Review of compliance

Barchester Healthcare Homes Limited Washington Grange	
Region:	North East
Location address:	Burnhope Road Barmston Washington Tyne and Wear NE38 8HZ
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Washington Grange is a 40 bed care home. The service is registered with the Care Quality Commission for the regulated activities of accommodation for persons who require nursing or personal care and the treatment of disease, disorder or injury. The service provides personal care only to older people with mental health and general care needs.

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

Our current overall judgement

Washington Grange 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

How we carried out this review

We reviewed all the information we hold about this provider, 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

We met with over half of the people living at the service most of who had varying degrees of dementia. We spoke with six of the people who were up and dressed at 6.00am and found that several did not know what time it was. Several were unhappy and voiced their dissatisfaction. Their comments included; "I like to get up about 8 o'clock", "I'm fed up and cold, what time is it?", "I think I got up at 5am when the staff came in, I have had a wash" and "I didn't want to get up".

What we found about the standards we reviewed and how well Washington Grange 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 using the service were not treated with respect. Their views or the views of those who could represent them were not sought or acted upon to enable people to exercise choice and influence the delivery of their care.

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

Care planning, risk management and the delivery of care were inconsistent and did not

demonstrate that people using the service received continuity of care, safe intervention or planned support.

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

We found that people using the service were not protected from abuse or the risk of abuse.

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

We found that people using the service were not protected against the risk of fire.

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

We found there were insufficient numbers of staff to meet the needs of people using the service and ensure their safety.

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. 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 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

There are major concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We had received information from an anonymous source alleging that people suffering from dementia were being woken, taken out of bed and then washed and dressed from 4.00am onwards irrespective of their wishes or care needs. Due to their mental health problems these people were unable to protest and the informant stated "even if they did they would have no option anyway".

We found that at least 15 people were up, washed and dressed when we arrived just before 6.00am. Most were fast asleep in armchairs in either their bedroom or the lounge and reception areas. Everyone we met with had some degree of dementia but several were able to talk to us. Comments included; "I like to get up about 8 o'clock", "I'm fed up and cold, what time is it?", "I think I got up at 5am when the staff came in, I have had a wash" and "It's too early for me and I haven't had a wash. I like to get up when I'm not tired. I didn't want to get up".

The three night staff confirmed that they had been getting people up since before 5.00am. They told us about several people who did not go to bed at all and who slept in chairs either in their rooms or communal lounges. This was confirmed from these people's care records.

We asked the night staff and staff who came on duty at 8.00am why people were being got up, washed and dressed so early. Staff responses included; "The only ones who are up are those who were wet and awake", "They get them up, washed and dressed if they are wet", "I got her up, washed and dressed at 5am", "That's how it's always been, some people like to get up and they can tell us if they don't want to.

Other evidence
We looked at individual care records for five people who were up and fully dressed when we arrived at the service. We saw that 'sleep' care plans were in place and that some specified individual preferences about rising and retiring. However the recorded information did not correspond with what we found and the actual care being delivered.

For example an entry which stated; "Has problems with sleeping and will often ask for a lie-in in the morning". We found that this person had been up, washed and dressed since before 5am and their daily progress records indicated that they were always up and dressed before the day shift commenced. In another example the sleep care plan stated "sleeps in her bedroom chair with a blanket on her". We found that this person was fast asleep in an armchair in the lounge. A care worker told us "this person sleeps in here where we can see them".

Most of the people we met with were suffering with dementia and were unable to tell us about how and when they got up or how they were cared for. We saw no evidence of discussions with relatives to establish preferences where people were unable to speak for themselves.

However, even when staff had recorded individual preferences and choices and when people were clearly telling us that they didn't want to be up and dressed, we found that staff had failed to respect those individual choices and requests.

The night staff confirmed that they were following established routines which prevented them from respecting individual's human rights and diverse needs. We did observe, although the night staff were under pressure, that they were kind, gentle and patient when dealing with people.

Our judgement
People using the service were not treated with respect. Their views or the views of those who could represent them were not sought or acted upon to enable people to exercise choice and influence the delivery of their care.

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
The majority of people using the service had dementia. Some were unable to communicate with us due to their medical conditions and others were asleep.

We saw that some people had evidence of injuries and the staff told us that these people had regular falls. One person had been found on the floor in their ground floor room just after midnight.

The night staff gave out cups of tea and plain biscuits. Saucers and plates were not used and cups and biscuits were place directly onto bedside and lounge tables.

We had received information from an anonymous source alleging that someone had not received prompt attention when they had become unwell in July 2011. We examined this person's records and found that the specific details which had been raised with us appeared to be substantiated and that the home's records to do with this matter were inadequately detailed. This matter has been referred to the Sunderland City Council Safeguarding Adults team and is under further investigation.

Other evidence
We examined accident records for the past three months. We found there were no records available for July 2011. We saw that 19 accidents had been recorded for June 2011, seven of which were un-witnessed and had occurred overnight. Thirteen accidents had been recorded for August 2011, six of which had been un-witnessed and had occurred overnight. We saw that six accidents had been recorded so far for

September 2011, three of which were un-witnessed and had occurred over night. The accident report for the un-witnessed fall which had occurred that night had not yet been added to this list.

We saw that accident records were inadequately detailed. For example where accidents had been un-witnessed there was no detail of the time the person was last seen. There was insufficient detail of what had occurred, what people had told the staff, specific detail of how and where people had been found and the extent of their injuries.

We examined care records for five people who were up, washed and dressed when we arrived at the service. We found a variance in the content and quality of recording. For example, some care plans were person centred and comprehensive about care needs and how care was to be delivered. Others were less specific and we found omissions and inaccuracies. We found that key information about people's conditions had not been recorded and examples where people had not received appropriate intervention when their care needs had changed.

For example one person's care plans had been rewritten in May 2011. These included a range of care needs such as communication, hygiene, mobility and dexterity, nutrition and sleep. We found that none of these care plans had been evaluated and reviewed since they had been written in May. The deputy manager told us that all care plans were evaluated monthly and could not explain this omission.

We saw that this person's body weight records detailed a recent weight loss of almost 3kgs in 20 days. However there was no additional information about this observation anywhere within this person's records. The senior day staff knew nothing about this when we brought it to their attention.

Four, un-witnessed falls were recorded within the September 2011 daily progress notes for this person who we saw had superficial head injuries. The night care worker told us that this person slept badly and made regular trips to the toilet. However there was no evidence that this person's condition, their symptoms or recent serious incidents had been further investigated, risk assessed or acted upon.

Another person, who was frail and required full assistance from two people, was asleep in an armchair in the ground floor lounge. A night care worker told us this was because this person had recently fallen and was at risk of falling out of their chair when unobserved. However we saw that accident reports for this person detailed two recent un-witnessed falls from armchairs while the person had been in the lounge.

This person was fully dressed at 6.00am and the staff were unable to provide information about when they were routinely washed, bathed and dressed. An in-house bathing record indicated that this person had last received a bath on 1 August 2011. The day staff told us that bathing records were not up to date.

We found information about another person within a staff handover file which stated that they had a "sore bottom". However the night care worker told us that she knew nothing about the condition of this person's skin. When we examined this person's daily progress notes and skin integrity care plan we found that there was no information regarding this person's sore skin. The most recent care plan review entry stated "has no tissue viability".

All of our observations in relation to individual people and their care delivery have been shared with the Sunderland City Council Safeguarding Adults team.

A senior night care worker told us that her duties included a morning medicines round on the top floor. We observed her giving medicines to some people who were laid on their backs in bed which posed a potential swallowing and choking risk.

All three night staff and staff who came on day duty were wearing various items of jewellery such as chunky watches, rings with stones and raised edges and hoop earrings. This posed a risk of injury to people's skin and meant that staff were unable to wash and dry their hands thoroughly.

Our judgement
Care planning, risk management and the delivery of care were inconsistent and did not demonstrate that people using the service received continuity of care, safe intervention or planned support.

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 major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We had received information from an anonymous source which raised various concerns over people who were using the service. In particular whether they were being protected from abuse and whether their human rights were being respected and upheld. We have passed this information to Sunderland City Council Safeguarding Adults team who are also looking into the matter.

We spoke with people who were up and fully dressed when we arrived at the service. Several confirmed that they had been got up against their wishes and expressed their dissatisfaction. One person complained about a member of staff and their attitude towards them.
Comments included; "I'm fed up and cold, what time is it?", "they came and got me up and stripped my bed", "It's too early for me and I haven't had a wash. I like to get up when I'm not tired", "I daren't tell you about their attitude".

Other evidence
We identified several issues of concern where people's safety and welfare was compromised. We confirmed that people who were suffering from dementia were being got up from before 5.00am, washed and dressed and placed in armchairs.

We found evidence of poor and ill informed staff practice and inadequate care delivery which had compromised people's safety and wellbeing. For example, the standard of record keeping, examples of shortfalls in individual care delivery, the incidence of un-witnessed accidents and inadequate accident records.

Our observations have been shared with the Sunderland City Council Safeguarding Adults team.

Our judgement
We found that people using the service were not protected from abuse or the risk of abuse.

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 moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We did not speak with people using the service about the premises. However we found conditions which compromised their safety and comfort.

Other evidence
We did not examine the premises in detail but made observations as we toured the building to meet with people using the service.

At 6.50am we found that the entrance door to the ground floor laundry area was wide open and held in position with a wooden wedge. This high fire risk area was located on a bedroom corridor and was directly opposite two occupied bedrooms.

The main ground floor kitchen door was open by several inches and we could not get the door to stay closed. The kitchen was located on a bedroom corridor and was directly opposite an occupied bedroom.

A worn and damaged 'Permapad' cushion was in place on an armchair in the ground floor lounge. We saw that some armchair cushions in this room were split at the back and that the inner cushion and plastic covering were exposed.

Several windows around the home were obscured with condensation between the glass layers.

Our judgement
We found that people using the service were not protected against the risk of fire.

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 major concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We had received information from an anonymous source alleging that three care workers worked overnight in a service where 40 people, many of whom have dementia, were accommodated.

We found that three staff were on duty for 37 people who were living at the home and observed that staff were under pressure to complete their work. When we talked to people using the service they were unaware of how many staff were on duty.

We saw a care worker struggling to assist someone to get up out of bed. This person, who received continuous oxygen, told us they did their best to help but it was hard with only one 'helper'.

Other evidence
A senior care worker was in charge of the night shift. She worked upstairs with another care worker and a third care worker worked alone on the ground floor. All three staff were experienced and had worked on night duty at the service for several years. Information within their individual training records indicated that they were up to date with training in fire safety and first aid.

We asked all of the night staff and the senior day staff whether they thought that three night staff were sufficient for the current occupancy of 37 elderly people. Their responses included; "It's hard with only three staff; I work upstairs with another carer and the other carer works alone downstairs and rings me when she needs help. We

start on shift at 10pm when most people are already in bed. I have to do the morning medicines on the first floor which takes quite a while", "there are not enough staff on duty", "I'm not aware of any problem at night, they cope".

A night care worker described how she worked alone with 19 people using the service on the ground floor. She did not carry a mobile phone and had to go to reception to use the phone to call for assistance from upstairs or would ring the emergency bell within peoples' bedrooms.

The night care workers described the amount and extent of non care duties which they had to complete as part of their shift. The list included:
: Laundry duties including washing, drying and ironing.
: Washing of carpets and armchairs with steam type cleaners usually twice a week.
: Setting the dining tables for breakfast.
: Hoovering of the reception areas.
: Cleaning of bathrooms and WCs.

We identified that the daytime domestic staff and laundry staff only worked in the mornings and there was no cover after 2.00pm

Our judgement
We found there were insufficient numbers of staff to meet the needs of people using the service and ensure their safety.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People using the service were not treated with respect. Their views or the views of those who could represent them were not sought or acted upon to enable people to exercise choice and influence the delivery of their care.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: People using the service were not treated with respect. Their views or the views of those who could represent them were not sought or acted upon to enable people to exercise choice and influence the delivery of their care.	
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: Care planning, risk management and the delivery of care were inconsistent and did not demonstrate that people using the service	

	received continuity of care, safe intervention or planned support.	
Treatment of disease, disorder or injury	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: Care planning, risk management and the delivery of care were inconsistent and did not demonstrate that people using the service received continuity of care, safe intervention or planned support.	
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
	How the regulation is not being met: We found that people using the service were not protected from abuse or the risk of abuse	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: We found that people using the service were not protected from abuse or the risk of abuse	
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 is not being met: We found that people using the service were not protected against the risk of fire.	
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met:	

	We found that people using the service were not protected against the risk of fire.	
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: We found there were insufficient numbers of staff to meet the needs of people using the service and ensure their safety.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: We found there were insufficient numbers of staff to meet the needs of people using the service and ensure their safety.	

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.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
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