Review of compliance

Mr HN & Mrs SJM Dennis and Mr DM & Mrs AM Baker Honiton Manor	
Region:	SW
Location address:	Exeter Road Honiton Devon EX14 1AL
Type of service:	Care Home with Nursing
Date the review was completed:	April 2011
Overview of the service:	Honiton Manor is registered to provide 24 hour nursing care for up to 22 people who have needs relating to 'older people'. The two-storey home is an older style building situated on the main road into, and quite close to, Honiton and the local amenities. It is on public transport routes. There are eleven single bedrooms and five double bedrooms situated on the ground and first floors. One of the double bedrooms has an en-suite bathroom. A passenger lift and a

	staircase link the floors.

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

What we found overall

We found that Honiton Manor was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Meeting nutritional needs
- Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 18 February 2011, observed how people were being cared for, talked to five people who use services and two relatives, talked to eight staff, checked the provider's records, and looked at records of people who use services. The manager was not on duty on the day of the visit. There were 20 people living at the home at the time of the visit.

What people told us

We spoke to people living at the home about the meals and about staffing numbers and whether they felt that their needs were met. People said that the staff were 'lovely' but they were 'rushed off their feet'. Two relatives were concerned that often 'staff were not around when help was needed'. One relative felt that they had to be at the home as much as possible to ensure that their relative's needs were met.

We saw that staff were very busy, call bells were ringing and being answered as soon as staff could but staff were not available on the ground floor for long periods.

One relative said that they had to go and find staff to get help if someone needed assistance to mobilise. The cook said that it was not unusual for them to have to leave the kitchen to try and find staff. The activity co-ordinator also works as a carer and said that they sometimes have to stop activities to assist people in the lounge as other staff are not around. People living at the home said that they were disappointed when a quiz had to stop when the activitiy co-ordinator had to go and assist people who required help.

We heard that staff were very caring and felt to be ‘trying their best’. Relatives said that staff were not able to sit and talk to people living at the home and staff said that this was the case because they were busy upstairs. We heard that seven people living at the home need two staff to mobilise on a regular basis and some people also need help to eat and drink. This means that two staff can be occupied for longer periods with one person.

We asked people about the food and provision of special diets at the home. We heard that the food was excellent, home made and ‘very nice’. Staff showed us how they managed special diets for people. There is an excellent system in place to ensure that people living at the home are identified as needing a special diet and that this is given safely. We heard how specialist advice is sought and that this is followed with good records to back this up.

Relatives said that they thought that the food was good. One relative said that they did worry when the tea trolley was in the lounge because some people who need assistance to walk sometimes try to move by themselves. They said that this was because there was no way for people to call for help in the lounge other than a relative going to find staff. Relatives said that they worried about leaving boiling water unattended on the trolley.

What we found about the standards we reviewed and how well Honiton Manor was meeting them

Outcome 5: Food and drink should meet people’s individual dietary needs

People living at the home benefit from nutritious meals in a sociable environment and dietary needs, including special diets are met safely on an individual basis.

Overall, we found that Honiton Manor was meeting this essential standard.

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

Staffing levels at the time of the visit were not always sufficient to safely meet the needs of people living at the home.

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

Action we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

We looked at how staff were providing special diets for people living at the home. We looked at three peoples' care in depth. Their three care plans were very detailed about their nutritional needs. There was clear advice recorded from the speech and language therapist showing what sort of diet the person should be having. Staff had ensured that everyone involved in providing help for these people were clear about what diet needed to be given and how that person needed to be fed.

There is an excellent system in place to ensure that people on special diets have their nutritional needs met safely. A 'traffic light 'system is used in the kitchen and each colour shows which type of diet each person at the home needs such as pureed, thickened liquid or fork mashable food.

There are caution notices and individualised lists showing peoples' likes and dislikes such as 'ensure that this person has pureed prunes'. Each person living at the home has an individual tray. People with special diets have a red tray to alert staff to their needs relating to nutrition. The trays have a laminated card tied to them detailing the named persons' nutritional needs.

We spoke to one person who had particularly complex nutritional needs. They said that they felt that staff looked after them very well. We saw that this person had all

the equipment they needed for their mouth-care organised by their bed. A notice told staff what to do on a regular basis. We could see that this was being done and the person looked well cared for. Records were good and showed a clear plan for staff to follow to meet this persons' needs. Specialist advice had been followed about how to meet their nutritional needs and related hygiene care.

Other evidence

We had information from the multidisciplinary team before the visit about some peoples' nutritional needs at the home. We found that these were all met during the visit and that advice given to the home had been followed.

Our judgement

People living at the home benefit from nutritious meals in a sociable environment and dietary needs, including special diets are met safely on an individual basis.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are major concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

We spoke to all eight staff on duty during the visit and observed them providing care to people living at the home. All staff spoken to said that staff morale was low due to not enough staff. One staff member said ‘I love it here but now I’m thinking, no’. We saw that there was one nurse in charge of the shift, two care workers upstairs and two care workers downstairs, an activities co-ordinator, care support and cook. We were told that staff felt that it was difficult to meet peoples’ needs and that it was ‘go, go, go’.

There are seven people who need two care workers to help them move using a hoist. We saw that it takes about 15-20 minutes to use the hoist for them. One staff member said that someone who needs a bed to chair to transfer takes 20 minutes upstairs at 2pm when one care worker is on a break so ‘we have to rush the person’. A domestic said that they often have to help care workers as the bells are going. They said that they spend a lot of time looking around for staff and found it stressful. One care worker said ‘it’s like a chase’. They had worked at the home for a long time and said that the home wasn’t like this before.

Staff said that they had been told by the manager that they have to ‘get everything done by 10am’ to ensure that people living at the home are washed and dressed. The Manager responded following the visit that they had not said this. Staff said that people did not have any choice about when to get up. We spoke to one person who

said that they liked to get up around 8.30am. A falls record showed that they had been assisted to get up at 6am. Staff said 'I don't know why he was up then, he doesn't like getting up that early', however it could be that on that occasion they had decided to get up independently at 6am. Two other people living at the home said that they get up when staff come as they are so busy.

We heard that at 10am until 11am two care workers go off for their break. At 11am until 12 midday , the other two care workers go for their break. This means that between10am-12 midday there are two care workers on the floor and the qualified nurse to care for the people at the home. Staff said that they have been told by the manager that they have to have this break. At 10.30am a care worker has to do the tea trolley and serve the mid morning drinks leaving one care worker to meet peoples' needs around the home. The activity co-ordinator person said that they are often asked to serve the midmorning drinks rather than continue with one to one sessions with people. They are now contracted to work as an activity co-ordinator and a care worker and have received the appropriate training, however there are no time distinctions between when they are doing which role. The Provider said that it is the role of the activities co-ordinator to serve the mid morning drinks but the activities co-ordinator was not clear about this. Care workers are also expected to do the laundry and lay up meal trays.

Two staff said that the work was 'task orientated' and 'people get fed one after the other.' We heard that as soon as someone living at the home stirs in the morning their breakfast tray goes to their room. Those people who are vocal about not wanting their breakfast too early are left until later. One person living at the home said that this was the case. We were told by the Provider that when an audit was carried out of 15 staff members, staff were asked to explain what they thought the concept of person centred care was and all answered appropriately.

We spoke to one relative who was concerned because their relative needed help with feeding. They said that staff did not have the time to sit with people. Staff said that this was true and included during end of life care. The Provider told us that the manager had rung the home that day to ask if staff needed extra help and that they had said no. We saw that staff tried to spend time with one person but were unable to sit with them for long. Staff said that sometimes staff stay after a shift to sit with people. Another relative said that they had never seen staff sit with people living at the home except when they were being helped to eat. The Provider said that they do encourage staff to sit with people when able.

We spoke to two relatives about whether staff were available when people living at the home are in the lounge. They said that there were no call bells accessible to people who had limited mobility in the lounge. They said that two people in particular who need assistance moving sometimes get up by themselves. They said that once someone who needs help to move had got up by themselves and made it across the room holding onto chairs and then got stuck, needing staff assistance. The relatives said that they spend time looking for staff especially in the afternoons and that there is no-one at the desk. We looked at residents' meeting minutes from February 2011. These said that relatives felt that 'often staff are not around when help is needed' and 'one of the residents needs a call bell to summon help as staff are just not around'. Staff said that these comments had been made at previous meetings but had not been addressed. The manager had not attended the meeting and the staff

member at the meeting had had no feedback. The Provider said that all minutes are addressed although there may be a week or so delay. They said that the manager does not attend all the meetings but that issues will be addressed. The last staff meeting was in September 2010.

We looked at the falls records book. We looked at one record about one person who had a history of falls. The actions recorded were that staff should ensure that the person is always walking with a frame under supervision or being checked. We saw this person walking unaided using the walls as support and staff said that they could not be sure that this person was always safe. Records showed that this person continued to fall. We could not see a falls audit showing how falls are being managed and risks minimised. Another record gave the reason for the fall as 'couldn't get there on time, found on floor'. Another record for another person living at the home said that the person had fallen because 'not enough staff on the floor as two nurses occupied with hoisting'.

There are seven people living at the home who have a pressure mat on the floor in their rooms to alert staff when these people stand on it. There were no records as to any multidisciplinary discussions with the person about how this decision was made. Staff said that if they hear this alarm then they run in and sit the person back down. This is not person-centred care. Staff said that person centred care was 'not here'.

In the afternoons there are three care workers on duty and a qualified nurse. Care workers take breaks between 2pm and 5pm so for three hours there are only two care workers working who can provide care and support to people .Staff all said that it was difficult to carry out all the work and care that they needed to do. The Provider said that the Registered Nurse is also available to assist care workers 'on the floor' during this time.

One relative said that when there is no-one able to watch the tea trolley in the lounge, then they feel anxious about leaving the room to get staff in case the trolley gets knocked. They went on to say that they couldn't praise the staff enough with what they have to put up with'.

Staff said that they are often contacted by the manager on their days off to cover shifts. We saw that the home does not use agency staff. Staff were all feeling unhappy about the staffing situation and felt 'put on' to do extra shifts. They said that they had spoken to the manager and the owners but nothing had changed.

We asked staff if there was a system to assess how many staff were needed relating to the needs of people living at the home. Staff said that they worked to the numbers on the rota not according to peoples' increased needs. However, we heard from the Providers that there is a need dependency assessment tool which has been used in the past to increase staff hours.

Other evidence

We received information from the multidisciplinary community team that indicated that staffing levels may not be appropriate to meet peoples' needs at all times such as feeding people, spending time with people and giving personalised unrushed care.

Our judgement

Staffing levels at the time of the visit were not always sufficient to safely meet the needs of people living at the home.

Action
we have asked the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons requiring nursing or personal care	**22**	13
	How the regulation is not being met: Staffing levels at the time of the visit were not always sufficient to safely meet the needs of people living at the home.	

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

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

The provider's report should be sent to us within 7 days of this report being received.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

Document purpose	Review of compliance report
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