Review of compliance

Ambercare East Anglia Limited Stewton House	
Region:	East Midlands
Location address:	28 Stewton Lane Louth Lincolnshire LN11 8RZ
Type of service:	Care home service with nursing
Date of Publication:	April 2012
Overview of the service:	Stewton House is situated in Louth Lincolnshire and is registered to provide accommodation with nursing care for up to 48 people.

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

Our current overall judgement

Stewton House 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, carried out a visit on 8 March 2012, 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

On the day we visited Stewton House had 38 people living there, 18 of which required nursing care.

People told us they were happy with the care received at Stewton. One relative we spoke with said, "The rooms are always nice and the care is consistently good."

People told us they had a choice of food and that the food was good. One relative said everyone had recently received a questionnaire about the menu and what improvements they would like.

One person told us the activities lady was excellent, while another told us there was always something happening such as bingo, dominos and keep fit. Another said the cook bakes cakes and they had a coffee morning where friends and family were welcome.

Three relatives we spoke with were concerned about the level of fluids people received. They told us that while drinks were handed out, people were not encouraged to drink. We saw three people had cold cups of tea they had not drunk. Water was available in the communal rooms but people were not always mobile enough to help themselves.

People who have reduced mobility can be at risk of developing pressure ulcers. To prevent ulcers occurring special equipment such as mattresses and cushions are used. We saw two people had their pressure ulcer prevention reduced by removing special mattresses. We checked their care plans and could see there was no reduction in their risk level.

What we found about the standards we reviewed and how well Stewton House was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People were fully involved in the planning and delivery of their care needs. Their privacy and dignity was respected and their independence was promoted.

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

Individuals were not always protected against receiving inappropriate or unsafe care.

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

People were protected by clear systems and knowledgeable staff.

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

People lived in a home which was clean and tidy. Staff had access to information and training in order to prevent and control infection.

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

We found that although some improvements were needed,
people who used the service were generally protected against the risks
associated with unsafe premises.

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

People were supported a sufficiently skilled staff team, however people's needs may not always be met due to deployment of staff.

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 benefited from a quality assurance system that included their views and opinions, and identified, monitored and managed risks.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

Personal records did not ensure service users were protected from risk and were not always stored confidentially. Management records were not always completed.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Two different hairdressers visited the home and the assistant manager explained if people wanted to use a different hairdresser they would help them to do so.

People were given the opportunity to practice their faith. In March 2012 there was Church of England and catholic services held. At present there were no people of other faiths living in the home, however the assistant manager assured us should they have a person who wanted to practice a different faith they would make the required arrangements.

We saw when one person who lived in the home was unable to use a standard call bell, the assistant manager had arranged for assisted technology to be used. This gave the person independence and allowed them to call for help when needed. It also worked their television, radio and talking books. We also saw this person had a fridge in their room where they stored drinks and snacks.

People told us they had a choice of meals, one person's relatives told us, "Staff go round at tea time with the menu for the following day." Another person said, "They ask you what you want the day before." We saw the menu for the day was available in the communal areas.

We spoke with one relative who told us the tea cups were too heavy for their mum. They said they had offered to bring in a china mug, but staff had said they couldn't as it would get broken. We spoke to the assistant manager about this, they said they were happy for people to bring in mugs for their relatives to use

Other evidence
We reviewed five care plans and we saw people had received an assessment of their needs before living at Stewton House.

The home had a system of flags to identify when carers were in a room tending to a person so people did not enter the room while they were in the middle of giving care.

The assistant manager showed us completed surveys from people living in the home about the meals they received.

Our judgement
People were fully involved in the planning and delivery of their care needs. Their privacy and dignity was respected and their independence was promoted.

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
The home had an activities co-ordinator five mornings a week. The activities co-ordinator told us they did the activities in the morning and set the afternoon activities for the care staff to deliver. They described how they reminisced with people and had a box which contained items that started discussions. They also looked at the local paper with people. We could see each bedroom had the weekly activities sheet on the door so people were aware of activities. The activities co-ordinator told us when new people moved into the home they encouraged friendships to help them settle in.

Three people visiting the home each told us they were concerned their relatives were not getting enough fluids. They told us people were given a cup of tea but not encouraged to drink it. They also said while water was available in each communal area, it was placed on a table centrally and people were not always able to get to it. We saw water was available in each room but all the jugs we saw were full and we did not see individuals with a glass of water.

Before we visited the home we reviewed all the information we hold about them. This raised concerns that more people were being admitted to hospital from de-hydration than we would expect.

People also told us that although fresh fruit was available in the communal areas people were not always mobile enough to get to it.

Other evidence

We reviewed five care plans of people living in the home and we could see they had appropriate risk assessments.

In two of the care plans we reviewed we saw there had been a reduction in the level of protection against pressure ulcers by removing special mattresses. There was no explanation for this reduction and the risk assessments of pressure ulcers for both people remained high. We checked with the assistant matron who was able to tell us neither person had developed pressure ulcers.

We saw one person was asked to stand and walk a short distance assisted by a single member of staff. This person was unsteady, easily tired and had fallen the previous day. We discussed this with the assistant manager who told us they would care plan.

Staff we spoke with were able to describe how people liked their care. They knew people's routines and their likes and dislikes. They explained how they helped people maintain their dignity and independence. They were aware of which equipment was needed to provide care and to keep people safe.

Our judgement
Individuals were not always protected against receiving inappropriate or unsafe care.

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
One relative we spoke with told us, "I'm happy this is a safe environment."

Other evidence
Staff we spoke were able describe the signs of abuse. Staff told us they knew how to report abuse within the home. They were aware whistleblowing and safeguarding concerns could be reported to external agencies. Contact details for external agencies were available in a folder in the staff room.

Staff told us they had received training in safeguarding and we saw the certificates of the training.

Where the management looked after people's money, there was a monthly check by the regional manager that the money available matched the accounts.

Our judgement
People were protected by clear systems and knowledgeable staff.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
A relative we spoke with said, "The home is always beautifully clean."

We saw the home was clean and tidy. We checked the cleanliness in five rooms and could see that the housekeepers were thorough in their job. Tables, armchairs and mattresses were all clean.

We saw the staff toilet had hand washing instructions, soap and sanitizer.

We saw there was a rusty metal mop bucket in the sluice room. We spoke with the senior housekeeper about the mop, they were unaware it was there. Once identified it was removed before we left the home.

We saw some chairs in the bathrooms were Velour and could increase the risk of infection.

The majority of rooms had ensuite facilities but where people needed to use a commode, this was taken to them. The commode was clean and the staff were able to describe their cleaning process, this was appropriate.

Other evidence
Bins in bathrooms, the hairdressing room and other places did not have lids on them. We spoke with the assistant manager who explained this had been identified as an issue at an infection control inspection. The assistant manager has a programme in place to replace all the open bins. Bins for the segregation of waste and sharps were in place and clearly marked.

We spoke with a housekeeper who was able to describe the cleaning schedule used for the home. We could see there was a checklist of all the cleaning that needed doing on a daily, weekly and monthly basis. Mops heads were changed twice a week and were colour coded for different areas.

Our judgement
People lived in a home which was clean and tidy. Staff had access to information and training in order to prevent and control infection.

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 minor concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
There was only one shower room for people to use and it was accessed through the hairdressing salon. The assistant manager told us the shower room was not used while the hairdressing room was occupied. This restricted peoples access to the shower.

We saw the incontinence supplies were stored in a room off the shower room. The assistant manager told us staff stock their trolleys before their rounds so shouldn't need to go into shower room while it was being used, however, this did happen on occasion. To allow access to the continence supplies the shower area was screened off if people were using it. However there was no notice to indicate that someone was in the shower.

Other evidence
We saw the shower room was used to store a hoist and commode. We also saw a bathroom was used as a store for hoists, trolleys and other equipment. The equipment blocked access to the bath and toilet.

The floor in the incontinence supply room was in poor condition with torn linoleum covering half, while the other half was bare floorboards.

Our judgement
We found that although some improvements were needed,
people who used the service were generally protected against the risks associated with unsafe premises.

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 minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us they were happy with the quality of staff employed in the home. One person said, "The nursing staff are good," while another told us, "The staff are wonderful." The activities co-ordinator was described to us as, "Excellent."

Other evidence
Staff we spoke with told us there were enough carers to meet people's needs. However they identified that some afternoon shifts were busy and people had to wait to go to the toilet. Two relatives we spoke with both told us that when people wanted to go to the toilet staff did not respond quickly enough. One lady who lived at Stewton House told us, "It's alright if you are able but people in wheelchairs have to rely on others."

The assistant manager described the staff rota to us. During the day and early evening one nurse and five carers were available. The night shift had one nurse and two carers all night, with an extra carer until 1am to help put people to bed. We looked at the rota's for the last month and could see they matched the staffing levels described to us. We spoke with the assistant manager about people who had to wait to go to the toilet. They told us they would review the deployment of staff.

Staff told us they were supported by the management and had yearly appraisals and six supervision sessions a year. We saw records of supervision and appraisals that had taken place.

Staff told us they attended training as needed, this included areas such as infection

control, dementia, safeguarding, continence and team leading. We saw certificates of training attended.

Our judgement
People were supported a sufficiently skilled staff team, however people's needs may not always be met due to deployment of staff.

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
Each person had a copy of the complaints leaflet in their room. The assistant manager told us the complaints process was discussed with each person at their pre-assessment.

The assistant manager explained they had surveyed visitors to the home in January/February 2012. We saw completed copies of they survey, they had comments such as, "Dad seems well cared for and comfortable," and, "I think it's about as good as it gets."

Other evidence
The assistant manager described how complaints were dealt with, verbal complaints were recorded as well as written complaints. The outcome for each complaint was discussed with person making the complaint. We saw where the outcome required supervision for a member of staff, this took place and was recorded. We saw that complaints were analysed on an ongoing basis and any trends identified.

We saw copies of a monthly audit completed by the regional manager. The audit included people's views on how the service was run. It also covered care plans, incidents and complaints, training, cleanliness and routine maintenance. The assistant manager told us when an incident or accident occurred it was followed up to identify if staff need further training or if further occurrences can be reduced.

Our judgement

People benefited from a quality assurance system that included their views and opinions, and identified, monitored and managed risks.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We saw a temperature chart in the bathroom that recorded the temperature of the water when people had a bath. However this record did not contain anything to identify which person had taken the bath. If there was a problem, there were no systems in place to identify which person's bath the temperature recording related to

Other evidence
We saw night check, food and fluid sheets were left unsecured in the corridor. This meant that people living in the home and their visitors were able to look at other peoples information.

We saw in one persons care plan the language used to describe the process to deal with their challenging behaviour did not maintain their dignity It also did not record their ability to make a decision for themselves, where they clearly had capacity to do so. We spoke with the assistant manager and staff about managing this person's behaviour. The care they described was more respectful of the person and more inclusive of their wishes than what was recorded in the care plan. We asked them to review the care plan, to reflect the care given.

We could see there was a checklist of all the cleaning that needed doing on a daily, weekly and monthly basis. Although all the rooms we inspected were clean we could see that not all items had been checked as being completed. We discussed this with

the housekeeping supervisor who told us they did not audit the sheets on a routine basis.

Our judgement
Personal records did not ensure service users were protected from risk and were not always stored confidentially. Management records were not always completed.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Individuals were not always protected against receiving inappropriate or unsafe care.	
Diagnostic and screening procedures	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: Individuals were not always protected against receiving inappropriate or unsafe care.	
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: Individuals were not always protected against receiving inappropriate or unsafe care.	
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 although some improvements were needed, people who used the service were generally	

	protected against the risks associated with unsafe premises.	
Diagnostic and screening procedures	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 although some improvements were needed, people who used the service were generally protected against the risks associated with unsafe premises.	
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 although some improvements were needed, people who used the service were generally protected against the risks associated with unsafe premises.	
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: People were supported a sufficiently skilled staff team, however people's needs may not always be met due to deployment of staff.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People were supported a sufficiently skilled staff team, however people's needs may not always be met due to deployment of staff.	

Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People were supported a sufficiently skilled staff team, however people's needs may not always be met due to deployment of staff.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Personal records did not ensure service users were protected from risk and were not always stored confidentially. Management records were not always completed.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Personal records did not ensure service users were protected from risk and were not always stored confidentially. Management records were not always completed.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Personal records did not ensure service users were protected from risk and were not always stored confidentially. Management records were not always completed.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

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

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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