Review of compliance

Hamra Associates Limited **Cana Gardens Residential Home**	
Region:	East Midlands
Location address:	174 Scraptoft Lane Leicester LE5 1HX
Type of service:	CHS – Care home services without nursing
Publication date:	June 2011
Overview of the service:	Cana Gardens Residential Home is a service providing support for up to 8 adults under the following regulated activity:- Accommodation for persons who require nursing or personal care. The service supports people with a learning disability.

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

What we found overall

We found that Cana Gardens was not meeting one or more essential standards. Improvements were needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews and considered the following outcomes:-

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- 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 6 June 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

One person told us "I'm going on a climbing holiday in South Wales with staff." We asked them if they were happy living at Cana Gardens and they said "It's somewhere to live and you have to be positive in life." We asked them how they spent their time and they told us "I've been in hospital as I wasn't well but I'm better now. I go to Mountsorrel day centre and I enjoy playing snooker."

Staff we spoke with and records we viewed showed that people have access to a range of community activities, which included going to church, swimming, visiting public houses, eating out and going for walks.

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

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
Care plans do not comprehensively provide information as to the support and care people need which has the potential to impact on the care people receive. The service does not always respond promptly to the recommendations agreed with professionals.

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

Outcome 7: People should be protected from abuse and staff should respect their human rights
Staff have received training and are aware of how to safeguard adults who are at risk. Staff awareness of mental capacity and the rights of people isn't clearly understood.

- Overall, we found that Cana Gardens was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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 service does not have a continuous quality improvement system in place to monitor and improve the service it provides.

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

Action 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.

Other information

None

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 4:
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 moderate concerns

with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

One person told us “I’m going on a climbing holiday in South Wales with staff.” We asked them if they were happy living at Cana Gardens they said “It’s somewhere to live and you have to be positive in life.” We asked them how they spent their time and they told us “I’ve been in hospital as I wasn’t well but I’m better now. I go to Mountsorrel day centre and I enjoy playing snooker.”

We looked at the care plans and records for two people. Risk assessments were in place to support care plans. People centred plans were in use however they were not dated and were not comprehensive and therefore we were unable to ascertain whether the person had achieved any of their goals or aspirations. Training records showed that a majority of staff have not received training in person centred care.

The records for one person showed that a review involving health and social care professionals had recently taken place due to ongoing concerns about an increase in challenging behaviour displayed by the person and disturbed sleep patterns. The review had made three recommendations for the service to follow up of which one had not been acted upon. We asked the manager as to why one of the actions had not been followed. They told us that they had spoken with the owner of Cana Gardens but were waiting for them to take action. A delay in responding to the

request had the potential to impact on the person's ability to sleep well.

The care plan for this person provided staff with information as to how to support them with their behaviour and detailed that staff who had received training in distraction techniques should work with them. The care plan did not provide information as to what distraction techniques were effective with this person. This has the potential that staff do not provide a consistent response in supporting the person.

Training records showed that staff have not received training on the management of behaviour. A majority of staff have received training on the use of distraction techniques but we found that how this training was to be implemented by staff was not detailed within the persons care plan.

We looked at the care plan and records of another person and found that they were supported by risk assessments which were regularly reviewed. The care plan provided information about the person's lifestyle before moving into Cana Gardens and detailed how staff were to support them with their day to day lives.

We spoke with a member of staff who told us that they take two of the people who reside at Cana Gardens to church on Sunday. They said that they had recently taken someone to a flower festival held at church. They said that people go swimming during the day and that they help out in the kitchen and spend time with staff when staff prepare and cook meals.

Records showed that people access a range of activities within the community including day centres and colleges. We read that people have a range of social events they visit in the community which includes, discos, public houses, swimming, eating out and going for walks.

Other evidence

The records we looked at showed that staff record incidents where people who use the service experience behaviour which is challenging. Records show that staff record health care appointments. Health action plans and emergency grab sheets were available so that if people were admitted to hospital in an emergency hospital staff would have information they needed about them.

The provider told us that people are supported to attend health care appointments and that care plans and risk assessments are regularly reviewed and updated. They told us that records are kept of incidents within Cana Gardens involving people who use the service.

Our judgement

Care plans do not comprehensively provide information as to the support and care people need which has the potential to impact on the care people receive. The service does not always respond promptly to the recommendations agreed with professionals.

Outcome 7:
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 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

We were not able to find out whether people felt safe as we could not communicate effectively with them.

We looked at the risk assessments of two people and found that they were at risk from financial abuse and exploitation. The risk assessment for one person stated that a detailed record of financial transactions was to be kept by staff along with receipts. We saw that this was acted upon and found records to be in good order. We looked at the financial records of this person and found that each month the manager audited the person's financial records and signed to say that they were in good order.

Other evidence

Records show that all staff had received training on the safeguarding of vulnerable adults from abuse. We spoke with a member of staff who confirmed that they had received training and they were able to tell us what their role was in reporting concerns.

Leicester City Council who funds the care of some of those who reside at Cana

Gardens told us in April 2011 that the local authority acts as financial appointees for people.

The provider told us that staff have receiving training on the safeguarding of vulnerable adults from abuse and that there is a whistle blowing policy for staff at Cana Gardens which details who they should contact and when if they have concerns. Staff have not received training on the Mental Capacity Act.

Our judgement
Staff have received training and are aware of how to safeguard adults who are at risk. Staff awareness of mental capacity and the rights of people isn't clearly understood.

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
Records showed that people who use the service and their relatives are sent questionnaires which seek their views about the service provided at Cana Gardens. Comments were in the main positive and any negative comments had been followed up in staff meetings with changes made.

Other evidence
The manager told us that there is no formal quality assurance process in place. Whilst questionnaires are sent out as part of quality assurance these are not collated and the outcome is not shared with those who took part.

The manager told us that resident meetings take place. Minutes of resident meetings showed that only one meeting had taken place which was in April 2011. Records of the meeting showed that people had discussed menu choices, activities and holidays.

The provider told us that quality assurance questionnaires are sent to health and social care professionals, relatives of those using the service and people who use the service. The provider told us that as part of quality assurance they carry out

medication audits, staff meetings and staff supervisions. Meetings are held between relatives and the service to review the care and support people receive.

Our judgement
The service's quality assurance system is not sufficiently robust.

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	11	7 Safeguarding people who use services from abuse
	Why we have concerns: Staff have received training and are aware of how to safeguarding adults who are at risk. Staff awareness of mental capacity and the rights of people isn't clearly understood.	

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.

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.	9	4 Care and welfare of people who use services
	How the regulation is not being met: Care plans do not comprehensively provide information as to the support and care people need which has the potential to impact on the care people receive. The service does not always respond promptly to the recommendations agreed with professionals.	
Accommodation for persons who require nursing or personal care.	19	16 Assessing and monitoring the quality of service provision
	How the regulation is not being met: The service's quality assurance system is not sufficiently robust.	

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 28 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
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