Review of compliance

Sharnbrook Lodge
Sharnbrook Lodge Care Home

Region:	East
Location address:	17a Park Road North Houghton Regis Dunstable Bedfordshire LU5 5LD
Type of service:	Care home without nursing.
Date the review was completed:	11 March 2011
Overview of the service:	Sharnbrook Lodge is a Care Home which provides personal care and accommodation for up to 24 people, who are mainly 65 years of age and over. People who use the service have a range of needs including dementia and physical disabilities. This location is subject to the following three restrictive conditions:

	1. The Registered Provider must ensure that the regulated activities, ‘accommodation for persons requiring nursing or personal care’ are managed by an individual who is registered as a manager in respect of the activity, as carried on at or from the location Sharnbrook Lodge, 17A Park Road North, Houghton Regis, Dunstable, LU5 5LD. 2. The Registered Provider must only accommodate a maximum number of 24 service users at Sharnbrook Lodge, 17A Park Road North, Houghton Regis, Dunstable, LU5 5LD. 3. The Registered Provider must not provide nursing care under ‘accommodation for persons requiring nursing or personal care’ at Sharnbrook Lodge, 17A Park Road North, Houghton Regis, Dunstable, LU5 5LD.

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

What we found overall

We found that Sharnbrook Lodge was not meeting one or more essential standards. Improvements are 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 concerns were identified in relation to:

- Care and welfare of people using the service.
- Respecting and involving service users.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 11 March 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

We met with nine of the 23 people who live in the home at our visit. Eight of the people we met, had limited verbal communication or reduced cognitive ability, so were unable to tell us about their experiences, so we observed the care they received.

Information of concern had been received by the CQC in March 2011; one area of concern was that people who use the service were being woken by staff in the morning. Sometimes people were being woken and dressed as early as 05:45, this was not their choice.

We commenced our visit at 06:45, we noted that nine people were up and dressed when we arrived, most of whom were sitting in the lounges. On speaking with staff and looking at the staff rota two night staff were on duty, the people who were up had been assisted by them. On questioning staff as to what time people had been woken, they confirmed that they needed to start by 05:45 so that they would have enough time to get everyone up that they needed to.

Through looking at care records and speaking with both staff and people who use the service, it was only the personal choice of one out of the nine people to be up at this time.

The other areas of concern received by CQC were in relation to wound care and falls.

We found one person who was assessed as being at high risk of falling, that they had fallen a number of times within the past two months. No accident form had been completed for any of these falls, neither had any safeguarding referral been made relating to any of these falls as required.

None of the information about the falls had been entered onto the falls risk assessment or care plan for this person. The times and locations of these falls showed a clear pattern, in that they occurred at a similar time and place. Despite this the manager still did not introduce any additional measures to reduce risk in this area, or make a referral for specialist help. The person then fell again and sustained injuries.

What we found about the standards we reviewed and how well Sharnbrook Lodge was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run.

There is little evidence to suggest that people who use the service and/or their representatives are involved in the development of their plan of care. The outdated systems in place did not support the delivery of personalised care.

We had concerns about the arrangements for supporting people who lived at the home. At times the support in place failed to promote autonomy, dignity and choice. Some people were being woken too early and not because of personal choice, resulting in the delivery of inappropriate care and support.

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

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

We have concerns about the care delivery provided to some of the people living at this home. The assessment and care planning processes were ineffective. Managerial oversight and monitoring of the care being provided by staff was deficient.

No safety measures had been taken when a person had shown a pattern of falling; the person continued to fall and subsequently sustained physical injuries that may have been able to be prevented.

There had been a failure to monitor blood sugar levels, and a failure to recognise a person's change in behaviour being connected to their unstable blood sugar levels. There had been shortfalls in the management of wound care and guidance to staff was inappropriate at times.

This places people at risk of harm. We cannot be confident that people would consistently receive the care and support that they need to ensure they are safe and their dignity is maintained.

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

Action 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.

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 1:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:

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

What we found

Our judgement

There are major concerns with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

Information of concern had been received by the CQC in March 2011; the concerns were that people who use the service were being woken by staff in the morning. Sometimes people were being woken and dressed as early as 05:45, this was not their choice.

We commenced our visit at 06:45 on 11 March 2011 and we noted that nine people were up and dressed when we arrived, most of whom were sitting in the lounges. On speaking with staff and looking at the staff rota two night staff were on duty, the people who were up had been assisted by them. On questioning staff as to what time people had been woken, they confirmed that they needed to start by 05:45 so that they would have enough time to get everyone up that they needed to.

Through looking at care records and speaking with both staff and people who use the service, it was only the personal choice of one out of the nine people to be up at this time.

Other evidence

We saw a list of names on the notice board in the staff room, this had been written by the registered manager and was titled ‘assistance schedule’. This instructed staff on the names of the people night staff should assist to get up, and a list of people to be assisted by day staff, who commenced their shift at 07:00.

Guidance within this document stated, ‘on client’s bath day that are on the list replace with another service user. If a double being bathed replace with a double/single replace with a single’. Staff confirmed that they followed this guidance and explained the term ‘double’ and single’, was how many staff were needed to assist a person with personal care.

Eight of the nine people we saw up and dressed at 06:45 had their names written on this list. However there were no entries within their individual care documents to show that they wished to be woken at this time and many of these people had dementia. This showed the delivery of care was not person centred, people had not been consulted about the times they wished to get up. In staff following instruction from one list to care for several people who had very different needs and wishes from each other was unacceptable; staff should have been following the guidance within an individual person’s care plan.

Our judgement

There is little evidence to suggest that people who use the service and/or their representatives are involved in the development of their plan of care. The outdated systems in place did not support the delivery of personalised care.

We had concerns about the arrangements for supporting people who lived at the home. At times the support in place failed to promote autonomy, dignity and choice. Some people were being woken too early and not because of personal choice, resulting in the delivery of inappropriate care and support.

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

Our findings

What people who use the service experienced and told us

Information of concern had been received by the CQC in March 2011; the concerns were in relation to wound care and falls.

We did not request direct feedback from people using the service as part of this review.

Other evidence

At our visit on 11 March 2011 we looked at one person's records and these showed they had been living at the home for less than two months. Their pre admission assessments documented that they were prone to falls. The falls risk assessment showed the last entry to be made on 18/01/2011, with a score of 13 showing high risk of falling.

From admission up to 09/03/2011 the daily notes or the communication book showed the person had fallen several times. One day they had fallen and been found on the floor on four occasions. No accident form had been completed for any of these falls, or had any safeguarding referral been made relating to any of these

falls as required, as many were not witnessed.

It was a concern that none of the information about the falls had been entered onto the falls risk assessment or care plan for this person. The times and locations of these falls showed a clear pattern, in that they occurred at a similar time and place. Despite this the home still did not introduce any additional measures to reduce risk in this area, or make a referral for specialist help.

Then days before our visit on 11 March 2011 the person fell again, this time sustaining considerable facial injuries and was taken to hospital. A safeguarding alert to Central Bedfordshire Council (CBC) was made by the home relating to this fall. The alert stated that a referral was now being made to the falls clinic; however this was only following instigation from the hospital following the person's admission to accident and emergency. The alert also stated supervision was in place; however records show that there had been no supervision by staff at the time of the fall, as they were attending to other people in the home.

This person also had diabetes; during their two months living at the home they had their medication relating to this changed several times due to unstable blood sugar levels. Documents contained entries that they must have their blood sugar tested twice daily. There were numerous occasions when this had only been carried out once a day, and several when it had not been tested at all. At times there was no testing on consecutive days. Daily notes regularly reported the person 'to be aggressive', no correlation was ever made to the possible reasons for this and that it may be due to unstable blood sugar levels.

We made a safeguarding referral to CBC on 11 March 2011, regarding our concerns on the care and treatment received by this person.

Care records for another person contained entries by the District nursing team. They showed they had been called in by the home in January 2011 to attend to a persons pressure wounds. The District nurse noted that the mattress pressure was set at over 100kg, although the person's weight was recorded as only being 50.4kg.

The district nurse made a safeguarding referral to CBC concerning this, highlighting their concern over the incorrect setting of the mattress and this possibly causing deterioration in the skin integrity for this person. The registered manager told us a new mattress was secured following this as there had been a fault with the previous one.

We were very concern to note one written entry in a persons records which instructed staff not to leave a person lying in urine as their room was not that warm, it went on to state as lying in urine would make them feel even colder. There was no follow up taken as to why this had happened for this person, just this general statement by the registered manager in the communication book.

Our judgement

We have concerns about the care delivery provided to some of the people living at this home. The assessment and care planning processes were ineffective.

Managerial oversight and monitoring of the care being provided by staff was deficient.

No safety measures had been taken when a person had shown a pattern of falling; the person continued to fall and subsequently sustained physical injuries that may have been able to be prevented.

There had been a failure to monitor blood sugar levels, and a failure to recognise a person's change in behaviour being connected to their unstable blood sugar levels. There had been shortfalls in the management of wound care and guidance to staff was inappropriate at times.

This places people at risk of harm. We cannot be confident that people would consistently receive the care and support that they need to ensure they are safe and their dignity is maintained.

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.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for people who require nursing or personal care.</td><td>17</td><td>Outcome 1:
Respecting and involving people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
People who use the service and/or their representatives have limited involvement in the development of their plan of care. Outdated systems did not support the delivery of personalised care.

At times the support in place failed to promote autonomy, dignity and choice. Some people were being woken too early and not because of personal choice, resulting in the delievery of inappropriate care and support.</td></tr>
<tr><td rowspan="2">Accommodation for people who require nursing or personal care.</td><td>9</td><td>Outcome 4:
Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
The assessment and care planning processes are ineffective. Managerial oversight and monitoring of the care being provided by staff was deficient.

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

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

The provider's report should be sent to us within 14 days of this report being received.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Adult 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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