Review of compliance

Potensial Limited Middleton Lodge	
Region:	North East
Location address:	Station Road Middleton St George Darlington Co Durham DL2 1JA
Type of service:	Care home service without nursing
Date of Publication:	August 2011
Overview of the service:	Middleton Lodge is a single storey building that has been refurbished to provide a modern living environment for ten people with a learning disability. The home is set in it's own grounds and provides single room en-suite accommodation. The home is in the village of Middleton St George and can be reached by both public and private transport.

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

Our current overall judgement

Middleton Lodge was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 because concerns were identified in relation to:

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 14 January 2011, carried out a visit on 14 June 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

Many of the people who lived here could not give us their view because of their communication difficulties.

What we found about the standards we reviewed and how well Middleton Lodge was meeting them

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

The care planning process did not fully reflect all aspects of the service user's individual circumstances, and their immediate and longer term needs. Risk assessments were not fully identified, and did not state how these should be managed.

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

There were inadequate records kept to identify where people who used services were at risk of malnutrition, poor nutrition, and dehydration.
The plans of care did not include how any risks identified could be managed.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The provider did not comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance and failed to ensure that there were effective arrangements for the appropriate cleaning and decontamination of equipment.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People did not have their medicines administered to them safely, because staff did not have the competency, training and skills needed.
Published guidance about how to use medicines safely were not being followed.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People who use services and people who work and visit the home were not protected against the risks of unsafe or unsuitable premises because the building was not adequately maintained.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Staff were not fully supported or trained to ensure that service users personalised care, treatment and support needs were properly implemented.

Actions we have asked the service to take

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

We have taken enforcement action against Potensial Limited.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are major concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We did not talk to people about this outcome.

Other evidence

We looked at each service users support plans and the plans about how staff would support each person. The support plans were generally person centred and described each person's likes dislikes, family, friends, hobbies and interests. Information included diet, health, medication, morning, afternoon and evening routines. There were sections on communication, choices and decisions, how money is managed and support networks.
Overall the support plans were well written and informative. However, we found that there was reference in the staff support plans that highlighted individual risks, for example: one person was at risk of choking, but there was no specific risk assessment in place about how this should be managed.
In another support plan it clearly stated that one person was at risk of malnutrition, and should be weighed weekly however, there was no evidence of a special diet or a specific risk assessment in place for this person. This person's weight had not been recorded on their weight chart since 23 May 2011.

In another support plan for another service user, there was a risk assessment on file which indicated the need to implement the behavioural management guidelines and plan, but there was nothing available for staff to follow. This related to someone who had a behaviour which involved harming them self. There was no clear management

plan in place regarding this behaviour.

We found that the social activities plan's/diary for each person were out of date, or not being followed. For example: one person no longer attended a social gathering, but their support plan stated that they attended this venue several times each week.

We found that staff were taking several services users out every day to local shops, pubs, and local places of interest. However, there was no social structure or formal planning for these outings. These ad hoc arrangements were exacerbated by 2 service users who displayed very challenging behaviour, and staff told us that service users were taken out to avoid them becoming stressed by this. We saw very little constructive or meaningful activity with service users in the home. This was because the staff team were spending a great deal of their time trying to manage/cope with 2 service users with challenging behaviour.

During the visit on 14 June 2011 one service user was displaying very challenging behaviour, they had a 'when required' medication plan in place and this was exhausted during our visit, there was no other plan in place to tell staff what to do when these medicines were exhausted. We found that the daily records gave little information about the individual's health and social wellbeing, and did not relate to the individuals support plans.

The acting manager told us that she had made arrangements to audit each service users support plans, because she had already identified lots of gaps and out of date information since she commenced employment. She was particularly concerned about the lack of risk assessments, management guidelines, the lack of menu planning and how meals were being prepared.

Our judgement
The care planning process did not fully reflect all aspects of the service user's individual circumstances, and their immediate and longer term needs. Risk assessments were not fully identified, and did not state how these should be managed.

Outcome 05:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are major concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
One service user said that enjoyed going out for meals with staff. He said meals in the home were good.

Other evidence
The acting manager said that she had requested a visit from Environmental Health because she had concerns about how food was being prepared by staff for service users. An Environmental Health Officer from Darlington Borough Council had visited Middleton Lodge on 7 June 2011. We saw a report which stated that 2 legal requirements relating to Food Safety Act 1990, EC Regulation 852/2004, Food Hygiene (England) Regulations 2006 and Food Labelling Regulations 1996 had been contravened; and that these had also been previously contravened at an earlier inspection on 12 June 2009.

On 27 July 2011 we examined the care plans of one service user which stated that they were at risk of poor nutrition and needed a suitable diet with encouragement and support from staff. The care plan stated, "I need encouragement to eat at meal times as I keep losing a lot of weight." And "I have puddings with all of my meals and 'Complan' drinks twice per day." In the section entitled "How to support the service user, the care plan stated, "The service user is offered a choice of cereals and toast and hot and cold drinks for breakfast. Team members will organise this. "The service user is offered a choice of meals at lunch time. Team members will organise this." The service user will choose their evening meal from the selection available".
We saw that the care plan stated "The service user eats a variety of foods which are all monitored on a dietary recording sheet."

On 30 June we visited Middleton Lodge and asked the senior in charge of the home for the dietary recording sheet for this service user, the senior provided us with records entitled 'Menu Planner and confirmed that this was the only record kept which showed what the service user's diet had been. We saw that the entries for the week beginning on 16 May 2011 showed that there was no record of breakfast being given to this service user for one day, no record of mid morning snacks for three days, no record of lunch for two days, no record of a mid afternoon snack on five days, no record of dinner on three days and no record of supper on five days. Records showed that on 18 May 2011 the only food given was a drink of milk. We saw that the entries for the week beginning on 13 June 2011 showed that there was no record of mid morning snacks for one day, no record of lunch for three days, no record of a mid afternoon snack for two days, and no record of supper for five days. A total of seven entries in the 'snacks' section stated that only the drinks "juice', drinks' or 'tea' were given. We saw that the entries for the week beginning on 20 June 2011 showed that there was no record of mid morning snacks for four days, no record of lunch for three days, no record of a mid afternoon snack for four days, no record of dinner for two days and no record of supper for the entire seven days. Records showed that on 22 and 23 June 2011 the only food that was given at each of these days was at breakfast.

We looked at the service users care plan which stated that a 'Weight and Malnutrition Screening Tool' was to be used and stated that their "weight is recorded weekly." However records at the home showed that the service user had only been weighed twice in each month from 1 January to 31 March 2011 a total of six times in 13 weeks, but also had not been weighed at all since 23 May 2011, a total omission of five weeks. When we asked the senior in charge she confirmed there were no other records of the service users weight kept.

On 5 July 2011 we looked at the medication administration record (MAR) for the same service user. They had been prescribed with two nutritional supplements by a doctor because they needed specific support to manage their diet. We saw that the medication 'Pro-Cal shot liquid' had been prescribed and treatment had commenced on 29 January 2011. Person 1 should have received 40ml of this supplement 3 times per day. However when we examined the MAR chart we saw that staff had not signed to indicate that they had administered this supplement from 26 June 2011 at 16:00 until 2 July 2011 at 12:00. The MAR showed a total of 16 omitted administrations and there were no written explanations.

We also saw that the medication 'Fortisip liquid' had been prescribed and treatment had commenced on 23 April 2011. The service user should have received a carton of this supplement 3 times per day. However when we examined the MAR chart we saw that staff had not signed to indicate that they had administered this supplement from 26 June 2011 at 16:00 until 2 July 2011 at 12:00. The MAR showed a total of 16 omitted administrations for this medication and there were no written explanations.

CQC made a safeguarding referral to Darlington Borough Council's Adult Protection Team regarding the nutritional needs of this service user.

Our judgement
There were inadequate records kept to identify where people who used services were at risk of malnutrition, poor nutrition, and dehydration.
The plans of care did not include how any risks identified could be managed.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are major concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not talk to people about this outcome.

Other evidence
On 14 and 15 June 2011 Compliance inspectors with the commission, carried out unannounced site visits to Middleton Lodge, as part of a planned responsive review. On our visit of 14 June we saw that the building was in a very poor state of cleanliness, with very strong unpleasant odours, brown coloured smears to several walls and mattresses being used by service users despite being heavily soiled

In 2 occupied bedrooms we found that the mattresses in use were heavily stained with large areas of brown/black and yellow substance on both sides and edges. When we asked the acting manager, who had been in post for approximately 3 weeks, about the steps that the home had taken to make sure that people's mattresses were clean, she said that there wasn't any but she had not realised that they were so dirty. When we visited the home again on 15 June 2011 these mattresses were still being used by service users.

We looked at the carpets and wall coverings in bedrooms and communal areas of the home. We saw that the carpet in an occupied bedroom was heavily soiled with dark grey/black staining and there were smears of a brown substance across 2 of the bedroom walls. There was a strong unpleasant odour in the room. In another occupied bedroom we smelt a strong unpleasant odour. We asked, the acing manager, why there was an odour in the room and she said that the service user had previously suffered from a continence issue and that the carpets had not been cleaned in the time she had been manager at the home (three and a half weeks). A senior care worker at

the home for 3 years said that the carpet had not been cleaned following the service user's continence issue.

We looked at the floor coverings in the central communal lounge next to the kitchen and saw that it was heavily soiled with dark grey/black staining. We smelt an unpleasant odour in the room. We saw that the furniture was stained with white and dark brown/black areas and we saw that blankets had been placed on top of the stained base cushions of the 2 sofas.

We looked at the 'quiet lounge' next to the laundry and saw that the floor was stained with areas that were a grey colour and saw that 2 sofas and 2 chairs were extensively stained with dark brown and light patches. The base cushions for the furniture were missing. One of the sofas had been overturned. We smelt a very strong unpleasant odour in the room. We were told by the acting manager that the staff could not meet the needs of one service user who was regularly and frequently incontinent whilst sitting on the floor and furniture of the room. We examined the overturned sofa and found that it was extensively stained with dark brown and light patches and it remained wet and had a very strong unpleasant odour. We were told that the home's practice was to overturn the furniture when these had become too wet to sit on and this was a frequent, daily occurrence.

We asked about the home's procedure for cleaning furniture and carpets, the acting manager said that that there was no mechanical equipment at the home or available for staff to use to clean carpets, nor was there an arrangement whereby external contractors could be used to hygienically deep cleanse carpets and furniture. We were told that there were no staff employed who had specific responsibility for maintaining standards of cleanliness at the home. When asked, a senior carer said that there had never been a mechanical carpet cleaner at the home in the 3 years she had worked there.

We looked at the flooring and furniture in the dining room. We saw that each table leg had a band of a grey/black substance around it for approximately 10cm from the floor. All of the chairs in the room had a residue of spilled food on their backs and seats; some lounge chairs were being used in the dining area and having absorbent fabric, were heavily stained with food spills and smears.

In an occupied bedroom we saw that there were large patches of a black and red mould like substance on 2 tiled walls and on the mobility rails in the attached bathroom. The light blue vinyl flooring in the attached bathroom was wet, and discoloured with dark grey and yellow algae like substance. In another occupied bedroom we saw that there was a black mould like substance around the bath top area in the attached bathroom.

In the communal bathroom area between 2 bedrooms we found that the toilet bowl was stained, had brown coloured water and there was an unpleasant odour in the bathroom. The acting manager said that the bathroom was used as a storage area for clothing and bedding for 2 service users. We saw chests of drawers and boxes which contained underwear, night and daytime clothing as well as a variety of bed linen, which was piled into the bath and on the floor around the toilet pan.

We looked at the bathroom in an unoccupied bedroom. We smelt a strong odour from the bathroom attached to the bedroom. The acting manager confirmed that the

bathroom was not in use, which was why it had an unpleasant odour.

We were told that there were no procedures in place nor was there any inspection or treatments carried out by external contractors to make sure that people living and working at the home were not at risk of water borne infection from poorly maintained water supply systems.
On 15 June 2011 the acting manager showed us documents held at the home entitled 'Annual tank inspection record,' 'Record of Shower, De-scaling and Disinfection,' 'Monthly tap temperature check,' ' Weekly record of flushing little used outlets' and 'Log Book Inspection Record'.
None of these records had been completed with any entries and the acting manager said that these were not being used at Middleton Lodge.

We looked at the laundry room and found that there were no facilities for staff to wash and hygienically clean their hands despite soiled linen and clothing being processed there. The acting manager, said that the nearest available facility was along a corridor in a different part of the home.

We saw that a washing basket full of laundry (these were tabards and tea towels) was being stored under an open fronted kitchen food preparation bench. The acting manager confirmed that these were soiled items of clothing.

We looked at the kitchen area of the home and found that the cooker hob was heavily soiled with both burned-on and more recent crumb like food residue. We saw that the oven housing unit was heavily soiled with brown black substances that had dripped from the oven doors and pooled onto the edge of the unit housing. The cooker extractor fan filters were coated with yellow grease like substance. Directly outside the kitchen door to the garden exit there was a large tin approximately 30cm wide which was full with discarded cigarette butts.

The acting manager said that she had requested a visit from Environmental Health. An Environmental Health Officer from Darlington Borough Council had visited Middleton Lodge on 7 June 2011. We saw a report which stated that 2 legal requirements relating to Food Safety Act 1990, EC Regulation 852/2004, Food Hygiene (England) Regulations 2006 and Food Labelling Regulations 1996 had been contravened; and that these had also been previously contravened at an earlier inspection on 12 June 2009.

Because of the serious concerns identified by compliance inspectors regarding Cleanliness and infection control at Middleton Lodge, CQC issued safeguarding alerts to Darlington Borough Council's Adult Protection Team.

Our judgement
The provider did not comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance and failed to ensure that there were effective arrangements for the appropriate cleaning and decontamination of equipment.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not talk to people about this outcome.

Other evidence
We looked at the MARs for 9 service users dated week beginning 18 June 2011 to 05 July 2011, with the exception of service user, dated 21 May 2011 to 05 July 2011. From these records we saw that there were unexplained gaps on the MARs where the administration of medicines had not been recorded. This meant that it was not possible to determine if the service users had received these medicines, as prescribed, on these dates.

There was inconsistent practice among staff for the recording of 'as and when required' PRN medication. The majority of staff had left the administration record blank, whilst a few staff had on only four occasions used the appropriate non-administration code for one service user. This meant that it was not possible to determine if the service users had been offered, refused or received these medicines, as prescribed, on the dates when no entry had been made.

There was a record of the quantity of controlled drug medicine administered, to service users for variable dose medicines; however, we found that the records for the amount held in storage were not clear. This meant that stock control systems were not robust.

There was no clear system used to record the stock of medicines held in the home for

medicines not supplied as part of the Boot's monitored dosage system. This meant that stock control systems were not robust.

External medication applied by care staff was not always documented as administered, for example gels, and creams, emollient. This meant it was not possible to determine if service users had received their medication as prescribed.

There were gaps on one hand written entry on the MAR sheets, including a second staff signature to verify the medicine details and instructions were correct. This meant that systems to help prevent recording errors were not consistently applied.

We looked at the MARs chart for week beginning 21 May 2011 we were able to ascertain that support staff, from shortly after one service user's admission 16 months ago, and up until 25 June 2011 had been administering Novax 30 penfill injection twice daily. On 5 June 2011, a senior support staff told us that only 1 support worker had been trained by a District Nurse to administer this injection. When we checked the training records for this particular member of staff, we found that there was no record of this training having taken place. We were told that 3 other staff had been shown how to administer the injection by the previous registered manager (who was not qualified to provide such training). This meant that service user was placed at risk by receiving medicine administered to him by staff that were not qualified or trained to do so. Following a safeguarding meeting held on 25 June 2011, from 26 June 2011 the District Nursing Team were administering this medication.

We looked at each support workers individual training records. These records showed that only 2 members of the support staff had been appropriately trained to administer Midazalam. This meant that 2 service users were placed at risk by receiving medicines administered to them by other support staff that were not qualified or trained to do so. They also showed that accredited medication training had lapsed for the majority of staff. There was evidence of some in house training provided by the previous registered manager.
This meant that the medicines in the custody of the home were not handled according to the requirements of the Medicines Act 1968, guidelines from the Royal Pharmaceutical Society and the requirements of the Misuse of Drugs Act 1971.

We looked at the organisations standard staff induction training record. The medication record stated: All medication procedures should be shown and described to the new staff member. This should include how medication is stored, administered, ordered, recorded returned and reporting of wrongful drug administration. Information of how the service tracks ordering of medication from Doctor to the service should be explained. Initially discussion re the topic should be held and then as the induction process develops the new staff member should be shown how this works, (they should shadow an experienced member of staff in these procedures and then they should be shadowed in completing these procedures.) There was no reference to accredited medication training taking place at all, for new staff employed.

Because of the serious concerns identified by compliance inspectors regarding medication practices at Middleton Lodge, CQC issued safeguarding alerts to Darlington Borough Council's Adult Protection Team.

Our judgement

People did not have their medicines administered to them safely, because staff did not have the competency, training and skills needed.
Published guidance about how to use medicines safely were not being followed.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are major concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We did not talk to people about this outcome.

Other evidence
In occupied bedrooms we saw the door frames were damaged; the door latches on the inside of the bedroom doors were broken and there were missing latch parts. This prevented the doors from being opened from the inside. We saw that the keys for the doors were hanging on hooks on the outside of the bedroom door frames. This increased the risk of the service user being locked in their bedrooms.

We saw an electrical light switch that was badly damaged, and these were taped to the wall. This presented a high risk of electrocution to people as they could touch the live wiring inside the exposed light sockets. When we asked the acting manager about the damage to the light switches, she said that it had happened over the previous weekend and that this was a regular occurrence by this particular service user. We asked her how this was to be resolved, she said that the handyman would usually respond within 24 hours to carry out any repairs, but on this occasion this had not taken place because there was only one handyman for all the provider's other locations in the area.

We saw damaged furniture in an occupied bedroom and noted in particular that the wardrobe doors were missing and that damaged door hinges with sharp edges were still in place. These were located at eye level and posed a risk of injury to people. The paintwork was damaged and scuffed in several areas and there were holes in the plaster walls around the door frame. The room was very sparse, there was little evidence of the existence of the service user's personal belongings, and the wardrobe

contained only a few items of clothing.

In an occupied bedroom we saw that in the en-suite bathroom that the tap handles had been removed. Therefore the service user was unable to use this facility. We also saw that the radiator was damaged and was held together with tape. There were areas of damaged and scuffed paintwork and the plaster walls were broken around the door frame. The floor covering was of linoleum and there was a mattress on the floor, rather than a bed. There was no other furniture in the bedroom; the room appeared sparse and unlived in. The window in the room had no curtains or blinds, and an opaque film had been applied to the glass in the window frame. This restricted natural light coming into the bedroom and the service user's ability to look out of the window.

In the ground floor bathroom we saw significant growth of mould around the bath, shower tray and walls and noted that the vinyl flooring was stained in places. This posed a potential health hazard.
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In the main kitchen we saw dirty laundry (tabards) stored in the food preparation area. The oven was dirty, badly stained with remnants of food and grease. The nearby kitchen units were dirty with grime and splashes of grease from the oven.

Because of the serious concerns identified by compliance inspectors regarding Safety and suitability of Premises at Middleton Lodge, CQC issued safeguarding alerts to Darlington Borough Council's Adult Protection Team.

Our judgement
People who use services and people who work and visit the home were not protected against the risks of unsafe or unsuitable premises because the building was not adequately maintained.

Outcome 14:
Supporting staff

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 competent staff.

What we found

Our judgement

There are major concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not talk to people about this outcome.

Other evidence
We looked at the staff training records, we could find little evidence that staff had received appropriate support in relation to their responsibilities to enable them to deliver care and treatment to service users safely when administering medication, keeping and maintaining accurate up to date care records, maintaining nutritional records, and identifying risks, and how these would be managed and reviewed.

The acting manager, said that she intended to re-assess the needs of each member of staff, using the skills of other professionals involved in their care. With the support from these professionals, then plan the delivery of care, treatment and support so that each service user would be safe and their welfare fully protected. The care records would then clearly state how each person's needs would be met, reviewed and evaluated by support staff. She said that staff would receive all the support and training necessary to ensure that the service users experienced effective care, treatment and support that would meet their needs. Policies and procedures would also be reviewed to ensure that they were in line with current legislation and best practice.

The acting manager provided evidence that accredited medication training had been arranged for all staff on 19 July 2011. Additional medication training on the use of midazalam (rescue medication) had also been arranged as had safeguarding adults and mental health awareness training

Our judgement
Staff were not fully supported or trained to ensure that service users personalised care, treatment and support needs were properly implemented.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Service users holistic needs were not identified appropriately. This meant that staff did not have the information necessary to meet the needs of the service users.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff were not adequately trained to meet the holistic need of the service users,	

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

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

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

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

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

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	Service users at risk - concerns identified		11 August 2011

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	Concerns identified - placing service users at risk		11 August 2011

Enforcement action taken
Warning notice This action has been taken in relation to:

Regulated activity	Regulation or section of the Act	Outcome	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	Concerns identified- placing service users at risk		11 August 2011

Enforcement action taken

Warning notice

This action has been taken in relation to:

Regulated activity	Regulation or section of the Act	Outcome	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	Concerns identified-placing service users at risk		11 August 2011

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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