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: 26 September 2014

Date of Publication: October 2014

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✖ Action needed
Management of medicines	✓ Met this standard

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.
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

We carried out this inspection to check whether Mildenhall Lodge had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Management of medicines

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 26 September 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 were accompanied by a pharmacist.

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

We last inspected this service on 31 July 2014 and found that people's needs were not being met and that poor care practices had placed people at risk. We had particular concerns about the care for people who had a diagnosis of dementia and those with diabetes. We took enforcement action which required the service to improve the way it provided care and support to people and gave a deadline for them to achieve this. The service submitted an action plan to us which outlined how they would ensure the required improvements were made. We returned at this inspection to check that improvements which related to people's care and welfare had been made. At this inspection we found that there was evidence of some improvement to comply with the warning notice we had issued but some concerns still remained.

Before our inspection we also received information of concern regarding how the service managed people's medicines. We followed this up to make sure that people received medication safely and in a way that met their needs.

During our inspection we spoke with four people who used the service, eight relatives, eleven members of staff, the support manager and the regional manager. We carried out a structured observation and observed staff providing care and support on two of the units, including the nursing unit. One unit was closed to visitors as a part of an infection control procedure and so we did not inspect there. We also looked at the care records for five people. Other records we reviewed included staff files, medication records 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?

We found that medicines were being managed in a way that kept people safe. Care plans for people with diabetes had been improved and staff were more knowledgeable about caring for people with this condition. We were concerned that low staffing numbers and the use of agency staff who were not familiar with people's needs placed them at potential risk.

Is the service effective?

We found improvements had been made with regard to the care plans for people with diabetes and the completion of food and fluid charts, although some people were still not reaching the agreed target set for fluid intake. We were concerned that there was still little in the way of leisure opportunities for people. We were also concerned that the numbers of staff on the nursing unit, and at times on the dementia unit, did not meet people's needs. The needs of people who used the service were documented in their care plans but sometimes information was not easy for staff to locate and did not contain all the information they needed to support people effectively.

Is the service caring?

People we spoke with told us they were happy with the care they received. One person told us, "They look after me excellently - everybody's very nice". Relatives told us that although they had concerns about the numbers of staff they found the staff to be kind and very caring.

Is the service responsive?

People who used the service and their relatives told us they sometimes had to wait a long time for staff to help them with personal care. We found that the service did not always update people's care plans promptly when there had been a change in their needs.

Is the service well led?

It was clear that the management of the service had made improvements with regard to the monitoring and auditing of care plans and medication. We remained concerned about the lack of management strategy to address the lack of staff at critical times.

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 13 November 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

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 ✖ Action needed

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 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

During our last inspection on 31 July 2014 we were concerned that the service was not meeting the needs of people with a diagnosis of diabetes. During this inspection we looked at the care plans for two people with diabetes and saw that there was clear information about how their diabetes should be managed. We saw that people had their blood glucose levels tested appropriately and that this was recorded. We found that staff showed an increased understanding of diabetes and were working in partnership with the local GP service to support one person with a change to their medication in order to manage their condition.

We observed some care practice that concerned us on the dementia unit. When we arrived we noted that one person remained in bed and had their drink and call bell out of reach. We raised the matter with a member of staff and these were immediately placed within reach. We saw that one person's care plan stated that their food should be cut up and, if possible, sauces added to meals to moisten them. We saw that this person was eating fish, chips and peas which had not been cut up and noticed that they were pulling the food apart with their fingers. This meant that staff had not followed this person's care plan and which resulted in them eating in a way which could compromise their dignity.

We also saw that the agency member of staff who was on duty was giving a person their lunch in bed. We saw that the person was lying almost horizontal on the bed and was at risk of choking. Again we alerted a member of staff. We established that the agency staff member had not read the eating and drinking care plan for the person they were supporting and noted that staff were busy supporting other people at the time. This incident placed this person at risk of unsafe care.

At our last inspection we were concerned that low staffing numbers meant that people's

care needs were not met in a timely way. At this inspection we found staff numbers reduced at times to a level that meant people did not always receive support promptly. On the nursing unit two people were still in bed at 11.00. Staff told us that they were sometimes pushed to get people up in time for lunch. We noted that relatives came in to assist their family members with their meals. They told us they did this because they were concerned that their family member would not receive their food on time. Staff confirmed to us that without this support they would struggle to meet the needs on this unit. Relatives also had concerns about how long their family members had to wait to receive support to go to the toilet or have their incontinence pad changed.

We saw that the service used the CAPE dependency assessment. However we found that staffing levels were not always assessed in line with people's everyday needs. We saw that on the nursing unit the impact of this was that people's basic care needs were not always met in a timely way. We asked how often people had baths or showers on this unit and established that one person was able to communicate verbally and asked for a daily shower which they were given. The other people were less able and staff told us that baths and showers were not offered frequently. For some people there was no evidence in records that they were given regular baths or showers.

We noted during our inspection that at 14.10 the team leader was on duty on the dementia unit and supporting someone in their room. The only other member of staff on duty was on a shadow shift as they were new to the service and they told us their shift should have finished at 14.00 but they had stayed on as no other staff were around. We asked the support manager how they could ensure people were kept safe with these staffing levels. They told us they were unaware that the unit's staffing for the afternoon was for only two people, one of whom was on their break. They arranged for additional staffing but we were concerned that this error in staff allocation placed people at potential risk of unsafe care.

We spoke with eight relatives of people who used the service and despite the issues noted above most made positive comments about the quality of the care provided. One person told us, "[My relative] is much brighter here, the environment is right for their needs". Another person said," [My relative] has put on weight since being here". A third relative said, "They have had some teething troubles but I have no major gripes". People who used the service told us they were happy with the care they received. One person told us how much they enjoyed the garden and we observed them access the garden during our inspection. We saw that people were well groomed and had clean hair and, with one exception, clean nails.

We looked at five care plans and three accompanying electronic records. We saw that the daily notes were completed on the electronic record and were person centred and detailed. We found that two members of staff did not have a 'log in' to access the electronic record and staff told us that in this circumstance, and when agency staff were on duty, a handwritten record was kept. We noted that this was not cross referenced on the electronic record which made it seem that there were gaps in records and also created possible confusion for staff which might place people at risk. We spoke to the support manager about this and they told us they would ensure that records were cross referenced to ensure that staff were able to locate all the important information they needed to meet people's needs promptly. A generic log in was also available for staff to use, however some staff we spoke with were not clear about this.

We asked staff about the information that would accompany a person who used the service if they had to be admitted to hospital. Staff were unclear and inconsistent. This

meant that we could not be assured that information would be shared with other professionals effectively to ensure continuity of care.

We noted on the dementia unit that eating and drinking records had been fully completed. Where people had been identified as being at risk of malnutrition their food intake had been increased and snack plates provided. We saw that the completion of daily charts was monitored by the team leaders on a daily audit form. We saw that weights were regularly monitored and recorded. This meant that people on this unit were protected from the risk of malnutrition as the service had systems in place.

On the nursing unit we found that there was evidence that people did not always receive the required amount of fluids. In some cases fluid intake was low, well under half the agreed target set by the service. We noted that where people had acquired an infection which could have affected their fluid intake this information was not always noted on their fluid chart. This meant that the risk of dehydration was not being actively monitored for some people.
We saw that electronic care plans, whilst detailed in some areas, did not always include clear strategies for staff to follow. For example we noted that one care plan identified that a person's behaviour could be challenging when they became agitated and anxious. There was no documentation of possible triggers or strategies which might help to make the person feel less anxious. There was also no assessment of the risk they posed to themselves and others and no analysis of incidents. Staff told us that the person was often unwilling to receive personal care. They demonstrated to us that they knew the person's needs well but strategies they used were not recorded. This meant that other staff, especially agency staff, would not always know the best way to support the person successfully.

We discussed the Care UK approach to Activity Based Care with the support manager. They told us that the provision of activities was to be led by care staff but admitted that this was not happening as it should. We noted that no social activities took place on the nursing unit on the day of our inspection. Two people who used the service attended a coffee morning in the next door wellbeing centre and staff led a craft activity in the afternoon on the dementia unit. Staff told us that it was difficult to make enough time to provide opportunities for people to follow their interests and hobbies. The support manager told us that the service was in the process of increasing the provision of leisure activities for people.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

At this inspection we looked at medicines storage, medicines and records about medicines for people using the service and reviewed documents supplied by the service.

We saw appropriate arrangements were in place for obtaining medicines. Staff told us how medicines were obtained and we saw that supplies were available to enable people to have their medicines when they needed them.

As part of this inspection we looked at the medicine administration records for 18 out of 27 people. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded. However the provider should note sometimes the incorrect code was used when people were not able to take their medicines for some reason.

Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw that controlled drugs were managed appropriately.

We also saw the provider did daily and monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken. This meant the provider had systems in place to monitor the quality of medicines management.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** The provider did not ensure that people who used the service were protected against the risks of receiving unsafe care and treatment as care and treatment was not planned and delivered in a way that ensured their welfare and safety. Regulation 9 (1) (b) (ii).

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 13 November 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.

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.

Contact us

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