. We noted that food and fluid charts for people with diabetes, and for others, were incomplete and action was not taken in response to particularly high blood glucose levels or low fluid intake. This meant that there was no effective care plan monitoring system in place to identify and manage the risks relating to people's health and welfare.

We were concerned that staffing levels had been assessed using a system which did not sufficiently take into account people's specific healthcare needs. The staffing levels for the nursing unit were assessed as the same as for the other units despite the fact that more people required active support with nutrition and mobility on this unit. We observed throughout our inspection that staff were difficult to locate and staff told us that they had raised the issue of low staff numbers with the provider before our inspection. We noted that people who used the service spent time looking unsuccessfully for members of staff to support them.

We observed that there was no clear process in place for staff to communicate with their colleagues when they were leaving the unit. Twice we observed that the dementia unit was left with only one member of staff on duty because the team leader was not on the floor and had failed to inform the other member of staff. This placed people at risk. On inspection of the rotas we saw that the service regularly failed to provide the assessed staffing levels.

Although a comprehensive staff training programme was underway we found that some of the staff on duty on the day of our inspection had not received all the training they needed to carry out their roles safely and effectively.

We saw that although the fire system and fire-fighting equipment was maintained and tested regularly the call bell system had not been. The service was unaware that one of the call bells was not working correctly as they had not tested it. This also meant that the service was unaware of how promptly staff responded to call bells as they told us they did not know how to access a list of response times to the call bells even though this was possible and was supplied to us after the inspection.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We saw that the service used both paper and electronic records. The quality manager told us that a printout from the electronic system should be placed in the care plan folder once a month so that the most up to date information would be on the electronic record but that written information would be no more than four weeks old. During our inspection we looked at seven electronic and paper records. In two cases we found that paper records had not been successfully transferred from the person's previous service and that the record contained very little information.

The electronic record provided a running daily record for each person which was detailed and identified which member of staff had entered the information. We found that some of the paper and electronic records contained conflicting information. For example one person's electronic record stated on 27 July 2014 that they had eaten 'two pieces of toast and a cup of tea' all day whereas their paper record stated that they had eaten 'two biscuits, soup, pork roast (all)' This record related to a person with diabetes who required accurate recording of their food and fluid intake to effectively manage their diabetes. This meant that we were not assured that records always provided an accurate record in respect of each person who used the service.

We found that the electronic system was not easy for staff to access and navigate. One relative of a person who used the service told us that they found that staff could not access information quickly. They had recently come in to ask how their relative had got on with the GP that morning. They found that the staff member on duty did not know and took some time to locate the information. They told us, "They said they didn't know if the GP had been as they had just come on. Their handover doesn't seem very good – people aren't up to speed".

We looked at how the service recorded appointments such as this person's relative's GP appointment. We saw that appointments were routinely recorded in a number of different locations including a GP appointments book, daily notes, handover notes and the health section of the care plan. This could have been confusing for staff and increased the risk of

staff being unaware of a person's changing needs.

We noted that the handover sheet contained a lot of information but did not contain information about what activity each person had undertaken during the previous shift. We asked staff how we could find out who had taken part in activities in recent days. Staff told us we would have to access each individual daily record in the electronic system. We looked at the electronic records for two people for the previous week and found no mention of activities recorded there.

We asked to see six staff files. Training, supervision and appraisal sessions were recorded appropriately in most cases. The registered manager told us that one new staff member had undertaken their competency assessment for moving and handling and had received a structured induction. The service was unable to provide records to verify this.

We asked the registered manager to supply us with an up to date training record for all members of staff to be sent to us following the inspection. We noted that one member of staff who was on the rota on the day of our inspection did not appear on the training rota. This meant that we were not assured that records relating to staff training were complete and accurate.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: The provider had not ensured that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff. Regulation 22
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The provider did not have an effective system to assess and monitor the quality of the service and to identify, assess and manage risks relating to the health, welfare and safety of the people who used the service. Regulation 10 (1) (a) and (b).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**

This section is primarily information for the provider

care Treatment of disease, disorder or injury	**How the regulation was not being met:** The provider had not ensured that people who used the service were protected against the risks of unsafe care and treatment because they had not maintained accurate records in relation to their care. Regulation 20 (1) (a).

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 by 16 September 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 22 September 2014 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
Treatment of disease, disorder or injury	**How the regulation was not being met:** The provider had not taken proper steps to ensure that people who used the service were protected from unsafe care and treatment because care was not delivered in a way that ensured their welfare and safety. Regulation 9 (1) (b) (ii).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - 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.

Moderate impact - 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.

Major impact - 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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