Review of compliance

Alpha Care Homes Wayside Care Home	
Region:	West Midlands
Location address:	25 New Road Bromsgrove Worcestershire B60 2JQ
Type of service:	Care home service with nursing
Date of Publication:	August 2011
Overview of the service:	Wayside Care Home is registered to provide both nursing and personal care for a maximum of the 30 people.

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

Our current overall judgement

Wayside Care Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 07 - Safeguarding people who use services from abuse
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, carried out a visit on 23 June 2011, checked the provider's records, 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

People who use the service told us they were happy with the care and treatment they were receiving. They said "the staff are caring and competent". They also said the food was very good and they were given choices about what they wanted to eat, "sadly they bought me a cold cup of tea this morning but as soon as I pointed this out to them it was changed".

People said they liked living in the home and liked the way the home supported their ongoing relationships with family and friends. One person told us "we can go out to the pub for a lunch, there's trips out too I like but mostly I like it when my wife visits".

What we found about the standards we reviewed and how well Wayside Care Home 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 who use the service are not always treated with respect. This will need to be improved upon.

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

People using this service experience care, treatment and support that meets their needs.

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

People who use the service are protected from abuse, or the risk of abuse. Staff have the training and understanding to make sure abuse is reported appropriately.

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

People who use the service can be assured there are systems in place to ensure the continuous assessment and monitoring of the service provision.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 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

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
People told us the staff are very kind to them. They said "the carers are very good and they help me with my care when I need it".

Other people told us "the staff always ask me what I need and if I am happy", and "you do get choices about when you want to get up and go to bed, most of the time this happens".

One person told us "I'm a feeder, I don't like being called that but I put up with it".

(a "feeder" is label given to a person who needs assistance to eat and drink).

Other people told us the care workers and nurses talk to them about their care and involve them in decisions about this. They said "I like to go to bed in the afternoon for a lie down, this is my choice".

There are visitors throughout the day and those who want to are able to eat a meal with their relative.

Other evidence

We were contacted by an anonymous source who told us people did not have a choice about when they got up, when they went to bed or what food they would like to eat.

We spoke with the manager about these concerns. We wanted to know what systems were in place in order to give people a choice about their care and the opportunity to participate in their treatment. The manager told us people have the choice about getting up in the morning, stating "many people like to have breakfast in bed, we accommodate wherever we can".

On the day we visited we saw a number of people were still in bed and they told us they had chosen to have a lie in.

We spoke with a carer who told us the care workers were very attentive and they could recall several occasions where choices had been offered to their mother. They also told us the care workers keep them informed of changes in their relative's condition.

We observed throughout the day and saw that care workers were attentive to the people living in the home. They paid attention to privacy and dignity. This was demonstrated in one example by care workers knocking on a persons bedroom door before entering.

Our judgement
People who use the service are not always treated with respect. This will need to be improved upon.

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

Our findings

What people who use the service experienced and told us
People told us "I have a bath once a week, I'd like it more than that but once is fine" and "when the carers get me washed in the morning I don't feel like they are rushing me".

A visitor told us "my relative fell over and banged their head, the home was very quick to get them the medical attention they needed".
Another person commented "nothing seems to be too much trouble although at times the staff do seem to be thin on the ground, I don't worry though".

Other evidence
The care records showed that people and their representatives are involved in the planning and review of their care. We saw that visits and contact with health care professionals were not always written in care records. The home needs to improve upon its recording of information. People who were able to speak with us told us they are kept updated with any changes made as a result of these visits.

We spoke with three staff who demonstrated they had a clear understanding of the care and support people need and this knowledge was reflected in the information in people's care records. For example, care workers told us one person has trouble with moving and handling and cannot get in and out of a chair without help. They told us they have to use specialist equipment to help them do this. When we were observing people's care we saw care workers moving this person with the appropriate lifting equipment. The person appeared relaxed and comfortable with how the care workers had assisted them. All of this information was recorded in the persons care records.

We observed people being supported during lunchtime. People who needed support with eating their food were provided with assistance in a sensitive and dignified way. Throughout the day we saw people being offered drinks and snacks, such as fresh fruit. Care records showed that people have their weight measured which enables staff to monitor weight loss or gain. The home must make sure that this is done on a regular basis as there were some gaps in recording this information. The home also completes risk assessments that indicate which people may be at risk of malnutrition. The completion of these risk assessments enables the home to take action promptly thereby reducing the risk to the people living there.

We looked at three medication administration charts. These charts showed the medication people need and at the times they need it. Staff had signed on the charts when the medication had been given. There were recently concerns raised about medication not being given as prescribed but we did not find evidence of this during our visit. The home has an electronic medication system which will not allow staff to administer medication when it has not been prescribed or be given at the wrong times.

Our judgement
People using this service experience care, treatment and support that meets their needs.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us "if I was unhappy or worried about anything I would tell the staff".

Other evidence
As part of this review we looked at the information we hold on this provider. We have been made aware of two safeguarding referrals in the last two months. The referrals to the safeguarding team centred on people's care and treatment. One referral was about the possible incorrect administration of medication and the other referred to the possibility of delays in care and treatment to a person following a fall. Both of these issues were investigated by the local authority safeguarding team and both issues were found to be "not proven". This means there was no evidence to demonstrate the home had failed to protect the people using the service by giving inappropriate care.

We spoke to six members of staff during our visit. All but one of the staff we spoke to told us they had taken part in training that showed them what abuse was and how to recognise the signs. They all told us they would feel confident reporting any allegation of abuse and knew how to do this. One member of staff gave us an example of where this had happened. They told us they recognised inappropriate care practices and had used the home's whistle bowing policy to report the concerns confidentially. The concerns were investigated and the practices were stopped.

We also spoke with the manager who was able to demonstrate the action she would take if she suspected abuse had taken place or an allegation had been made.

The home has policies in place that offer additional guidance to staff about dealing with safeguarding and abuse.

We looked at the training records the home holds for staff and we could see that most of the staff had taken part in safeguarding vulnerable adults training.

Our judgement
People who use the service are protected from abuse, or the risk of abuse. Staff have the training and understanding to make sure abuse is reported appropriately.

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

The provider is compliant 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 speak with people directly about the assessment and monitoring the quality of service provision.

Other evidence
We asked the provider to send us information about how they assess and monitor the quality of the service they provide. We call this a Provider Compliance Assessment (PCA).

The PCA shows there are systems in place to gather information about the safety and quality of the service. This includes regular audits, looking at information from complaints and compliments and other professional bodies. There are systems in place for the recording of adverse events, incident and near misses. This sort of information gathering enables them to see areas of development where there is a risk of non compliance and to be able to address this.

We also spoke to the manager during out visit about how quality and standards are reviewed in the best interests of the people using the service. The manager told us there have been changes in the service provision. People are given more choice about how they live their lives, in terms of getting up and going to bed, going out on visits and changes to the menu. These changes have taken place following consultation with the people living in the home. There is a home meeting each month and people are encouraged to share their views and their ideas for change. The minutes for these meetings are placed on the notice board for people to read. The home then produces

an action plan for the coming month of the work they intend to undertake.

Our judgement
People who use the service can be assured there are systems in place to ensure the continuous assessment and monitoring of the service provision.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People who use the service are not always treated with respect. This will need to be improved upon.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People who use the service are not always treated with respect. This will need to be improved upon.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People who use the service are not always treated with respect. This will need to be improved upon.	

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 within 28 days of this report being received.

CQC should be informed in writing when these improvement 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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