Review of compliance

Sussex Housing & Care (SHC) Woodlands	
Region:	South East
Location address:	Beacon Road Crowborough East Sussex TN6 1UD
Type of service:	Care home service without nursing
Date of Publication:	August 2012
Overview of the service:	Woodlands is registered to provide accommodation and personal care for a maximum of 38 older people. The home is a two storey detached property located in Crowborough. Bedrooms provide ensuite facilities and people living at the home have access to a range of internal and external communal spaces.

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

Our current overall judgement

Woodlands was not meeting one or more essential standards. Action is needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 14 - Supporting workers

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 23 July 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us that they liked living at Woodlands and that it was a they felt "safe" and "well looked after". People said that staff treated them with respect and kindness. Two people told us that they thought the home could benefit from some additional staff on duty as they sometimes had to wait a long time for staff to answer their call bells.

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

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

The provider was not meeting this standard. We judged that this had a moderate impact on the people using the service.

Staffing levels within the home did not reflect the level of care, treatment and support as recorded in the care plans.

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

The provider was not meeting this standard. We judged that this had a moderate impact on the people using the service.

The systems in place for managing medication within the home were not sufficiently robust to protect people against the risks associated with medicines.

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

The provider was meeting this standard.

People were cared for by a team of staff who were appropriately trained and supported to undertake their roles.

Actions we have asked the service to take

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

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

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

Outcome 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

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us that staff were "really attentive" to their needs and "kind and respectful". One person said that they were "treated really well". Two people told us that they thought there may not be enough staff to support the number and needs of the residents as they sometimes had to ait a while when they rang their call bell.

Other evidence
We reviewed the care plans for six people who lived at Woodlands. Three of the care plans viewed stated that these individuals required the support of two care staff. On the basis of the information recorded in the care plans, staffing levels during the day were insufficient. Current staffing levels provided three care staff and one senior staff member across the waking day. This was raised with the manager who stated that individuals required less support than was documented.

Two staff spoken with indicated that staffing levels would benefit from being increased, especially in the morning. We analysed fall records which were highlighted by the Provider themselves as being higher than expected for the service. Data in May and June indicated that 35% of falls were due to an unknown cause, which indicated that staff were not present at the time of occurrence. This information was reflected back to the Provider to investigate as either staffing levels were insufficient or support plans were not accurate and effective.

There was evidence in the care plans that the home had worked appropriately with

other external professionals to provide a holistic approach to care and ensure people's healthcare needs were met. Records of contact with doctors for example were appropriately recorded.

During our visit, people living at the home looked well cared for and feedback from two relatives echoed this view. One relative told us that her mother was looked after by " a good team of staff who are really patient". Both relatives said that the home always kept them fully informed and that they were impressed by the speed at which medical attention was sought when needed.

At the time of our visit, there was a choice of activities for people to participate in and people were observed spending their time as they chose.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on the people using the service.

Staffing levels within the home did not reflect the level of care, treatment and support as recorded in the care plans.

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

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People told us that staff supported them with their medicines and that they had no concerns about the ay in which this was handled.

Other evidence
Prior to the inspection, we received some concerns about the management of medication within the home. As such, we spoke with staff and undertook an inspection of the way medicines were handled at Woodlands.

All staff spoken with confirmed that only senior staff were permitted to manage medication at the home. As such, all senior staff had received appropriate training. A conversation with two staff members however identified that some senior staff requested that junior staff administer medication that they have pre-dispensed. The staff spoken with demonstrated that they were clear that this practice was unsafe, but stated that they had observed other staff had agreed to participate in this activity.

A review of the Medication Administration Records (MAR charts) highlighted a number of errors in the way people had recorded the medicines they administered. There was no designated system for the recording of occasional medication and as such it was not possible to accurately track how often such medicines were administered. Similarly, recording was poor in respect of residents who partially administered there own medicines. The processes for administering inhalers, creams, gels and drops were particularly confusing.

Where prescribed medication stated "give one or two tablets", the majority of staff had not recorded how many tablets had been given and there was no record or care plan to indicate how the decision had been reached.

We identified numerous gaps on the MAR sheets where medicines had not been recorded as administered and in some cases the corresponding tablet was still in the blister pack. There were no records available which stated why these medicines had been omitted and what follow up action had been taken.

The manager stated that the home regularly audited medication within the home. It was our judgment that these audits were not effective.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on the people using the service.

The systems in place for managing medication within the home were not sufficiently robust to protect people against the risks associated with medicines.

Outcome 14:
Supporting workers

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

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
People told us that staff were "lovely", "really good" "very attentive" and "kind and respectful".

Other evidence
We spoke with three members of staff who all told us that they had access to regular training and said that they felt fully equipped to carry out their roles.

We viewed the training records in place for all staff and these evidenced that people undertook both mandatory and service specific training. The home had an appropriate system in place for updating training at regular intervals.

The manager confirmed that there was a system in place for the formal supervision and appraisal of staff. The staff we spoke with confirmed that they received regular supervision and line management support.

The Provider may wish to not that during the inspection process, we identified that some staff did not feel wholly supported in their roles. There was no evidence that this was impacting on the care received by people who lived at the home, but the Provider may wish to investigate these issues further.

Our judgement
The provider was meeting this standard.

People were cared for by a team of staff who were appropriately trained and supported

to undertake their roles.

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.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
Staffing levels within the home did not reflect the level of care, treatment and support as recorded in the care plans.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 09: Management of medicines</td></tr>
<tr><td colspan="2">How the regulation is not being met:

The systems in place for managing medication within the home were not sufficiently robust to protect people against the risks associated with medicines.</td></tr>
</table>

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

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

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

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

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

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

Information for the reader

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