Review of compliance

Gracewell Healthcare Ltd The Pines	
Region:	South East
Location address:	Furze Hill Hove East Sussex BN3 1PA
Type of service:	Care home service with nursing
Date of Publication:	December 2011
Overview of the service:	The Pines provides personal and nursing care for up to 35 older people. It is owned by Gracewell Healthcare Ltd, who took ownership of the home on 03/10/2011. The home is situated in a residential area of Hove, East Sussex, and is within walking distance of the seafront. Accommodation is provided in thirty-five single rooms, all of which have en-suite

	facilities, thirty of these providing en-suite showers. Communal space includes a lounge/conservatory, quiet lounge, dining area and garden.

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

Our current overall judgement

The Pines was not meeting one or more essential standards. Improvements are 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 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

People told us that they were happy living at the home. They described the staff as, "Pleasant" and "Very helpful". They also said that the care was good.

They said that due to staff shortages they sometimes had to wait for long periods of time to get assistance. One person said that the nursing staff were really good, but that they did not know when nurses would come to attend to them.
People told us that they were happy living at the home. They described the staff as, "Pleasant" and "Very helpful". They also said that the care was good.

They said that due to staff shortages they sometimes had to wait for long periods of time to get assistance. One person said that the nursing staff were really good, but that they did not know when nurses would come to attend to them.

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

Outcome 01: People should be treated with respect, involved in discussions about

their care and treatment and able to influence how the service is run

People were involved in the decisions about the care provided and are provided with choices.

Overall, we found that The Pines was meeting this essential standard.

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

Generally people were in receipt of care that was safe and appropriate to their individual needs. However some areas of care planning were incomplete which placed some people at risk of not receiving the appropriate level of care for their individual needs.

Overall, we found that The Pines was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

Staff spoken with demonstrated an awareness of their responsibility towards keeping people safe. However not all staff had received appropriate training to support them in their knowledge and understanding.

Overall, we found that The Pines was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

Staff follow correct infection control procedures. They do however need more guidance as to how to care for people with contagious diseases / infections. Generally the home is kept clean, however staffing shortages meant that this had recently been compromised.

Overall, we found that The Pines was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

Some medication practices carried out at the home are unsafe, putting people at risk. The risk of errors being made is enhanced during busy times of the day or when there is less staff on duty. There is a lack of appropriate monitoring of medication records.

Overall, we found that improvements were needed for this essential standard.

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

Staffing levels are not maintained to meet people's care and support needs.

Overall, we found that improvements were needed for this essential standard.

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

Staff generally receive sufficient training.
However care staff were not provided with regular supervision and did not feel well supported by management.

Overall, we found that improvements were needed for this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The new organisation has started to introduce some better systems to monitor the quality of care provided to people. However within the home there is very little auditing or monitoring of records. This does not provide sufficient safeguards for people who live at the home.

Overall, we found that improvements were needed for this essential standard.

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.

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.

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
In general everyone that we spoke with said that they were supported and helped to do things for themselves. People said that they made their own decisions such as what time to get up or go to bed and what to wear. One person said that they got up and went to bed at a time that suited them. Another person was observed to push themselves in a wheelchair, and told us that this was their choice as they liked to be independent.
The only comment to contradict this was from someone who said that staff had used the hoist to move them the previous day, which they had found very upsetting. This person's notes about moving and handling said that they could be transferred using a Zimmer frame and one member of staff, and did not mention using the hoist.

Other evidence
We looked at people's care notes which demonstrated that they had been able to make choices. For example within the daily notes for one person it stated, "X has chosen to stay in bed as they find this more comfortable". Another entry made shortly after someone had moved in to The Pines stated, "Medicines have not been administered according to resident's wish. The resident does not want to be disturbed so early". The notes also recorded that the person's family had been involved in planning their care, for example through meeting with the kitchen staff about their food preferences. The

use of bed rails had been discussed with the person, and their wishes about resuscitation had been discussed with the GP and were clearly documented. We saw in this person's notes that there was detailed information about their career and life before coming to live in the home.

In response to recent allegations, members of adult social services from Brighton and Hove City Council visited the home in October 2011 and reviewed 16 people's care and support needs. No concerns related to this outcome area arose from that review. A report from adult social services confirmed that people said that they could and did exercise choice with regard to the clothes they chose to wear.

We received information from an anonymous whistleblower on 31/10/2011, who alleged that night care staff had been instructed to help people who lacked capacity to make their own decisions, get up, washed and dressed early in the morning before the day shift came on duty. We did not find any evidence to substantiate this allegation.

We observed that staff started to take people to the dining room from 11.30am onwards. Lunch was served at 12.30pm. People that we talked to said it was a long time to be waiting at table.
Staff reported that the reason for this was that the lift, was small and unless they started early they would not get everyone to the dining room in time for lunch.

Members of staff spoken with provided evidence that they placed a high value on offering and maintaining people's choices. They also said that they used a lot of non verbal cues with those people unable to communicate their needs verbally. However they did report that there was an expectation from some staff to assist people who were unable to make their own decisions, to retire early to bed and help them rise early in the morning. This was to assist staff rather then be of benefit to the individual. Other staff, however, denied doing this and were adamant that they did not do this and that they always provided people with the choice.

Our judgement
People were involved in the decisions about the care provided and are provided with choices.

Overall, we found that The Pines was meeting this essential standard.

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 minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People said that they were happy with the care that they received. A visitor to the home said that they were quite happy with their relative's care, and that the staff were good. Another person said, "They take good care of me" and described the staff as, "Pleasant" and "Very helpful". Another person we spoke to told us that they were very happy living in the home and that the care was good.

Other evidence
During the visit to the home we looked at the care plans and associated information held on file for four people who live at the home. Staff had recently started to revise the care plans with the aim of making them more person centred. We were told that the new provider was supportive of this and keen to see this achieved.

One staff member involved in the revision of the care plans told us that the new personalised format was a significant improvement on the previous plans which had been tick box assessments. At the time of our visit there were five remaining plans to be rewritten in this new format.

Three of the care plans and associated documents such as risk assessments seen had been reviewed and updated on a regular basis. Care plans and associated documents provided us with enough information to demonstrate that health care needs were being met and that people had access to a range of health services. We saw evidence that the home liaised and sought advice promptly for any health care concerns. A report on one person's file from a speech and language therapist stated, "We are confident in the

management by the staff at the Pines who will call us if any concerns or queries arise".

Care plans provided evidence that people's preferences as well as their needs had been taken into account.

The new provider had introduced several new systems and checks that staff had been instructed to carry out. An example of this being that one person with dementia care needs had been assessed as unable to use a call bell to summon staff and was receiving hourly checks throughout the day. Records were seen to demonstrate that this was happening.

We looked at the notes of one person who had moved into the home eight days before our visit. The notes contained a two page summary sheet which contained basic information about how to care for them. The daily records of care were detailed and demonstrated that the person was receiving personalised care in response to their needs.
For one person we saw a risk assessment for pressure ulcers which identified the person to be at high risk. There was a weight chart within the care plan which had not been completed, and no nutritional risk assessment present when the daily care notes recorded that the person had a poor appetite and was not eating well. This person's care plan did not contain instructions on how to manage the delivery of care despite the assessments indicating the were at high risk of developing pressure ulcers and the notes pointing to a likely nutritional problem.
The writing of care plans had been delegated to senior nursing staff. We were told that there had not been time to do the full care plan, and that staff were using the two page summary in the meantime. A staff member said that it could take four hours to do a care plan, and that their time was completely taken up with nursing responsibilities when they were on shift. The staff member had not been allocated any management time to enable them to do the care plan. They told us that meeting people's immediate care needs would always take priority over planning and management tasks, which sometimes were left incomplete.

Another person's care plan stated that they had a history of epilepsy. However there was no risk assessment or instructions as to how this should be managed.

In discussion with one care staff they confirmed that they had access to everyone's care plan and associated records. They said that they monitored and reported any changes in people's care and support needs to the nursing staff who in turn amended the care plan.

Our judgement
Generally people were in receipt of care that was safe and appropriate to their individual needs. However some areas of care planning were incomplete which placed some people at risk of not receiving the appropriate level of care for their individual needs.

Overall, we found that The Pines was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are minor concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We did not receive any specific comments regarding this outcome area, from people living in the Home.

Other evidence
We carried out this visit as a result of concerns raised to us. Recently there have been two safeguarding investigations undertaken by the local authority in relation to concerns raised about the home. The first investigation related to concerns prior to the present provider (Gracewell Healthcare Ltd), taking ownership of the home and was found to be unsubstantiated.

The second investigation was carried out as a result of allegations raised since Gracewell Healthcare Ltd took over the home. All bar one of the issues were found to be unfounded. The proven allegation was concerning neglectful practice connected with medication administration. (See outcome 9).

Staff spoken with knew how to recognise the signs of abuse. They said that they had received relevant training and that they were aware of their responsibility to report any concerns. The manager said that 'safeguarding' training was provided to staff as part of 'managing challenging behaviour' training. Training records for all staff showed that only eight out of 20 care staff had received this training. (For more information regarding staff training see outcome 14)

The home was secure. Visitors to the home were required to sign in and out of the

building and during the day time this was monitored via a receptionist. At other times the entrance to the home was monitored by CCTV.

Our judgement
Staff spoken with demonstrated an awareness of their responsibility towards keeping people safe. However not all staff had received appropriate training to support them in their knowledge and understanding.

Overall, we found that The Pines was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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 minor concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
One person commented that staff hand washing was, 'meticulous'.

Other evidence
One member of staff identified one person as requiring 'barrier nursing' (a method used to care for a person known or thought to be suffering from a contagious disease, to control the risk of cross infection) The person's notes included information about an infection, but the care plan did not give any instructions to staff on how this was to be managed.

Staff were observed to follow correct infection control procedures. When administering medication they used antibacterial gel between attending to one person and going to the next. Liquid soap and paper towels were available in toilets and bathrooms and aprons and gloves were provided for staff use. Training records showed that the majority of staff had received infection control training.

On the day of our visit there were no domestic cleaning staff on duty due to staff absence. This had impacted on the cleanliness within the home. We observed that the home was dirty in some places. Some carpets were stained and had not been recently vacuumed. A member of staff told us that they had recently pulled out an armchair in a bedroom and found that the carpet was mouldy. They said that tables were often sticky.

Our judgement
Staff follow correct infection control procedures. They do however need more guidance as to how to care for people with contagious diseases / infections. Generally the home

is kept clean, however staffing shortages meant that this had recently been compromised.

Overall, we found that The Pines was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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 moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We spoke to one person who said that the nurse who gave medication was very good and commented, "She always tells me what she is doing and watches me take it".

Other evidence
We looked at one person's daily care notes which provided evidence that staff had monitored the impact of a recently prescribed medication. The notes also recorded that pain relief which was available on request had been offered and declined. We saw in this person's notes that a doctor was called first thing in the morning after they had mentioned a minor problem the previous evening.
We saw in people's notes that medication was reviewed by their GP. When new medicines were prescribed, this was recorded in detail in their daily notes and entered in their Medication Administration Record (MAR). We looked at the notes of one person whose medication had recently changed and saw that the medication record in the notes was out of date. However the nurse doing the medication round had a good understanding of all the medication this person was taking and it was all recorded in the MAR chart.
We spoke to the two trained nurses who were working during our visit. Both said that they had received training in medicines management, including recent training in medication administration for people with dementia. They told us that only trained nurses administer medication in the home. The Manager told us that the home had recently contracted a new pharmacy provider due to difficulties with the previous one. Staff told us that training with the new pharmacist was booked for 15/11/2011.

We saw that there were clear processes in place for the safe storage of medication, including controlled drugs. Medication was kept in a locked cupboard, fridge or trolley at all times. We looked at MAR charts for a sample of people, and saw that they reflected the prescribed medication listed in their notes and that administered medication doses had been signed for. MAR charts were clearly labelled and contained a photo of each person.
We observed a medication round, and saw that the nurse administered medication individually, and recorded it on the MAR chart after it had been taken. The nurse talked to people in a kind and friendly way, woke them up gently when required, explained to them what the medication was for and encouraged them to take it. She said that sometimes it could take a long time for people to take their medication, and we observed that she was patient with people. The nurse told us that the method of administering medication reflected people's preferences; we saw that one person's medication was given to them in a small liqueur glass as this was how they liked it.

A recent safeguarding investigation was undertaken by the local authority in relation to concerns raised since the new provider (Gracewell Healthcare Ltd) took over the home. The allegation concerned neglectful practice connected with medication administration. The local authority carried out a visit to the home on 27/10/11 and found that nursing staff were regularly leaving medication with people for them to take themselves without supervision. This was substantiated in discussion with staff and people who live at the home.

One person told the investigators that all of the nurses apart from one left their medication for them to take themselves without supervision or assistance. The person concerned said that they found it hard to take the medication without staff support. Another person was being left to take their medication unobserved at their own request. However the home had not carried out a risk assessment as to the person's ability to self medicate.
During our visit to the home the nurse administering the medication observed each person take their medication.
One member of staff told us that at times medication is left for people to take themselves without supervision. They said that this can happen when there is only one nurse on duty and they are interrupted when doing the medication round. The member of staff said that on four days a week, there is only one trained nurse on shift during the evening medication round, and that if there is a more urgent demand on their time then medication may be left out for people. The Manager said that she had ordered red tabards to be worn by nursing staff when doing the medication round. This would alert staff and visitors that the Nurse should not be interupted at this time.
In the period between our visit, 01/11/2011 and issuing this report we have received a notification from the home to inform us of a medication error. On 07/11/11 the manager was informed that an error had been discovered with stock balances of a controlled medication. This had happened as a result of the wrong dosage being administered to an individual on the night shift morning of 04/11/11.The person responsible said that it had been a busy part of the morning.

Our judgement
Some medication practices carried out at the home are unsafe, putting people at risk. The risk of errors being made is enhanced during busy times of the day or when there is less staff on duty. There is a lack of appropriate monitoring of medication records.

Overall, we found that improvements were needed for this essential standard.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One person told us that they were often short-staffed at the home. They said they needed help to stand up but didn't always get it.
During our visit to the home, we observed a call bell in a bedroom ringing for several minutes; a member of staff went to assist the person and closed the door while doing this. Half an hour later, we spoke to this person about their care, and they told us that they were cold and wanted to get into bed so they could be warm with a blanket (the person was sitting in a chair with no blanket). They said that they had called for assistance earlier and a member of staff had come, but that they needed two staff members to assist them into bed as they were not very mobile that day. The staff member had said they would have to wait and had left and not returned. We informed the manager about this person's needs, and when we returned later on they were comfortable in bed.

The same person told us that they had spent two hours in the chair the previous day wanting to move. They said that they had to wait until the nurse came to give them medication to get any help. They said that they were often cold but that staff told them that their room was the warmest room in the house. This person told us that the nursing staff were really good, but that they did not know when nurses would come to attend to them.

Overall people spoken with were happy with the attitude of the staff.

Other evidence

We looked at the staff rota for the period dated 23/10/11 to 30/10/11. A concern had been raised to us alleging that on certain dates within that period the home had been short staffed impacting on the level of care that people received. It was alleged that during one night shift they had been understaffed and that people requiring assistance to get to bed were most effected as they could not go to time bed at a time of their choice, as there were insufficient staff to support them. We were told that staff were unable to finish getting people to bed until 11:30 pm and that some people were asleep in their chairs waiting to be assisted to retire.

Examination of the rota showed that they had worked with one staff member less on that date during the night shift. Further examination of the staff rota for the period 23/10/11 to 30/10/11 showed that a total of 7 shifts had worked with less than the usual amount of staff.

In discussion some staff said that the manager had informed them that they could no longer use agency staff due to the cost involved. In the period that we looked at on the rota, agency staff had only been used on one occasion.

The manager told us that there had been an unexpected shortage of staff the previous week. The manager had been asked to limit the use of agency staff. A new protocol had been introduced whereby the manager had to ask the regional director's permission before booking agency staff. In discussion with the manager and regional director we were told that no requests for additional staff had been refused and that in an emergency situation the manager could book agency staff without prior discussion with the regional director. They also said that they were trying to recruit three more members of staff.

On the day of our visit there were no domestic cleaning staff on duty and this had impacted on the cleanliness within the home
(See outcome 8).

Discussions and observations of staff showed that they were caring and knowledgeable towards the people that they were caring for. One person said that it was a nice place to work and that the people living there were happy.

Our judgement
Staffing levels are not maintained to meet people's care and support needs.

Overall, we found that improvements were needed for this essential standard.

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 moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not receive any comments regarding this outcome area, from people living in the home.

Other evidence
From our discussions with staff and through direct observations during our visit, it was clear that morale, amongst the staff, was low.

In discussion with staff they said that they did not receive regular supervision. One person said that they did not always feel supported by management. Another said that they had not had supervision since about March or April but felt supported by colleagues.
We asked the manager when people had last received supervision. All nursing staff had received supervision within the last week. However the manager did not know when care staff were last supervised. In discussion we ascertained that the majority of care staff had not received supervision for approximately 6 months, unless there had been a specific issue that needed addressing. The manager had delegated the responsibility of supervising care staff to senior nursing staff. In discussion with one nurse delegated to supervise care staff they said that there had not been time to carry out supervisions. They said that they were not given time off from their nursing duties to do so.

All staff spoken with were of the opinion that they received sufficient training to meet the needs of the people that they cared for. This was supported through examination of training records, with the exception of safeguarding training as discussed in outcome 7.

The new organisation had introduced a training matrix, and was monitoring staff training. They had recently cancelled several courses and there were plans to introduce training through the use of DVD's and written assessments.

Our judgement
Staff generally receive sufficient training.
However care staff were not provided with regular supervision and did not feel well supported by management.

Overall, we found that improvements were needed for this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not receive any comments regarding this outcome area, from people living in the home.

Other evidence
We saw that there was a comments book in the dining room for feedback about the quality of the food. In the last three months there had been nine positive and six negative comments about the food. We also saw a completed catering questionnaire, which staff told us would influence the new menu which was to be developed.
We asked staff how they monitor the quality of care. Staff told us that they often get ad hoc feedback from people while they are doing their job, and that there are resident's' meetings where issues can be discussed. The manager told us that there is an internal audit programme which involves a number of tick lists, for example on the environment, personal care, laundry. She said that the new provider will be doing a questionnaire for people who live at the home and their families. She gave us a copy of a quality review done by the local authority in July, which listed a number of actions to be taken by the home; most of these were recorded as completed.
The deputy manager told us that an audit of care plans had recently been undertaken. We saw that five areas for improvement had been identified, and that these were being incorporated into the new care plans which were being developed. We saw evidence of changes being implemented, for example people's notes contained a summary of 'activities of daily living' at the front.
We reviewed the complaints book, which listed seven complaints in the last year. The complaints had all been investigated and lessons had been identified and acted upon.

The records of the complaint follow up demonstrated that the person concerned and their family had been involved in the investigation and resolution of the complaint, and that they had received apologies where appropriate.

Gracewell Healthcare Ltd only took over the ownership of this home on 03/10/11. In this short period they had started to review, assess and make improvements to systems used at the home. However evidence presented throughout this report has demonstrated that the current systems to monitor quality within the home are lacking in several areas such as some aspects of care planning, safeguarding training, cleanliness, medication administration, staffing levels in relation to people's support needs and staff supervision.

Our judgement
The new organisation has started to introduce some better systems to monitor the quality of care provided to people. However within the home there is very little auditing or monitoring of records. This does not provide sufficient safeguards for people who live at the home.

Overall, we found that improvements were needed for this essential standard.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

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
	Why we have concerns: Some areas of care planning are incomplete which place people at risk of not receiving the appropriate level of care for their individual needs.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Some areas of care planning are incomplete which place people at risk of not receiving the appropriate level of care for their individual needs.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: Some areas of care planning are incomplete which place people at risk of not receiving the appropriate level of care for their individual needs.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Not all staff have received appropriate training to	

	support them in their knowledge and understanding of safeguarding,	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Not all staff have received appropriate training to support them in their knowledge and understanding of safeguarding,	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Not all staff have received appropriate training to support them in their knowledge and understanding of safeguarding,	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	Why we have concerns: Staff need more guidance as to how to care for people with contagious diseases / infections. Cleanliness in the home is compromised by staffing shortages.	
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	Why we have concerns: Staff need more guidance as to how to care for people with contagious diseases / infections. Cleanliness in the home is compromised by staffing shortages.	
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control

	Why we have concerns: Staff need more guidance as to how to care for people with contagious diseases / infections. Cleanliness in the home is compromised by staffing shortages.

The provider must send CQC a report about how they are going to maintain 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.

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

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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Some medication practices carried out at the home are unsafe, putting people at risk. The risk of errors being made is enhanced during busy times of the day or when there is less staff on duty. There is a lack of appropriate monitoring of medication records.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Some medication practices carried out at the home are unsafe, putting people at risk. The risk of errors being made is enhanced during busy times of the day or when there is less staff on duty. There is a lack of appropriate monitoring of medication records.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Some medication practices carried out at the home are unsafe, putting people at risk. The risk of errors being made is enhanced during busy times of the day or when there is less staff on duty. There is a lack of appropriate monitoring of medication records.	

Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Staffing levels are not maintained to meet people's care and support needs.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Staffing levels are not maintained to meet people's care and support needs.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Staffing levels are not maintained to meet people's care and support needs.	
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: Care staff are not provided with regular supervision and do not feel well supported by management.	
Diagnostic and screening procedures	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Care staff are not provided with regular supervision and do not feel well supported by management.	

Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Care staff are not provided with regular supervision and do not feel well supported by management.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: Within the home there is very little auditing or monitoring of records. This does not provide sufficient safeguards for people who live at the home.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: Within the home there is very little auditing or monitoring of records. This does not provide sufficient safeguards for people who live at the home.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: Within the home there is very little auditing or monitoring of records. This does not provide sufficient safeguards for people who live at the home.	

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.

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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