Review of compliance

Mr & Mrs D Evely Averlea Domiciliary Care	
Region:	South West
Location address:	Fore Street Polgooth St Austell Cornwall PL26 7BP
Type of service:	Domiciliary care service
Date of Publication:	April 2012
Overview of the service:	Averlea Domiciliary Care agency provides personal care to people living in their own homes. The agency's office is in Averlea Residential Home. The agency provides a range of services including cleaning, shopping, meals and sitting services. The area covered by the agency is a 15 mile radius around St Austell, Cornwall.

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

Our current overall judgement

Averlea Domiciliary Care 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 31 January 2012, carried out a visit on 27 February 2012, carried out a visit on 28 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out a scheduled inspection of the domiciliary care agency and the care home at the same time as they operated from the same office located in Averlea Residential Home. We made unannounced visits to Averlea on 31 January, 27 February and 28 February 2012 when we talked to seven people who lived in the home, one relative who was visiting at the time, and three staff members who worked in the home. On 3 February 2012 we visited four people in their own homes, who received personal care services from the domiciliary care agency, and spoke with four of their relatives during the visits. During this inspection we also spoke with three staff members, in person or on the telephone, who provided personal care to people in their own homes.

During our first visit to Averlea we spoke with the registered manager of the domiciliary care agency but she was not available for the rest of the inspection. We spoke with the registered manager of the care home and one of the owners during all of the visits to Averlea.

At the time of this review the domiciliary care agency provided services to approximately 75 people, most of whom received personal care, and employed approximately 30 staff. There were 13 people living in the care home and 10 care staff were employed as well as domestic and catering staff.

During our visits to the office we looked at records pertaining to both the domiciliary care agency and the care home. These included records relating to the care and support people received, staff files, the operation of the care home, and policies and procedures.

We asked for the staff training records, and some other documentation, to be sent to us which we received on 19 March 2012. We also asked for the quality assurance records but were told by the registered manager of the care home that there was no system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others who may be at risk.

People who received care and support from the domiciliary care agency were very positive about the way they were treated by the staff who supported them. Comments from people receiving the service and their relatives included "them's lovely", "we think the world of them", "we can't praise them enough" and "they respect me as a person". People also said that the agency was reliable, flexible around people's changing needs, and time keeping was "very good". However the agency did not have robust arrangements in place to safeguard people against the risk of abuse as few of the staff had received training in this area and the agency's policies and procedures were not clear about the action staff should take.

People who lived in Averlea Residential Home said they were happy living in the home, felt safe and were well cared for. Comments included "we are so well looked after", the staff were "lovely" and "they treat me like one of the family". We observed interactions between the staff and people who lived in the home and saw that staff were friendly and respectful to the people they supported. People talked to us about their personal routines, the activities they enjoyed, and the meals provided in the home. People said they were involved and supported to make decisions about their personal and healthcare needs and that these were being well met by the staff team and visiting healthcare professionals. People received their medicines when they needed them and these were administered in a safe way. However we found that there was no protocol for the administration of 'as required' medicines and medicines were not always being stored or disposed of properly.

People also told us they had not been provided with any information about the home, they did not know how to make a complaint, they did not know who the registered manager was or her name, they were unaware of their care plans and had not been involved in writing them, no activities took place apart from bingo and they were never told what the next meal would be. They said there were no meetings held between the people who lived in the home and the management, they had never been consulted about the quality of care in the home, and had no involvement in how the home was run. We also found that the arrangements in the home to safeguard people from abuse, such as written policies and procedures, were not suitable which may place people at risk of abuse.

During our visit to the office we examined the care files belonging to five people who received a domiciliary care service and four people who lived in the care home. We found that the care and support plans for both people receiving domiciliary care and living in the care home contained detailed information about some aspects of people's care and gave clear directions to staff about how people wanted each task to be carried out. However, from discussion with the people who used the services, we found that the care plans did not contain all of their care and support needs; the people receiving a domiciliary care service said the staff did not always read them; and the people living in Averlea Residential Home were not aware of the existence of the care plans. We also looked at the financial records of three people who lived in the home whose spending money was administered by staff in the home. We found that these records were not audited on a regular basis to ensure accuracy and protect people from possible financial abuse.

During our visits to the care home we looked around the communal parts of the care home and eight bedrooms. We found that all the bedrooms were warm and most of them contained many personal possessions, although this varied from one person to another. The bedroom doors had locks fitted but, if locked from the inside, the staff were not able to enter in an emergency. None of the bathroom and toilet doors available to the people who lived in the home had locks fitted which meant that people's right to privacy was compromised.

During our first visit we found that none of the bedroom doors had 'hold open' devices fitted that would automatically close if the fire alarm went off but these had been fitted by the time of our second visit. After discussions with staff about what to do in the event of a fire, and the registered manager saying that the fire risk assessment needed updating and that she had not yet written the personal evacuation plans for each person living in the home, we made a referral to the fire service due to our concerns regarding fire safety awareness in the home.

We looked at staff training records and spoke with staff from the domiciliary care agency and the care home about the training they had received to enable them to do their jobs. We found that almost all of the staff had qualifications in care and had received some training related to essential areas of their work. However we also found that staff had not received training related specifically to the needs of the people they supported to enable them to deliver care and treatment to people safely and to an appropriate standard.

What we found about the standards we reviewed and how well Averlea Domiciliary Care 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 can be confident that Averlea Domiciliary Care will consult with them to assess their needs, agree how they will be met, and provide a reliable service. However people are not provided with appropriate information in relation to their care.

Overall, we found that Averlea Domiciliary Care is meeting this essential standard but, to maintain this, we suggested that some improvements are made.

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

People experience a high level of satisfaction in the way the care workers meet their care and support needs. However information gaps in the care plans and the absence of risk assessments in people's homes may result in important health or personal care tasks being missed or carried out in an inappropriate or unsafe manner.

This is a breach of Regulation 9(1).

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

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

People who receive a service from Averlea Domiciliary Care feel safe and well looked after by the staff team. However the agency's arrangements, such as procedures and staff training, are not suitable to ensure that people are safeguarded against the risk of abuse.

This is a breach of Regulation 11(1).

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

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

People receive the care and support they need from a caring and considerate team of staff. However staff are not provided with appropriate training to enable them to deliver care and treatment to people safely and to an appropriate standard.

This is a breach of Regulation 23 (1).

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

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 organisation does not have a system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others who may be at risk.

This is a breach of Regulation 10.

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

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

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

Our findings

What people who use the service experienced and told us
We visited four people who received a personal care service from the agency and also talked with four relatives who were usually present when the staff provided the care and support to their relatives. Everyone we spoke with said they were satisfied with the service. People said that the staff were polite, respectful and easy to communicate with. They told us that their privacy and dignity were respected and that personal care was always conducted with the bathroom/toilet door closed. However during one visit we were told that, when there were two staff members present, they sometimes conducted private conversations with each other and "talked across" the person receiving care thereby not treating the person with consideration and respect. We raised this with the registered manager of Averlea Residential Home (in the absence of the registered manager of the domiciliary care agency) who agreed this was not acceptable and said she would address this immediately with the staff concerned.

Each person had a copy of their care plan in their home and had signed it to show that they were involved in drawing them up and were aware of the content. People said that the staff team were helpful, kind, considerate, "look after clients" and were "good as gold". Relatives told us that people were well cared for and they were provided with the care and support in the way they wanted. Relatives also said the agency has "been brilliant" and they "can't praise them enough".

All of the people we visited told us the staff team were always on time or within half an hour of the expected time of the visit and they were satisfied with this. They said they had never experienced any missed visits.

We asked people if they had received any information from the agency about the aims and objectives of the organisation, and the services it provided, such as a statement of purpose. The people we visited said they had not received this type of information. One person said she would like a list of the staff who would be assisting her each week so that she knew who to expect in advance. We had a discussion about this with the registered manager of Averlea Residential Home (in the absence of the registered manager of the domiciliary care agency) who confirmed that people were not sent a rota of which staff would be visiting them during the week. Due to the lack of a quality monitoring process (see outcome 16) this had not been identified by the agency as a possible improvement to their service.

Other evidence
During our visit to the agency's office we looked at the personal files of five people who received a service from the agency. These showed that an assessment of people's needs was completed for each new person wishing to use the service so that the staff were aware of people's needs before a service was provided.

During our visits to people we saw that the staff team recorded the times they arrived and left in daily records. This showed that the staff were punctual and reliable, even when visiting people who lived in rural locations.

Our judgement
People can be confident that Averlea Domiciliary Care will consult with them to assess their needs, agree how they will be met, and provide a reliable service. However people are not provided with appropriate information in relation to their care.

Overall, we found that Averlea Domiciliary Care is meeting this essential standard but, to maintain this, we suggested that some improvements are made.

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

Our findings

What people who use the service experienced and told us
People told us they were entirely satisfied with the care they received. People said that the care provided was "very good" and a relative said it was "invaluable". They said their needs had been discussed and agreed with them when they first started using the agency and they felt confident to ask for changes if required. They said they had a regular team of staff who were attentive to their individual needs. People told us that the staff members always arrived on time and stayed for the full amount of time or long enough to complete all the tasks required without being rushed.

We looked at the care/support plans held in the homes of the four people we visited. We saw that the care plans contained detailed information about some of the person's care and support needs and how the staff were expected to meet those needs. However discussion with the people receiving a service showed that these care plans were not comprehensive as they did not always include all the aspects of care that people received or had not been updated when people's needs changed. For example one person had to be assisted with a bath in a particular way and that information was not in the care plan; the daily routine of another person had not been updated when the person's routine had changed. After each visit the staff member recorded the tasks completed and made some observations about people's health and/or well being to show what care had been delivered.

Other evidence
We looked at five care plan files held in the agency's office as well as the care plan files in the homes of the four people we visited. When we looked at the care plans in the

office we found that these gave detailed instructions for the staff team of the tasks they were required to do to meet people's needs. However the information gained during our visits showed there were some gaps in the care planning and some of the instructions were vague, for example, "prompt medication", and did not give clear instructions to staff as to what the medication procedure was for that particular person. Clear instructions for staff about how they should be meeting people's needs are essential to ensure that people received consistent care in the way they want it provided.

People's files in the office contained risk assessments related to moving and handling, medication and the environment to ensure that staff provided assistance to people in a safe way. The people concerned had signed the care plan and the risk assessments indicating that they were involved in drawing them up and were aware of the content. However copies of the risk assessments were not kept in people's homes therefore were not available for staff to check when they visited people to make sure they were working in a safe way.

We spoke to a district nurse who worked with people who received a service from the agency. She said they had a good working relationship with the registered manager and staff of the agency and any issues they found were sorted out immediately by the management and staff team.

Our judgement
People experience a high level of satisfaction in the way the care workers meet their care and support needs. However information gaps in the care plans and the absence of risk assessments in people's homes may result in important health or personal care tasks being missed or carried out in an inappropriate or unsafe manner.

This is a breach of Regulation 9(1).

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

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
People we spoke to who used the agency told us that they felt safe, that the care workers were "very good" and that they were "happy with the service". One relative said that the service provided by the agency has "been brilliant" and "invaluable" in the support provided. All the relatives were confident that people were safe and properly cared for by the staff team from the agency.

Other evidence
During our visits to the agency's office in February 2012 we spoke to a senior member of staff who worked for the domiciliary care agency who confirmed she had attended training about what action to take to safeguard vulnerable people from harm, abuse or neglect. We also spoke to two other members of the agency staff on the telephone who confirmed they had received this training. We asked them what action they would take should they suspect or witness any form of abuse. They said they would report the incident immediately to the registered manager or other member of the management team. However they were not entirely sure about which external agencies to contact should they need to, for example, the local authority and the police. They said they had received a staff handbook when they started working with the agency. We read the policy and procedure about abuse in the handbook and found that it was out of date and did not correspond with the guidance produced by the local authority about what action to take should allegations of abuse be received.

We asked the registered manager of Averlea Residential Home (in the absence of the registered manager of the domiciliary care agency) to send us details of all the training

that staff had attended so that we could confirm they had all received training in safeguarding vulnerable people from abuse. We received training information about 31 staff members on 19 March 2012. This showed that eleven staff had completed specific training on the subject of 'Abuse Awareness' thereby indicating that all staff may not be adequately trained in this important area.

Our judgement
People who receive a service from Averlea Domiciliary Care feel safe and well looked after by the staff team. However the agency's arrangements, such as procedures and staff training, are not suitable to ensure that people are safeguarded against the risk of abuse.

This is a breach of Regulation 11(1).

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

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

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
All of the people we visited said they were entirely satisfied with the staff members employed by the agency. They told us they were confident that the staff had been carefully recruited and trained. We were told that the staff were "very good", "very helpful" and "good mannered". People said that new staff members were always introduced and worked alongside a more experienced member of staff before they started visiting people alone. This showed that people were properly introduced to new staff members and the staff were familiar with people's needs before they were expected to provide the care on their own.

Other evidence
During this inspection we spoke to three members of staff either in person or on the telephone. The staff said they enjoyed their work and one staff member said that working in the community was "educating" because of people's diverse needs and this made her job interesting. The staff members said they were very well supported by the registered manager of the domiciliary care agency and, in her absence, the registered manager of the care home and one of the owners. They said that communication with the office was very good and, during their weekly visits to the office, they had an opportunity to discuss any issues or concerns with the registered manager. The staff confirmed they had regular one to one meetings, including appraisals of their work, with the registered manager. They also confirmed that observations of their work practices had been carried out, by a senior member of staff, whilst they were carrying out personal care tasks with people in their own homes. These observations were carried out to ensure they were working safely and in accordance with people's wishes. During one of our visits to the agency's office we were shown the records of when senior staff

carried out these 'spot checks' to make sure people were receiving the care and support they needed at the times, and in the way, they preferred.

The staff said they had received enough training to give them the skills and knowledge they needed to carry out all of the care tasks they were required to do. Ongoing training topics included moving and handling, health and safety, fire safety, first aid, food hygiene, medication and safeguarding. The staff said they had achieved professional qualifications in care, namely National Vocational Qualifications (NVQs) to level 2 and 3 and two of them said they had also attended a half day briefing/workshop about working with people with Parkinson's disease.

We asked the registered manager of Averlea Residential Home (in the absence of the registered manager of the domiciliary care agency) to send us details of all the training that staff had attended so that we could confirm they had received relevant training to give them the skills and knowledge to do their jobs well. We received training information about 31 staff members on 19 March 2012. These records showed that 30 members of staff had achieved, or were working towards, a qualification in care, namely a National Vocational Qualification (NVQ) to level 2 or 3 indicating that the management team had a positive attitude to ensuring the staff were properly trained to do their jobs. In addition most of the staff had received training in fire safety, health and safety, moving and handling and medication. However fewer than half of the staff had received training in first aid, food hygiene, infection control, dementia awareness and deprivation of liberty safeguards. These records did not show whether staff had received other specialist training, particularly in relation to the specific needs of the people they supported. There was no evidence that staff had received any training on some important aspects of their jobs that they told us they were expected to carry out, for example stoma care, although we were told they had received instruction from another member of staff.

Our judgement
People receive the care and support they need from a caring and considerate team of staff. However staff are not provided with appropriate training to enable them to deliver care and treatment to people safely and to an appropriate standard.

This is a breach of Regulation 23 (1).

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

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
We visited four people in their own homes and spoke with them and four relatives who were also present during our visits. Everyone said they were completely satisfied with all aspects of the service they received. One relative said that they had been visited by the registered manager of the agency who went through the care plan, to check it was up to date and accurate, and asked if they were happy with the service provided. However the other three people we visited said they had never been asked for any feedback on the quality of the care and support they received.

The people we visited, and their relatives, told us they "can't complain" or had "no complaints" about the agency. They were confident that, if they had cause for concern or complaint, they could raise these with the staff or registered manager of the agency and they would receive an appropriate response. One person told us that, a while ago, she was not happy with one particular staff member, the person raised this with the registered manager, and the situation was managed and resolved to the person's satisfaction. However none of the people we visited had been provided with any information about the agency therefore were unaware of the agency's complaints procedure.

During our visits to people in their own homes we checked that equipment used by the agency's staff had been regularly serviced to ensure it was safe to use. In one person's home we found that, according to the notice attached to an item of equipment, it was out of date for servicing. We asked the registered manager of Averlea Residential Home (in the absence of the registered manager of the domiciliary care agency) what

arrangements were in place to ensure that the equipment the staff used in people's homes was kept in good working order and safe but she was not aware of any arrangements.

Other evidence
During our visits to the agency's office we checked four staff files and found that they contained a copy of the motor insurance documents for each staff member who used their own car for work. However each policy document we read said that the insurance excluded the driver from using the car for business purposes. We asked the registered manager of Averlea Residential Home (in the absence of the registered manager of the domiciliary care agency) what arrangements were in place to ensure that staff had the correct motor insurance for their vehicles but she was not aware of any arrangements as she believed that the staff had the correct insurance. We also asked her how the quality of the service provided was assessed and monitored. We were told that there was no system in place.

Our judgement
The organisation does not have a system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others who may be at risk.

This is a breach of Regulation 10.

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

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
Personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People are not provided with appropriate information in relation to their care.	

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 14 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
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: Information gaps in the care plans and the absence of risk assessments in people's homes may result in important health or personal care tasks being missed or carried out in an inappropriate or unsafe manner. This is a breach of Regulation 9(1).	
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: The agency's arrangements, such as procedures and staff training, are not suitable to ensure that people are safeguarded against the risk of abuse. This is a breach of Regulation 11(1).	
Personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: Staff are not provided with appropriate training to enable them to deliver care and treatment to people safely and to an appropriate standard. This is a breach of Regulation 23 (1).	

Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The organisation does not have a system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others who may be at risk. This is a breach of Regulation 10.	

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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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

Review of compliance

Mr & Mrs D Evely Averlea Residential Home	
Region:	South West
Location address:	Fore Street Polgooth St Austell Cornwall PL26 7BP
Type of service:	Care home service without nursing
Date of Publication:	April 2012
Overview of the service:	Averlea Residential Home is a care home for a maximum of 14 older people who may also have dementia. The home has 12 single bedrooms, with one of these having en suite facilities, and one double room should people wish to share. People share the dining and lounge rooms. The home is close to a small shop and post office. There is limited parking available at the front of

	the home for visitors.

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

Our current overall judgement

Averlea Residential Home 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 31 January 2012, carried out a visit on 27 February 2012, carried out a visit on 28 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We carried out a scheduled inspection of the domiciliary care agency and the care home at the same time as they operated from the same office located in Averlea Residential Home. We made unannounced visits to Averlea on 31 January, 27 February and 28 February 2012 when we talked to seven people who lived in the home, one relative who was visiting at the time, and three staff members who worked in the home. On 3 February 2012 we visited four people in their own homes, who received personal care services from the domiciliary care agency, and spoke with four of their relatives during the visits. During this inspection we also spoke with three staff members, in person or on the telephone, who provided personal care to people in their own homes.

During our first visit to Averlea we spoke with the registered manager of the domiciliary care agency but she was not available for the rest of the inspection. We spoke with the registered manager of the care home and one of the owners during all of the visits to Averlea.

At the time of this review the domiciliary care agency provided services to approximately 75 people, most of whom received personal care, and employed approximately 30 staff. There were 13 people living in the care home and 10 care staff were employed as well as domestic and catering staff.

During our visits to the office we looked at records pertaining to both the domiciliary care agency and the care home. These included records relating to the care and support people received, staff files, the operation of the care home, and policies and procedures.

We asked for the staff training records, and some other documentation, to be sent to us which we received on 19 March 2012. We also asked for the quality assurance records but were told by the registered manager of the care home that there was no system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service and others who may be at risk.

People who received care and support from the domiciliary care agency were very positive about the way they were treated by the staff who supported them. Comments from people receiving the service and their relatives included "them's lovely", "we think the world of them", "we can't praise them enough" and "they respect me as a person". People also said that the agency was reliable, flexible around people's changing needs, and time keeping was "very good". However the agency did not have robust arrangements in place to safeguard people against the risk of abuse as few of the staff had received training in this area and the agency's policies and procedures were not clear about the action staff should take.

People who lived in Averlea Residential Home said they were happy living in the home, felt safe and were well cared for. Comments included "we are so well looked after", the staff were "lovely" and "they treat me like one of the family". We observed interactions between the staff and people who lived in the home and saw that staff were friendly and respectful to the people they supported. People talked to us about their personal routines, the activities they enjoyed, and the meals provided in the home. People said they were involved and supported to make decisions about their personal and healthcare needs and that these were being well met by the staff team and visiting healthcare professionals. People received their medicines when they needed them and these were administered in a safe way. However we found that there was no protocol for the administration of 'as required' medicines and medicines were not always being stored or disposed of properly.

People also told us they had not been provided with any information about the home, they did not know how to make a complaint, they did not know who the registered manager was or her name, they were unaware of their care plans and had not been involved in writing them, no activities took place apart from bingo and they were never told what the next meal would be. They said there were no meetings held between the people who lived in the home and the management, they had never been consulted about the quality of care in the home, and had no involvement in how the home was run. We also found that the arrangements in the home to safeguard people from abuse, such as written policies and procedures, were not suitable which may place people at risk of abuse.

During our visit to the office we examined the care files belonging to five people who received a domiciliary care service and four people who lived in the care home. We found that the care and support plans for both people receiving domiciliary care and living in the care home contained detailed information about some aspects of people's care and gave clear directions to staff about how people wanted each task to be carried out. However, from discussion with the people who used the services, we found that the care plans did not contain all of their care and support needs; the people receiving a domiciliary care service said the staff did not always read them; and the people living in Averlea Residential Home were not aware of the existence of the care plans. We also looked at the financial records of three people who lived in the home whose spending money was administered by staff in the home. We found that these records were not audited on a regular basis to ensure accuracy and protect people from possible financial abuse.

During our visits to the care home we looked around the communal parts of the care home and eight bedrooms. We found that all the bedrooms were warm and most of them contained many personal possessions, although this varied from one person to another. The bedroom doors had locks fitted but, if locked from the inside, the staff were not able to enter in an emergency. None of the bathroom and toilet doors available to the people who lived in the home had locks fitted which meant that people's right to privacy was compromised.

During our first visit we found that none of the bedroom doors had 'hold open' devices fitted that would automatically close if the fire alarm went off but these had been fitted by the time of our second visit. After discussions with staff about what to do in the event of a fire, and the registered manager saying that the fire risk assessment needed updating and that she had not yet written the personal evacuation plans for each person living in the home, we made a referral to the fire service due to our concerns regarding fire safety awareness in the home.

We looked at staff training records and spoke with staff from the domiciliary care agency and the care home about the training they had received to enable them to do their jobs. We found that almost all of the staff had qualifications in care and had received some training related to essential areas of their work. However we also found that staff had not received training related specifically to the needs of the people they supported to enable them to deliver care and treatment to people safely and to an appropriate standard.

What we found about the standards we reviewed and how well Averlea Residential Home was meeting them

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

People's personal care needs are supported by attentive staff who treat people with respect. However people are not treated with consideration, their rights to privacy are compromised, and they are not provided with information or fully involved in all decisions relating to their care and support.

This is a breach of Regulation 17(1) and 17(2)(a)(b)(f).

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

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

People are satisfied with the care provided and the attitude of staff. However information gaps in the care plans may result in important health or personal care tasks being missed or carried out in an inappropriate or unsafe manner.

This is a breach of Regulation 9(1).

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

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

human rights

People who receive a service from Averlea Residential Home feel safe and well looked after by the staff team. However the arrangements in the home, such as written policies and procedures, are not suitable which may mean that people are not safeguarded against the risk of abuse.

This is a breach of Regulation 11(1).

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

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People receive their medicines at the times they need them and in a safe way. However people are not protected against the risks associated with the unsafe use and management of medicines as there is no protocol for the administration of 'as required' medicines and medicines are not always being stored or disposed of properly.

This is a breach of Regulation 13.

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

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

People live in a home that is generally clean, comfortable and well maintained. However people are not protected against all risks because regular audits of the environment are not being carried out to identify areas where maintenance is needed.

Overall, we found that Averlea Residential Home is meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

People receive the care and support they need from a caring and considerate team of staff. However staff are not provided with appropriate training, in relation to the specific needs of the people they support, to enable them to deliver care and treatment to people safely and to an appropriate standard.

This is a breach of Regulation 23 (1).

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

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 organisation does not have a system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service.

This is a breach of Regulation 10.

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

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

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
During our visit to Averlea we saw and heard the people who lived in the home interacting with staff in a positive way. The atmosphere in the home was calm and peaceful with staff going about their tasks with a minimum of noise and disruption. We saw that the staff treated people in a friendly and respectful way and were attentive and quick to recognise when people needed assistance with personal care needs.

We spoke to seven people who lived in the home who said they were happy with the care provided. People told us that the staff were helpful, they were always treated with respect, and were satisfied with the personal care provided. They said that the staff were "lovely" and "very good". One person said "we are so well looked after" and "treated like one of the family". People told us that they could choose what time the staff came to assist them in the mornings and at bedtimes. People told us that they were satisfied with the weekly bath or shower regime and the registered manager told us that people could have as many baths or showers as they wanted.

On our first visit to the home we arrived just before lunch was served. We asked people what they were having for lunch but they said they did not know as they were never told what the meals were and were not offered any choices. People were not sure whether, once the meal had been presented to them, they could say they would

prefer something else. The opinion of the people we spoke with was that they had to accept whatever was given to them. A staff member confirmed that people were not told what food was on offer each day but said that the staff knew what people's likes and dislikes were. However we saw a staff member bring a meal to a person we were talking to and the person indicated that she did not like a food item on the plate. When we asked the registered manager about this she said it may be because the person had not been living in the home for very long. However when she checked the person's care plan she found that it was documented that the person did not like that particular food item. This indicated that the system in place did not ensure that people were only given the food they liked at every meal time.

We asked people if they had seen their care plan and been involved in drawing it up. Six people we spoke with said they did not know they had a care plan and had not been consulted or involved in writing them.

Our conversations with people living in the home demonstrated that people were not being treated with consideration, provided with information, or fully involved in all decisions relating to their care and support.

Other evidence
On our first visit to the home we were shown to a 'quiet lounge' which was one end of a person's bedroom. There was a curtain across the middle of the room, separating the person's sleeping area from the 'quiet lounge'. We were told by a staff member that this bedroom used to be a shared room but the person no longer wished to share with anyone else. We said it was not acceptable to use part of a bedroom as a 'quiet lounge' as that was an infringement of the person's right to privacy. When we visited again at the end of February the registered manager told us that the bedroom was not being used as a 'quiet lounge'. We were told there were plans in place to divide this room to create a 'quiet lounge' but it would be properly built thus ensuring that the person had a private bedroom.

When we looked around the home we found that bathroom and toilet doors did not have any form of lock fitted (apart from the staff toilet). The locks on the bedroom doors were the type that, if they were locked from the inside and the key left in, prevented the staff from gaining access in an emergency. We raised this with the registered manager and one of the owners as the absence of locks, or locks that were not able to be used by people when in their bedrooms, had implications for people's rights to privacy.

We looked at four care plans and found they had not been signed by either the people living in the home or a relative/representative. This indicated that they had not been involved in drawing them up despite the organisation's 'Service user plan of care policy' that said "The resident must ... sign or otherwise signify active consent to the plan of care and to the attendant risk assessments.".

Our judgement
People's personal care needs are supported by attentive staff who treat people with respect. However people are not treated with consideration, their rights to privacy are compromised, and they are not provided with information or fully involved in all decisions relating to their care and support.

This is a breach of Regulation 17(1) and 17(2)(a)(b)(f).

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

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

Our findings

What people who use the service experienced and told us
We spoke with seven people who lived at the home - four people in their bedrooms and the other people in the lounge or dining rooms. Everyone expressed satisfaction with their care and said that the staff knew what to do to assist them and provided that assistance in the way people requested. People said the staff were very nice and listened to them. All the people we spoke with said they saw doctors, nurses, dentists and opticians when they needed them and a chiropodist visited the home regularly.

We looked at the organisation's policy on quality care that said there was a "wide range of leisure activities" available. We asked people what activities took place in the home and were told that nothing happened except bingo occasionally. People told us that a staff member occasionally walked with them to the local shop but, apart from that, they were reliant on friends or relatives to take them on trips out of the home. We asked the registered manager and one of the owners about the activities and were told that these were not happening very often due to staff holidays and sickness. The registered manager confirmed that staff had not arranged any trips out for the people who lived in the home for some time but this was likely to happen again as the weather improved during the spring and summer. People told us that relatives and friends visited them in the home whenever they wanted to. The people we spoke with in their bedrooms did not have their own telephones but one person told us they could use the home's portable telephone if they wished to make a call. The registered manager told us that people could have their own telephones in their bedrooms if they wanted one so they could receive and make private telephone calls.

Other evidence
We looked at the records of four of the people who lived in the home and found that, before people moved into the home, assessments had been carried out to identify people's care and support needs. These assessments included information about aspects of their personal and health care needs, likes and dislikes, family and social networks and other information relevant to their support needs.

We looked at the care records of four of the people who lived in the home. These contained documents that covered various aspects of people's health and social care needs, including associated risks. The information in the care plans was, in the main, very detailed and gave staff clear instructions about how people's care and support needs should be met. However discussions with the people who lived in the home, one relative we spoke with, as well as the registered manager, indicated that there were some gaps in the care plans. For example people's mental health needs were not described in any detail and the care plan did not say how the staff were to meet those needs; the care plans listed what medication people were taking but did not say what the medication was for or under what circumstances 'as required' medication should be given.

The files contained information that showed health and social care professionals had been consulted and involved in people's care. We spoke to one of the district nurses, who visited the home regularly, who said the district nursing team were confident that the care provided by the staff team at Averlea was very good. She said that the management and staff team worked well with visiting health care professionals. The district nursing service had no concerns about the care of people who lived in the home, the end of life care provided by the staff team was "wonderful" and, if they did have any issues, the registered manager resolved them immediately.

Our judgement
People are satisfied with the care provided and the attitude of staff. However information gaps in the care plans may result in important health or personal care tasks being missed or carried out in an inappropriate or unsafe manner.

This is a breach of Regulation 9(1).

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

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
Overall the atmosphere in the home during our visit was relaxed and we saw that there was a good rapport between the people who lived in the home and the staff. We spoke to seven people who said they felt safe and secure living in the home and the staff treated them kindly and respectfully.

Other evidence
During our visits to the home we asked three staff members if they knew what to do should they witness an incident, or suspect, that a person who lived in the home was being mistreated, abused or neglected. Two of the staff members described the procedure to follow and who to contact should an incident occur. They said that the first person to contact would be the registered manager of the home. They were also aware that they could contact external agencies, such as Social Services, the police or the Commission if they had concerns. One staff member did not know what to do apart from talk to the registered manager. This staff member also said they had not received any training in safeguarding vulnerable adults from harm, abuse or neglect and was not aware of an organisational policy and procedure.

We asked the registered manager to send us details of all the training that staff had attended so that we could confirm they had all received training in safeguarding vulnerable people from abuse. We received training information about 11 staff members on 19 March 2012. This showed that eight staff had completed specific training on the subject of 'Abuse Awareness' thereby indicating that most staff had received training in this important area.

We also looked at the organisation's policies on protecting people from abuse and found that they were out of date and did not provide enough information for staff to know how to recognise and report abuse. We asked the registered manager if there was a copy of the local authority's 'Alerter's Guidance' that told staff what action to take, to make sure that correct procedures were followed, but there was no copy in the home.

We discussed the implications of the Mental Capacity Act and deprivation of liberty safeguards (DOLS) with the registered manager who confirmed that no-one in the home was subject to any restraint or restriction, for example, doors were not locked and people could come and go as they pleased. However we found that the front door had a coded lock on it and one person's freedom of movement/actions was limited due to her needs and at the request of relatives. Therefore we advised the registered manager to check with the local authority to establish whether this needed a 'best interests' meeting or DOLS authorisation. The Mental Capacity Act 2005 and deprivation of liberty safeguards provide a legal framework that protects people who lack the mental ability to make decisions about their life and welfare.

We looked at the way the home supported people to manage their own money. Some people had relatives who brought cash into the home for them and, if the person was not able to keep this, it was safely locked away but people could have access to it whenever they wanted. We looked at the records of money held by the home on behalf of three people and found that incomings and outgoings were documented and receipts were obtained when necessary. We found a discrepancy on one person's records (dated 1 November 2011) and the registered manager agreed to look into this as she was confident it was an administrative error. However this demonstrated that there were no auditing arrangements in place to ensure that the records were kept accurately as, if there had been, this discrepancy would have been identified and resolved prior to our visit.

Our judgement
People who receive a service from Averlea Residential Home feel safe and well looked after by the staff team. However the arrangements in the home, such as written policies and procedures, are not suitable which may mean that people are not safeguarded against the risk of abuse.

This is a breach of Regulation 11(1).

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

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We asked the people we spoke with about about how their medicines were administered. They told us that their medicines were kept safely by the staff who administered them at the required times. The people we spoke to were confident that they received the correct medicines at the correct times.

Other evidence
During our visit to the home we observed a staff member administering medicines at tea time. We saw that this was carried out safely in that the staff member checked the medicine being given against the administration records, gave it to the correct person, waited with the person until they had taken it and then signed the records to show the medicine had been administered. The home used a system where most tablets were received from the pharmacy in blister packs containing the tablets each person needed for different times of the day. Some people were prescribed medicines to be taken 'as required' however there was no protocol or procedure to tell staff under what circumstances this medicine was to be administered.

Medicines were stored in locked cupboards that were well organised and tidy. The home had a lockable metal cupboard for storing controlled drugs but the registered manager told us there were no controlled drugs in the home at the time of our visit. The home had a lockable refrigerator specifically for medications that required refrigeration. When we checked the content of the refrigerator we found that some items were being stored that did not require refrigeration and these were removed during our visit. This

indicated that proper audits were not being carried out to ensure that medicines were stored correctly at all times.

We asked a staff member how unwanted medication was disposed of, for example, if a tablet was dropped on the floor. We were told it would be put in the domestic waste bin. We asked the registered manager about how unwanted medicines were disposed of and were told that they would be disposed of in the clinical waste bin. This practice did not comply with the guidance from The Royal Pharmaceutical Society 'The Handling of Medicines in Social Care' that advises medicines should be returned to the pharmacy for disposal. The registered manager said she was not aware of this guidance as she had not seen the document we referred to. We looked at the home's medication policy and found that it said unwanted medicines were to be returned to the pharmacy for disposal thereby indicating that staff were not aware of the home's policy.

A pharmacist had visited the home in January 2012 and carried out an audit of the medicines held in the home. Following that visit the registered manager had obtained a stock of 'homely' remedies and these were given to people on request, provided that they did not have an adverse effect on the person in combination with prescribed medications.

Our judgement
People receive their medicines at the times they need them and in a safe way. However people are not protected against the risks associated with the unsafe use and management of medicines as there is no protocol for the administration of 'as required' medicines and medicines are not always being stored or disposed of properly.

This is a breach of Regulation 13.

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

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
We spoke to seven people about the accommodation in the home and they all said they had what they needed, were comfortable and very happy with the accommodation. We looked in eight bedrooms and these contained many personal items, although this varied from one person to another, and were individually decorated. The bedrooms we saw were warm, pleasant, homely and in a reasonable state of decoration. The registered manager told us that people could choose to have their bedrooms decorated in whatever way they wanted. However there was no lockable space for people to store money, valuables and medication.

Every bedroom door had locks fitted so that people could have privacy from unwanted intrusion or to make sure their personal belongings were kept safe if they were away from the home for any reason. However the type of locks on the doors meant that, if they were locked from the inside, staff would not be able to gain access in an emergency. People told us they did not have keys to lock their doors but the registered manager said each person did have a key to their own bedroom door.

We looked at the windows of some of the bedrooms on the first floor to see if they were restricted to prevent people falling or climbing out of them. We found that the type of restrictor in place was easily removed and, in one bedroom, had been removed completely. The registered manager was unaware of this but agreed to have them changed to something more robust as soon as possible.

On the day of our first visit we found bedroom doors propped open with objects, such as a blanket and a commode. None of them had 'hold open' devices fitted that would

automatically close if the fire alarm went off. By the time of our second visit the registered manager told us that 'hold open' devices had been fitted to all bedroom doors and we saw them on the bedroom doors on the ground floor. We asked to see the fire risk assessment and the registered manager showed us a file and said she had been told it was too big so she was in the process of re-writing it. We asked the staff we spoke with what they would do in the event of a fire and, whilst they had a good idea what to do, they were not entirely sure of the procedure and did not know how to remove people from the building. We asked the registered manager for the personal evacuation plans for the people living in the home and were told that they had not been written. Following our visit we made a referral to the fire service due to our concerns regarding fire safety awareness in the home.

Other evidence
During our visit we looked around the shared areas of the home that consisted of a lounge room and a dining room, where we spent some time talking to people. The dining room looked more like a kitchen, and some of the people who lived in the home referred to it as a kitchen, as it had kitchen type cupboards with a work surface top. However no-one minded this as it also contained facilities for people to make their own hot drinks and a microwave if they wanted to heat anything up.

We looked in eight (out of 13) bedrooms, bathrooms, toilets, the external patios and the kitchen. We found that one end of a person's bedroom was being used as a 'quiet lounge' and contained various items such as wheelchairs and board games. There was a curtain across the middle of the room, separating the person's sleeping area from the 'quiet lounge'. We were told by staff that this bedroom used to be a shared room but the person no longer wished to share with anyone else. We said it was not acceptable to use part of a bedroom as a 'quiet lounge' as that was an infringement of the person's right to privacy (see Outcome 1). When we visited again at the end of February the registered manager told us that the bedroom was not being used as a 'quiet lounge' and items not belonging to the person had been removed. The registered manager said there were plans in place to divide this room to create a 'quiet lounge' but it would be properly built, thereby ensuring that the person had a proper bedroom. The home had a stair lift from the ground to the first floor for those people who were not able to manage to walk up or down stairs. One of the bedrooms had an en suite toilet and shower however the registered manager said that the person did not use the shower.

We found that the home was clean and, apart from one bedroom, there were no unpleasant odours. The bedrooms we saw were warm, pleasant, homely, in a good state of decoration and personalised to the taste of the occupant. However one bedroom contained a chest of drawers with broken handles which the registered manager said she was unaware of. One bedroom was not clean and had an unpleasant odour and the registered manager said this was due to the specific needs of the person who lived in that room. By the time we visited again in February the registered manager said an action plan was in place to address the cleanliness of the room but this action plan was not evident in the person's care records.

The registered manager informed us that all the hot water taps on the baths, showers and sinks in people's bedrooms were fitted with thermostatically controlled valves to keep the hot water at a safe temperature and this was monitored to make sure they were working correctly. She also confirmed there were procedures in place to make sure there was no risk of legionella from any unused water outlets.

Our judgement
People live in a home that is generally clean, comfortable and well maintained. However people are not protected against all risks because regular audits of the environment are not being carried out to identify areas where maintenance is needed.

Overall, we found that Averlea Residential Home is meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People who lived in the home told us that the staff were always "nice", "friendly" and "helpful" and there were usually enough staff to meet their personal care needs. Overall people were satisfied that staff understood their preferences and needs.

During our visits to the home we found that the atmosphere was relaxed and people were being assisted at a pace which suited them. We saw some people in the lounge room, some people eating meals in the dining room, and some people in their bedrooms, indicating that routines at the home were relaxed.

Other evidence
There were 13 people living in the home during our visits. We looked at the staffing rotas and spoke to five members of staff and the registered manager who said there were enough staff on duty to ensure that people's personal support needs were met. We found that there were two members of care staff in the home during the day and at night, as well as catering and domestic staff, and the registered manager. We were told by one of the owners that activities were not happening very often as there were not enough staff to facilitate these due to holiday and sickness. The registered manager confirmed that staffing would be increased if necessary, for example, if someone was ill and needed more assistance.

The registered manager told us that, if possible, people had a choice of male or female staff to assist them with personal care. But, as the organisation only had one member of care staff who was male, this was not always possible. There was no information in people's care plans to show that people had been asked whether they had a preference

for the gender of staff who assisted them with personal care.

The staff members said they were very well supported by the registered manager and could talk to her at any time. We asked the staff if they met with the registered manager regularly, on a one to one basis, to discuss their work and identify learning and development needs but all of them were not sure whether this took place or not. However the registered manager produced documentation that showed she regularly met with every staff member on a one to one basis, the outcomes of the meetings were recorded, and staff received regular appraisals.

The staff said they had received enough training to give them the skills and knowledge they needed to carry out all of the care tasks they were required to do. The staff told us they had received some induction when they started working in the home but it did not sound very detailed. We asked the registered manager about the induction process who said they had not needed to use a comprehensive induction course as all of the recently recruited staff had previous experience in care and most of them had professional qualifications. The staff told us that ongoing training topics included moving and handling, health and safety, fire safety, first aid, food hygiene, medication and safeguarding. The staff said they had achieved professional qualifications in care, namely National Vocational Qualifications (NVQs) to level 2 and 3 and one of them said they had also attended training on dementia awareness. However the staff also said that some people who lived in the home had had diabetes or used a catheter but they had not received any training on these subjects.

We asked the registered manager to send us details of all the training that staff had attended so that we could confirm they had received relevant training to give them the skills and knowledge to do their jobs well. We received training information about 11 staff members on 19 March 2012. These records showed that all the staff had achieved, or were working towards, a qualification in care, namely a National Vocational Qualification (NVQ) to level 2 or 3 indicating that the management team had a positive attitude to ensuring the staff were properly trained to do their jobs. In addition most of the staff had received training in fire safety, health and safety, moving and handling, first aid, medication, food hygiene and safeguarding vulnerable adults from abuse. Approximately half of the staff team had received training in dementia awareness but only three staff members had attended training on the deprivation of liberty safeguards and one staff member had attended a course on the control of infection. These records did not show whether staff had received other specialist training, particularly in relation to the specific needs of the people they supported such as diabetes and catheter care.

Our judgement
People receive the care and support they need from a caring and considerate team of staff. However staff are not provided with appropriate training, in relation to the specific needs of the people they support, to enable them to deliver care and treatment to people safely and to an appropriate standard.

This is a breach of Regulation 23 (1).

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

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
We spoke to seven people who lived in the home who were satisfied with most aspects of the care and support they received but said they had not been provided with any information about the home and they had no opportunities to influence what went on in the home. They told us that no meetings were held between the management and the people who lived in the home, they had never been consulted about the quality of care in the home, and they had no involvement in how the home was run.

This demonstrated that the management of the home did not encourage people to feedback any positive or negative views about the way the home was managed.

We asked people if they knew how to make a complaint should it be necessary and we were told that they did not know what the home's procedure was but would tell a relative (if they had one). Some people were not sure who the registered manager was, or her name, but did say they thought there was a manager in the home.

The registered manager said the home had received one complaint in the last year. We had also been contacted by the complainants as they were not happy about the way the management of the home had handled their complaint. We discussed this with the registered manager who agreed that it should have been handled differently. We asked to see the complaints book referred to in the organisation's complaints procedure. The registered manager said this did not exist as complaints were now stored on an electronic database but the policy and procedure had not been updated.

Other evidence
The organisation had a quality assurance policy but it was out of date as it referred to previous legislation and the previous regulator. The staff we spoke with, and the registered manager, confirmed that staff meetings had not taken place for some time. We asked the registered manager how the quality of the service provided was assessed and monitored. We were told that there was no system in place.

Our judgement
The organisation does not have a system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service.

This is a breach of Regulation 10.

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

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 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	Why we have concerns: People are not protected against all risks because regular audits of the environment are not being carried out to identify areas where maintenance is needed. This is a breach of Regulation 15(1)(c).	

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 14 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: People's personal care needs are supported by attentive staff who treat people with respect. However people are not treated with consideration, their rights to privacy are compromised, and they are not provided with information or fully involved in all decisions relating to their care and support. This is a breach of Regulation 17(1) and 17(2)(a)(b)(f).	
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: Information gaps in the care plans may result in important health or personal care tasks being missed or carried out in an inappropriate or unsafe manner. This is a breach of Regulation 9(1).	
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: The arrangements in the home, such as written policies and procedures, are not suitable which may mean that people are not	

	safeguarded against the risk of abuse. This is a breach of Regulation 11(1).	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: People are not protected against the risks associated with the unsafe use and management of medicines as there is no protocol for the administration of 'as required' medicines and medicines are not always being stored or disposed of properly. This is a breach of Regulation 13.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: People receive the care and support they need from a caring and considerate team of staff. However staff are not provided with appropriate training to enable them to deliver care and treatment to people safely and to an appropriate standard. This is a breach of Regulation 23 (1).	
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
	How the regulation is not being met: The organisation does not have a system in place to assess and monitor the quality of care provided or to identify, assess and manage risks relating to the health, welfare and safety of people who use the service. This is a breach of Regulation 10.	

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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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