Review of compliance

Extrafriend Limited The Willows	
Region:	East
Location address:	Corders Farm Bury Road, Lawshall Bury St Edmunds Suffolk IP29 4PJ
Type of service:	Care home service without nursing
Date of Publication:	February 2012
Overview of the service:	The Willows is a residential care home which provides care and support to older people. The Willows is registered to provide accommodation for people who require personal care.

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

Our current overall judgement

The Willows 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 as part of our routine schedule of planned reviews.

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 and talked to people who use services.

What people told us

During our review we spoke directly to six people living in the home. People told us that they felt "happy" living in The Willows and that they had "no complaints". Each person we spoke with commented that they enjoyed the food and were happy with the choice of meals.

However, one person told us that they sometimes "felt bored" and another told us that they didn't get to go out and there was "not much going on outdoors, even in the summer".

We also spent some time observing the care being provided and our findings indicated that people were disengaged from their surroundings and that there were limited positive interactions from members of staff

What we found about the standards we reviewed and how well The Willows 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

The Willows is not compliant with this Outcome. Moderate concerns have been identified because people who use the service are not encouraged or enabled to be an active part of their community nor are they provided with person centred care which meets their individual needs and respects their rights.

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

and supports their rights

The Willows is not compliant with this Outcome. Moderate concerns have been identified because people are at risk of not having their care and welfare needs met because relevant information is not accessible to staff in order to provide care to meet people's individual needs.

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

The Willows is not compliant with this outcome. Minor concerns have been identified. People using the service are generally safe, but there are risks to their outcome, health and wellbeing because reporting requirements are not in place or implemented to ensure that suspected or actual abuse is addressed and dealt with appropriately.

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

The Willows is compliant with this outcome. People's needs are met by staff who are appropriately supported to carry out their role. However improvements are needed to ensure that the training being provided is sufficient enough to meet the needs of the people living at The Willows.

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 Willows is compliant with this Outcome. Management systems to review the quality of service are in place, however improvements are needed to ensure that these are updated, take place on a regular basis and identified areas for improvement are implemented.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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

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

Our findings

What people who use the service experienced and told us
As part of our review we spoke with six people living at the home and they all confirmed that staff were respectful and that they felt their privacy and dignity was always maintained. One person told us that the staff "never make me feel uncomfortable".

We also asked people if they had been involved in their care planning and we were told that upon moving into the home people, along with family members, did contribute to how they would like their care to be delivered. However, when we asked if people were aware of their care plan, we were told by four people they were not.

Another person told us that they feared "becoming institutionalised" and they felt that individualised activities were not provided. They told us that their concerns had been raised with a Director of Extrafriend (the company which provides The Willows) and that no response had been received. It is important that The Willows allow people individual choice and accommodate this as far as possible to ensure they are respecting people's right to dignity.

Other evidence
We reviewed the home's User Guide and Statement of Purpose which is given to residents when they come to live at the home. It contained good information about the

staff, financial arrangements, services available at the home, safety at the home and contact details for complaints.

As part of our visit we reviewed five care plans and saw that people had initial assessments to determine the level of care and support they needed. Assessments focused on Equality and Human Rights by exploring people's sexuality and spirituality and detailed arrangements about how the home could support these whilst providing care. For example, people living in the home had access to the local Church who regularly attended the Willows to hold a communion and befriending service.

We did however find that although initial assessments contained detailed information, there was no evidence available to demonstrate that people living at the home had been involved in any review of these assessments. A review date had been noted within the last three months for all plans we reviewed however, no detail was provided as to whether changes were needed or not. This did not evidence if people were being given the opportunity to have ongoing choices about their care and their lives living in the home.

During our visit we spent some time observing care being provided in a communal area during the afternoon. Our findings demonstrated that the majority of people in the communal area were disengaged from their surroundings. A member of staff had, during our observation, commenced a quiz activity with people living in the home. Eleven people were in the communal area at the time of our observation only two people were actively engaged with this activity. We also observed incidents where people living in the home were not treated with respect and dignity. For example the quiz was held but the carer running it had their back to the majority of the people in the room. We also saw a member of staff assisting a resident to drink a cup of tea but on two separate occasions they pulled the tea away from the resident with no explanation or warning. We fed these findings back to the manager at the end of our visit and she asked for advice about how to tackle these issues.

We also observed during lunch time that two people living in the home were taken to the dinner table and sat for 25 minutes before their lunch was served. It is not good practice for people to be sat waiting for long periods of time as it breaches their right to be treated with dignity.

Our judgement
The Willows is not compliant with this Outcome. Moderate concerns have been identified because people who use the service are not encouraged or enabled to be an active part of their community nor are they provided with person centred care which meets their individual needs and respects their rights.

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

Our findings

What people who use the service experienced and told us
During a visit to the home we spoke to six people using the services. One person told us that they felt "very comfortable" being at the home and that they could "not complain" or want to improve anything about living there. Another person told us that staff are "friendly and approachable", that they "get on well with other residents" and are "very happy" living at the home.

Other evidence
During our visit we reviewed five care files and were able to see that they had sections to include initial assessments, risk assessments, profiles which included personal information, medical history and medications.

We also saw that individual risk assessments were in place for people living at the home, including for hazards (such as individual activities like smoking) handling and falls. Each plan also contained a personal emergency/evacuation plan. These risk assessments demonstrated that the home takes into account risks to people's safety and welfare whilst providing care and support. We did however find that no medication risk assessments had been carried out. This meant that although details of people's medications were included their possible side effects were not. Not having these assessments in place means that staff would not easily be able to asses or recognise a persons needs in an emergency situation.

We also found that although care plans referred to peoples care needs, they did not sufficiently make reference to people's on-going medical needss or contain details

about people's mental capacity to make decisions. The manager had told us that there was a high number of people living at the home with dementia or other memory related illnesses. When we queried this with the manager we found that separate "client personnel" files were kept in the manager's office. These files contained details about people's on-going medical conditions and mental capacity assessments where appropriate. It is important that this information is contained within care files which are accessible to staff so that they may provide care in accordance with peoples assessed needs. .

As the majority of people living at The Willows lived with dementia or other memory related problem, we would have expected to see that the home had catered for these specific needs. However we noted that the home had not implemented any best practice guidance in relation to caring for people living with these conditions. We also only saw one care plan which positively addressed the needs of someone living with dementia, other care plans did not go into such detail. It is important that the needs of someone living with dementia or other memory related illness are individually assessed so that people are enabled to live fulfilled lives.

Our judgement
The Willows is not compliant with this Outcome. Moderate concerns have been identified because people are at risk of not having their care and welfare needs met because relevant information is not accessible to staff in order to provide care to meet people's individual 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

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
On this occasion, we did not speak to people about this outcome.

Other evidence
During a visit to the home we spoke with three members of staff about their knowledge of safeguarding people from abuse. They all demonstrated an understanding of the signs of abuse and the actions they would take if they suspected abuse was taking place. However when asked staff were not aware of any reporting requirements or procedures in place for The Willows.

We reviewed the home's safeguarding procedures and these were out of date, did not detail reporting arrangements nor refer to Suffolk County Councils safeguarding policy and guidance. This guidance was also not available separately. The manager of the home had also telephoned us the week prior to our unannounced visit to ask how she should deal with an alleged safeguarding incident, this demonstrated that the required reporting arrangements were not in place. It is important that up to date procedures and guidance are in place so that staff are able to refer to these and that correct reporting requirements are adhered to.

We reviewed seven staff training records and found that there was evidence of safeguarding training having been undertaken by the majority of staff. The manager confirmed that plans were in place for staff who had not undertaken training and new starters to access a course. We also saw evidence that some staff have been trained on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) and

that training was available for other staff to attend should the need be identified. It is important that staff are trained in these areas so they are able to identify and assess people's needs.

Our judgement
The Willows is not compliant with this outcome. Minor concerns have been identified. People using the service are generally safe, but there are risks to their outcome, health and wellbeing because reporting requirements are not in place or implemented to ensure that suspected or actual abuse is addressed and dealt with appropriately.

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

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
On this occasion, we did not speak to people about this outcome.

Other evidence
The Willows had in place a mandatory and optional training programme. We reviewed seven training records and saw that the majority of staff had completed their mandatory training. The manager had in place plans which monitored out of date training and ensured staff were made aware of this.

Optional training included courses to help meet people's specific needs; for example training on falls prevention, dementia, epilepsy and diabetes. On reviewing the training records for these optional courses we were able to see that a good selection of staff had been trained in each area. We were also told that each member of staff "champions" a particular training area, for example, there was a falls champion and continence champion. The role of these champions was to keep up to date with relevant information and share this with other staff members.

Staff told us that they felt they had all the training they needed to be able to carry out their role and confirmed that should they feel they lack knowledge they are able to request training and it would be provided by their manager.

However, given our findings under Outcome 1 and 4 of this report we are not confident that the training being provided at The Willows is adequate to meet the needs of the people living there. For example, although we were provided with evidence that training in dementia took place, there was no evidence of this being implemented at the home.

We spoke with three members of staff who all told us that they were happy working at The Willows, felt completely supported by their managers and felt confident in raising concerns should they need.

We reviewed staff files and saw that regular supervision sessions were held but formal annual appraisals had not been undertaken. The manager informed us that she had been carrying out end of year supervisions sessions but acknowledged that systems needed to be put in place for formal appraisals to be undertaken and that she was looking into ways in which this could be achieved.

We asked all staff we spoke to whether they felt they were appropriately trained and supported to meet the needs of the people living at the home and they all confirmed they did.

Our judgement
The Willows is compliant with this outcome. People's needs are met by staff who are appropriately supported to carry out their role. However improvements are needed to ensure that the training being provided is sufficient enough to meet the needs of the people living at The Willows.

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
On this occasion, we did not speak to people using the service.

Other evidence
During a visit to the home it was observed that The Willows had comprehensive policies and guidance in place which were accessible to staff. We did however note that these policies did not have an identified review date and some policies, for example, the reporting of unexpected deaths and safeguarding had not been updated to reflect current legislation.

We saw incident and risk management systems in place. We reviewed the Willows accident and incident book and noted that a full description of incidents had been noted together with details of the actions taken.

Extrafriend Limited, the company who provides The Willows services, completed a quality assurance review on a monthly basis. This review includes talking to people living at The Willows, talking to the staff, looking at the premises and the environment to identify areas for improvement. We reviewed the last three months reports and each report indicated that the home was operating effectively. Given the findings of our review of compliance; we are not confident that this assurance method is effective as shortfalls identified our report had not been picked up.

People get the opportunity to provide feedback about the care they have received, we reviewed two service user surveys at our visit to The Willows. The manager confirmed

that these surveys had recently been carried out and results would be collated and analysed for consideration and improvements where necessary. People were also invited to attend a "Residents Meeting". We saw a record of the last meeting and this demonstrated that people living in the home were updated on current issues and given an opportunity to raise any queries or concerns which they may have.

We were told by the manager at The Willows that regular audits are undertaken by herself but that these had not been undertaken for some time however, plans were in place for these to be re-implemented.

Our judgement
The Willows is compliant with this Outcome. Management systems to review the quality of service are in place, however improvements are needed to ensure that these are updated, take place on a regular basis and identified areas for improvement are implemented.

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 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: People's needs are met by staff who are appropriately supported to carry out their role. However improvements are needed to ensure that the training being provided is sufficient enough to meet the needs of the people living at The Willows.	
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
	Why we have concerns: Management systems to review the quality of service are in place, however improvements are needed to ensure that these are updated, take place on a regular basis and identified areas for improvement are implemented.	

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 7 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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: Suitable arrangements to provide appropriate opportunities, encouragement and support to service users in relation to promoting their autonomy, independence and community involvement are not in place.	
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: Proper steps have not been taken to ensure that each service user is protected against the risk of receiving care or treatment that is inappropriate or unsafe.	
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: Reporting requirements are not in place or implemented to ensure that suspected or actual abuse is addressed and dealt with appropriately.	

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 7 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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA