Review of compliance

Mrs A Jobson Ardgowan House Residential Care Home (Mrs Annie Jobson)	
Region:	North East
Location address:	4 Middle Street Newsham Blyth Northumberland NE24 4AB
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Ardgowan House is a detached house situated in a residential area on the outskirts of Blyth. The home provides accommodation for ten people with mental health problems or learning disabilities. Each person has their own bedroom and they share communal areas. There is a small front garden

	and a large back garden. The home is close to local shops and pubs. The town centre and the coast are close by.

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

Our current overall judgement

Ardgowan House Residential Care Home (Mrs Annie Jobson) 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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 10 - Safety and suitability of premises
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 13 September 2011, talked to staff and talked to people who use services.

What people told us

People told us that the home was comfortable and met their needs. They said they enjoyed living there and were well cared for. They said they could come and go as they pleased and enjoyed visiting local shops, cafes and pubs.

What we found about the standards we reviewed and how well Ardgowan House Residential Care Home (Mrs Annie Jobson) was meeting them

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

We found that the home was not meeting this essential standard.

People's needs may not be met if care plans are not evaluated regularly and risk assessments are not in place for all aspects of their care.

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

We found this essential standard was not being met.

The system in place for dealing with people's finances was not robust and did not protect them from abuse.

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

We found that there was a suitable system for storing, administering and recording medications.

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

We found that the home was not meeting this essential standard.

People were at risk if fire safety and food hygiene regulations were not met.

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

We found that the home were not meeting this essential standard.

People's rights to confidentiality may not be protected if personal information is accessible to everyone.

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. Any regulatory decision that CQC takes 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 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
The people who were spoken with said they enjoyed living in the home and felt they were well looked after. They said they enjoyed the food and there was plenty of choice. Some people said they bought a take away meal on Saturday evenings but there was always a meal provided in the home if they preferred this.

People said they enjoyed going shopping and visiting local cafes and pubs. Two people said they often went to the local shops to buy sweets and crisps.

One person said they had thoroughly enjoyed a trip to Whitby recently. They said they enjoyed having lunch there.

Another person said they enjoyed hoovering and dusting their bedroom.

People said they could come and go as they pleased and were able to go to bed and get up when they liked.

One person said that the manager gave them any mail which arrived for them at the home. They said they sometimes asked the manager to keep this in their file.

Other evidence
There were care plans in place which informed the staff of the care and support the people living in the home required. These included personal hygiene, mobility, mental, emotional and social needs. There were no care plans in place for people who required

help in managing their finances.

The files we looked at showed that multi disciplinary reviews had taken place and these were signed by the people living in the home to confirm they agreed with their content. There was no written evidence to show that monthly evaluations were carried out to ensure changes in people's needs were met.

The files were disorganised which made it hard to locate some documents.

The manager told us that the deputy manager completed risk assessments when they felt there was a problem. However there were none in place for people going out in the community and managing finances.

The staff supported people living in the home to access a range of activities both inside the home and in the community. Some people went shopping in the town centre, visited local cafes and attended day centres. The manager told us that she had recently taken one person to Blackpool for two days to see a concert and two members of staff had taken three people for a short holiday at Haggerston Castle Caravan Park.

Some people who were present in the home had fleeces or jackets on. They said this was because they kept going outside to have a cigarette and not because they felt the home was cold. The manager told us that the thermostat for the central heating is always set at 19 degrees centigrade to ensure an adequate temperature was maintained.

Our judgement
We found that the home was not meeting this essential standard.

People's needs may not be met if care plans are not evaluated regularly and risk assessments are not in place for all aspects of their care.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

There are major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Two people said they were given money to go out when they asked for it.

Other evidence
We looked at the system for recording people's finances. The manager kept money in the home for people who did not fully manage their own finances. A book was kept containing an individual record sheet for each person and their personal money was held in separate envelopes. However the amount recorded on two records did not correspond with the amount of money held in the envelopes. The manager said this was because when people requested money the staff were instructed to take it from the petty cash tin and record the amount taken on people's individual record sheets. The manager then balanced the records at the end of each week. There were receipts placed inside the record book but some did not include the name of the person they related to. Therefore it was difficult to relate all the receipts to the relevant transactions. The manager started to up date the records during the inspection.

Two individual records showed that £11 had been paid on a regular basis and recorded as 'escort'. The manager explained that two people living in the home paid this money to staff if they escorted them to various activities on their days off. She told us that this had been agreed with their care managers. However when we contacted the care managers they told us it had been agreed that these two people would pay for taxis to access activities but a member of staff on duty should escort them.

Our judgement

We found this essential standard was not being met.

The system in place for dealing with people's finances was not robust and did not protect them from abuse.

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

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
One person said they were given their medications at the same time each day.

Other evidence
We looked at the system for storing and administering medications. All medications were kept in a locked cabinet and there was a separate cabinet inside this to store controlled drugs.

The records for the week of the visit showed that staff had signed to confirm medications had been given at the appropriate times.

The manager confirmed that there were no medications required to deal with behaviour that may be challenging and no one required sedatives. She said one person required medication to help them sleep and the records showed that this was administered appropriately.

Our judgement
We found that there was a suitable system for storing, administering and recording medications.

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 moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
The people living in the home said they were comfortable and had their own bedrooms which suited their needs.

Other evidence
We looked at the communal areas in the home and found they were comfortable and clean.

We looked at three bedrooms which contained items which showed the person's taste and hobbies.

The fire doors in the home were closed. However the kitchen door was chocked open while a meal was being prepared. There were also various items obstructing the fire doors in the laundry and opposite the kitchen which would put people at risk if a fire broke out.

The records showed that the safety certificates for the fire alarm, fire fighting equipment, emergency lighting and resident's call system were up to date.

There was documentation to show that electrical appliances had been tested on 15 July 2011 and found to be satisfactory.

We looked at the storage facilities for vegetables in an outer building in the back yard. Carrots were stored along with numerous building items. The carrots were showing signs of mould. The manager said these were to be thrown away as they now do the

shopping on a daily basis. Frozen vegetables were available in the kitchen freezer.

We looked in the fridge in the kitchen and there were large bowls of food which had been left over from mealtimes. The manager said these had been kept as samples in case someone developed food poisoning. If these were reused it could put people's health at risk as they may be out of date. The manager agreed to inform the staff that this practice must not continue.

Our judgement
We found that the home was not meeting this essential standard.

People were at risk if fire safety and food hygiene regulations were not met.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak to the people living in the home about this outcome as we did not plan to review it.

Other evidence
The care plans were stored in a lockable filing cabinet in a corridor of the home. However this was not locked at the time of the inspection which meant everyone in the home could access confidential information. Also some documents containing personal information were kept in the daily recording sheets which were lying on the dining room table. This meant that personal information was not held in accordance to the Data Protection Act 1998.

Our judgement
We found that the home were not meeting this essential standard.

People's rights to confidentiality may not be protected if personal information is accessible to everyone.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Care plans and risk assessments were not in place to cover all aspects of people's care. Others that were in place were not evaluated regularly to ensure any changes in need were met. People's rights to confidentiality were not fully respected.	
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 system for dealing with people's finances was not robust and did not protect them from abuse.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: Fire safety and food hygiene regulations were not fully met which could place people at risk	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated	Outcome 21: Records

	Activities) Regulations 2010	
	How the regulation is not being met: Personal information about the people living in the home was not always held securely.	

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

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

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

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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

Care Quality Commission

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