Review of compliance

Miss A Stein The Chestnuts Nursing and Dementia Care Home	
Region:	London
Location address:	63 Cambridge Park Wanstead London E11 2PR
Type of service:	Care home service without nursing Care home service with nursing
Date of Publication:	September 2011
Overview of the service:	The Chestnuts Nursing and Dementia Care Home provides accommodation, nursing and dementia care services for 51 people. The home is set over three floors with 45 single bedrooms and three shared bedrooms. People have access to a large rear garden and all areas of the home can be accessed by two passenger lifts. The home is set back off a busy main road in Wanstead

	in the London borough of Redbridge. It is well-served by public transport and close to shops and other local amenities.

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

Our current overall judgement

The Chestnuts Nursing and Dementia Care 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 because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 02 - Consent to care and treatment
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 10 - Safety and suitability of premises
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 July 2011, carried out a visit on 18 July 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us that they liked living at the Chestnuts Nursing and Dementia Care Home. They told us that the staff were nice and friendly and available most of the times. Some of the comments included; "They all look after me, it is like one big happy family," "Staff always chat to me" and "They offer a good service here". People were also pleased with the activities in the home and enjoyed using the garden room, attending reminiscence meetings and weekly church services, as well as when entertainers visited the home.

People also told us that they and their family were involved in their care and treatment. They were pleased that they were given choices in most areas of life in the home, which included their meals, activities, determining the quality of the service and being able to personalise their private spaces. People were happy with the range of meals in the home, but many raised the concern that hot foods were often times served cold. Many also reported that they get to see a doctor as regular as they like and this leaves them

reassured that their healthcare needs would be taken care of.

What we found about the standards we reviewed and how well The Chestnuts Nursing and Dementia Care 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 were respected and involved in their care, treatment and activities in the home.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Systems were in place for people to give consent to their care and treatment. They were not always fully used to ensure that peoples' best interests were promoted and maintained at all times.

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

While some aspects of peoples' care and welfare were met, the lack of specialist knowledge, skills and care practices in relation to pressure area care and its management, did not always make it safe for people using the service. Appropriate action must also be taken to effectively manage peoples' non-compliance with their care packages.

Outcome 05: Food and drink should meet people's individual dietary needs

People received meals that were generally consistent with their choice, nutritional and cultural needs. Meals were not always served hot in and in this state were unappetising to the people affected by this aspect of the service.

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

Some systems were in place to prevent people from the risk of harm or abuse. The provider needs to demonstrate that appropriate action is taken to promote safe and effective pressure area care in the home at all times.

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

People live in an environment that is safe and generally fit for its purpose. Improvements are needed to remove unpleasant odours from all bedrooms in the home.

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

A system was in place to determine the levels and suitability of staff required to meet peoples' care and support needs. However, there were times when peoples' needs were not appropriately met by the numbers of staff on duty.

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

The level and quality of staff supervision including that of the manager is inadequate to ensure that people receive safe and appropriate care at all times.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Systems were in place to monitor and improve the quality of the services that people received. However, the current arrangements for clinical monitoring of the service were not robust and did not always identify weaknesses or gaps related to clinical practice.

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

Suitable arrangements were in place to manage and secure records held about people. However, some personal records relating to peoples' care and welfare were not always accurately maintained and stored.

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People told us that they and their relatives were involved in their care and treatment. One person told us, "My daughter deals with the care plan". One relative told us, "I am involved in mum's care plans and the whole thing is excellent". We observed staff interact with people and found that they were in most cases treated with dignity and respect. However, we observed on the first day of our visit, one member of staff feeding two people at the same time, which compromised their dignity. (See the staffing section for further details).

Other evidence
There was evidence that people had an assessment carried out on them prior to their admission and that either a relative and/or an external professional were involved in the process. People also had information about the service prior to coming to live there and this formed a key part in enabling them to make an informed choice about the home. We noted that people were supported to engage with their community either by going out with the support of an activity coordinator or by participating in community activities in the home e.g. church services. We saw records to indicate that people influenced decisions in the home through residents' meetings, annual surveys and regular reviews of their care and treatment. The service was monitored by the provider on a monthly basis to ensure that people were involved in their care.

Our judgement
People were respected and involved in their care, treatment and activities in the home.

Outcome 02:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
* Where they are able, give valid consent to the examination, care, treatment and support they receive.
* Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
* Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are minor concerns with Outcome 02: Consent to care and treatment

Our findings

What people who use the service experienced and told us
People told us that they take part in their care and would do so directly or with the support of their relatives. We saw that some people were unable to make decisions and their relatives acted as advocates on their behalf with regard to consenting to their care and treatment. However, there was one case in which there was no evidence that a critical decision made by a person's relative, followed appropriate 'Mental Capacity Act' or 'deprivation of liberty' safeguards. In this respect there was no evidence that a best interest meeting had taken place. As such, the provider could not demonstrate that the outcomes for the person concerned were in their best interests. The fact that the person was refusing key aspects of previously agreed care meant that they ended up without it. Alternative methods of providing the relevant care and support to the person were not fully explored.

Other evidence
There were systems in place to ensure that people gave consent to their care and treatment. We saw that for people sharing rooms, consent was sought on every occasion. We noted that the manager and staff did have training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We spoke to staff who understood the importance of promoting and protecting peoples' rights.

Our judgement

Systems were in place for people to give consent to their care and treatment. They were not always fully used to ensure that peoples' best interests were promoted and maintained at all times.

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
People told us that they were well-cared for and that the staff were good at meeting their needs. We saw that staff were continuously engaged with people delivering care and support to them. All the relatives we spoke to during the course of our visits were happy with the care, treatment and support that was provided to their loved ones. They also told us that they were involved in the care plan processes of their relations. We saw evidence that referrals were made to various professionals for example the dietician, tissue viability nurse, dentist and the GP to promote peoples' health and welfare.

Other evidence
We looked in detail at four care plans. Prior to our visit, the local safeguarding authority notified the Commission about concerns relating to three peoples' care, which we examined. We found that in all cases the care plans were fairly detailed and in most, they reflected peoples' wide ranging needs. In one case we found that a person was non-compliant with their care plan. We were concerned that a risk assessment was not in place to ensure that risks to the person and others in the home were kept to a minimum. This was particularly important as the person concerned carried a health bug, which required specific actions to make it safe for the individual, staff and other people using services in the home. We spoke to several staff in the home and the manager who had an understanding of the risks involved, but did not set down the risk control measures to keep people safe in the home. Some of the risks were particularly around the person's behaviour which staff felt powerless to deal with.

We had other concerns with the three other cases we looked at, as it became clear that peoples' specialist needs were not always met. People that required, effective pressure area care did not always receive it. There were examples where peoples' food intake and fluid balance charts were not properly maintained. Recordings were inconsistent and values were not tallied and used to evaluate peoples' nutritional and fluid intake. As a result, the care provided did not always meet peoples' needs as there was little connection between the monitoring charts and the care plans. Nutritional and fluid monitoring and their provision are key factors in providing good pressure area care, particularly, where people had reduced mobility and in this case some of the people were bed-bound. There was also evidence that turning charts for people were not properly maintained and for people with contractures, there were no clear plans in place to support and manage them. We were also concerned to have found that the issues we identified had not been fully addressed as they were reportedly raised by the tissue viability nurse and the community matron prior to our visit.

We spoke to the manager about the pressure area practices in the home and she informed us that they had started acting on the recommendations made by the tissue viability nurse and the community matron. We were told that the manager and staff did not know how to operate the pressure relieving equipment in the home and that some were found in June 2011, not to be working properly. This placed people in need of pressure area care at risk of coming to harm. The community matron reported that the manager and staff at the home did not always take up training to update their skills and clinical knowledge in the area of good pressure area care. The manager showed us an action plan dated 7/7/2011 which was devised to improve of the quality of their service delivery. Some of the areas identified included; having turning and 'pressure mattress' monitoring charts in place, providing training for staff in areas such as pressure management, the use of pressure relieving equipment and wound management.

The provider carried out monthly provider monitoring visits to the service, but we saw little evidence that the clinical aspects of the service provision were being robustly monitored. The manager conducted the bulk of the clinical monitoring in the service and would need to do more to ensure that people received safe and appropriate care at all times. This is important as there was evidence that guidance for involving the tissue viability nurse was not always followed by staff in the home. Staff were not always accurately recording the specifics of pressure area damage to people and so people were not in a position to receive the best possible care and treatment. These areas of concern were not overtly picked up by the manager. We were concerned to have learnt that the manager did not receive clinical or any other type of supervision but was expected to lead staff on clinical issues in the home. Action must be taken to bring about improvements in this outcome area.

Our judgement
While some aspects of peoples' care and welfare were met, the lack of specialist knowledge, skills and care practices in relation to pressure area care and its management, did not always make it safe for people using the service. Appropriate action must also be taken to effectively manage peoples' non-compliance with their care packages.

Outcome 05:
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

There are minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
People told us that the food in the home was nice. One person told us; "When I get fed up with sandwiches, I request eggs because I like it and I do get it". Another person told us; "We can have anything we like including a choice of white or red wine with our dinner". One other person told us; "Breakfast is always good, we get to choose what we eat in here". We saw that people were given varied diets that were consistent with their needs and choices. In one case we noted that a person preferred Kosher meals and this was made available to them. We were pleased to see that meals were served in different forms to people for example; pureed, soft and liquidised to enable them to maintain their nutritional well-being.

We witnessed people having their meals cut up into small pieces to allow them to use their fingers if they wanted to. This was particularly effective with people having a diagnosis of dementia as they were able to maintain their independence without worrying too much about having to use a knife and fork. We saw people being supported to eat their meals and in most cases this was done in a sensitive manner. However, there was at least one instance in which one staff member was feeding two people with little communication between them in the process. The time lapse between feeding one person and the other meant that their meals became cold. This was unappetising to some, who at times showed a disinterest in their food. Staff were also supporting people with their meals and at times left the area for brief moments, then returned to carry on supporting people with their meals. To add to our findings, a number of people told us that the food was served cold, by the time it got to them. We noted that the staffing levels at mealtimes were not appropriate to meet the dependency levels of the people requiring support with their meals. This is covered

further under staffing – (Outcome 13) of this report.

Other evidence
We noted that the dietician was contacted to obtain specialist input for peoples' benefit. There was evidence that nutritional screening and risk assessments were carried out on people, although in a small number of cases the recording of the information did not always accurately link to peoples' care plans. This was particularly important for those people who were at risk of malnutrition, dehydration and predisposed to pressure sores.

We examined the results of a 'relative and resident' survey carried out by the service in December 2010 and noted the comments on food, which stated that food was 'almost invariably cool'. We were concerned to have been receiving similar comments in July 2011 when we visited. We would expect the home to act on the information they collected to improve peoples' experience at mealtimes. There were positive comments about the chef being always available, although at the time they felt that he was doing other maintenance jobs around the home. There was no evidence of this being the case when we visited, as a dedicated maintenance worker had been employed in the home.

Our judgement
People received meals that were generally consistent with their choice, nutritional and cultural needs. Meals were not always served hot in and in this state were unappetising to the people affected by this aspect of the service.

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 moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
Most of the people we spoke to told us that they felt safe in the home. They told us that the staff were caring and treated them with dignity and respect. We spoke to peoples' relatives and friends who told us that they felt that their relatives were safe in the home. They told us that the staff were caring and worked hard to meet peoples' needs.

Other evidence
A safeguarding policy and procedure was available to staff in the home. We saw staff training records which confirmed that staff had completed safeguarding adults training. We spoke to various categories of staff who demonstrated an understanding of what was expected of them to safeguard people using services. We looked at some of the care practices and documentation around pressure area care and found that they were not adequate to prevent people from the risk of coming to harm. One example of this is where staff did not know how to operate pressure relieving equipment used in the home.

We found gaps in the records that staff were keeping in terms of turning charts, nutritional monitoring charts, fluid balance charts, ulcer monitoring charts and the care that was provided to people. This lead to people not always receiving safe and appropriate care in the home. The Commission was aware that action had since been taken by the manager, the tissue viability nurse and the community matron to improve the outcomes for people using the services. One such action has been the monitoring of pressure–relieving equipment twice per day, which commenced on the 8/7/2011 by the home manager. Up to twelve staff had training on the 1/07/2011 in using the pump

for pressure relief mattresses, which should have happened sooner.

At the time of writing this report we were aware that an investigation had been launched by the local safeguarding adults' coordinator into the pressure area care of three people who received services from the home. It was envisaged that the investigator would report the outcome to a meeting planned in September 2011. Although the safeguarding matter had not been concluded, we formed the view that improvements were needed to ensure that people receive safe and appropriate pressure area care at all times.

Our judgement
Some systems were in place to prevent people from the risk of harm or abuse. The provider needs to demonstrate that appropriate action is taken to promote safe and effective pressure area care in the home at all times.

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
People told us that they liked living in the home. They felt that it was clean and that they could access most areas of the home. Relatives told us that the home was well-maintained and that they enjoyed visiting their loved ones. We observed that people were comfortable moving around the home on foot or with the use of mobility aids.

Other evidence
The home is large and set over three floors with a large sized garden and laundry to the rear of the building. There were systems in place to ensure that the home was maintained and kept in a good state of repair. One such system was a rolling plan for the redecoration and refurbishment of the home. This plan also covered furnishings and fixtures. A maintenance officer had been employed for over seven months and was mostly responsible for ensuring that the environment was safe and fit for purpose. Safety information on the home was updated apart from a few minor areas, which were dealt with, within 24 hours of our visit.

There was damage on the ends of bathroom furnishings and at least in one bedside cabinet and we were assured that this would be dealt with. However, we were concerned to find a strong scent of urine in room 45 and a strong scent of faeces in room 44 both of which were in the Dementia unit. We were told of the reasons why they carried the unpleasant odours, but advised that improvements to those areas were required. We noted that the issue of the home carrying a urine scent came up in the December 2010 relatives and residents' survey and so the provider would have had this concern raised before.

Our judgement
People live in an environment that is safe and generally fit for its purpose. Improvements are needed to remove unpleasant odours from all bedrooms in the home.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us that staff were kind to them and available when they needed them. One person told us; "They all look after me – it's like one big happy family". Another person told us that they had a named nurse and a key-worker and they were usually available. There were 47 people in the home at the time of our visit and the staffing compliment was two qualified nurses and nine carers on day shifts and two nurses and four carers on the night shift. We looked at the rosters and saw a consistent pattern of staffing in place. We became concerned to see one member of staff feeding two people during the lunch period. We also saw staff feeding people, leaving them briefly and then return to the dining area. We formed the view that the staffing levels were not sufficient to meet the support needs of people using the service at that time.

Other evidence
We spoke to the manager about our concerns and she was uncertain as to why this had occurred. There was no written evidence available to show how the staffing levels were deployed throughout the home. The manager told us that it was based on the number of people in the home and their needs. We then asked about the overall staffing compliment and were told that there were eight full-time staff nurses, six bank nurses with one vacant position. In addition there were six senior carers with three vacancies and a total of 36 health care assistants. There were three ancillary staff, two activity coordinators sharing a shift from 10a.m. to 5p.m., two chefs; one for weekdays and one for the weekend, along with two assistants, a maintenance officer plus an administrator and a liaison officer. We formed the view that care staff were able to spend most of their time on providing care and support to people.

We looked at the staffing qualifications, which seemed appropriate to meet the needs of the people using services although there was evidence of a lack of applied knowledge in relation to pressure area care. From looking at the dependency levels of the people using services, we concluded that the staffing levels needed reviewing to ensure that peoples' needs were appropriately met. A clearer system needed to be in place to determine the staffing levels required and this should be kept under review. In this respect consideration must be given to the fact that the home provides services such as nursing, dementia and end-of-life care to people. We looked at the quality of the end-of-life care that was provided to people which was basic and not in line with any particular model such as the Liverpool Care Pathway or the Gold Standards Framework. This was discussed with the manager during the course of our visits to the home.

Our judgement
A system was in place to determine the levels and suitability of staff required to meet peoples' care and support needs. However, there were times when peoples' needs were not appropriately met by the numbers of staff on duty.

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 moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not ask people directly about the support that staff received in the home. However, most of the comments we received indicated that people felt safe in the home and that their needs were met. We spoke to relatives who also felt that the staff knew what they were doing. Relatives also told us that the manager was seen walking the floor when they visited.

Other evidence
We spoke to staff about the support they received in the home. They told us that the manager was very supportive and that they could approach her. They told us that they received supervision and appraisals from their manager. We saw that the manager, who does not have a deputy, carried out all the supervision and appraisals for a staff compliment of around fifty. The manager showed us records of three-monthly supervisions that were carried out with staff and there was evidence that appraisals were also carried out with them. There was little evidence that clinical issues were addressed as a matter of course, in these meetings.

More importantly, the manager told us that she received no formal supervision or indeed clinical supervision and so it wais difficult to see how she would develop and lead the team to clinical excellence. One example of this was where she informed us that she was not familiar with the operations of the pressure relieving equipment in the home. The impact of this meant that people requiring pressure area care were not receiving the best possible care in the home. There was little evidence to show that this concern was identified internally for improvement. This meant that people were put at risk of receiving unsafe and/or inappropriate care.

We looked at the training records of the staff and saw that training was regularly provided to all levels of staff. What was unclear was the mechanism for ensuring that staff were applying their knowledge to their practice. This was an issue that the provider and manager needed to address. We saw at least two examples in which staff had training in end-of-life care and the Mental Capacity Act, without actually transferring what they gained to their practice. In speaking with staff they had some knowledge of the two areas identified. There was a training plan set out for the year on most of the key areas that were relevant to the service provision. There were some gaps in peoples' knowledge relating to 'managing people with contractures', which we were told were now being addressed. Improvements are required to this outcome.

Our judgement
The level and quality of staff supervision including that of the manager is inadequate to ensure that people receive safe and appropriate care at all times.

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 minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that they are asked through surveys about the quality of service that they received. They told us that their relatives also contributed to this process. They also told us that they attended residents' meetings where they talked about what goes on in the home. We spoke to some relatives who told us that they were asked about the quality of the care in the home.

Other evidence
We saw that the provider carried out monthly monitoring visits to the home and we examined the most recent reports. We found little evidence that clinical practice was monitored at these visits. This was done by the manager who did not receive clinical supervision. This needed to be addressed to ensure that clinical practice, which was a key aspect of the home's care provision, was carried out to the highest standards.

We saw evidence that surveys were held with people and their relatives about the service and that they were mostly satisfied with the provider's response to the feedback that came from it. We noted that the comment made by people about the home carrying a scent of urine, was substantiated during the course of our visit..

We also saw evidence that the home carried out a self-monitoring evaluation (December 2010) as part of an arrangement with its commissioning authorities, which was then used to gauge the quality of the service. Where improvements were required, we saw the actions that were set to achieve the desired outcomes.

Since the safeguarding matter that was raised in June 2011, the manager had increased her monitoring of care plans and pressure relieving equipment in the home.

Our judgement
Systems were in place to monitor and improve the quality of the services that people received. However, the current arrangements for clinical monitoring of the service were not robust and did not always identify weaknesses or gaps related to clinical practice.

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 minor concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not ask people directly about their records, but we saw that monitoring records left unattended in lounge areas at various points in the day. We observed staff who moved in and out of the lounges leaving the records lying around as though it was custom and practice. We discussed this with the manager and it seemed that the case of convenience was given a higher priority over the importance of confidentiality. We told her that this needed to improve. In speaking with some of the people using the service, they told us that they saw their care plans and records and were happy with them.

Other evidence
We looked at four care records and found in at least three, that they were not maintained accurately. These documents included various aspects of care plans, which the manager instructed the staff on duty to rectify. It is important for these documents to be used as working tools by the staff in delivering peoples' care and support needs. There was also evidence of various key monitoring charts relating to peoples' care that were not properly maintained. They were brought to the manager's attention during the course of our inspection. Improvements were required in how records were maintained in the home.

We noted that there were appropriate storage facilities for records and peoples' personal belongings in the home. We did not look in detail at policies and procedures in

the home, but saw that they were last reviewed in July 2010. We were told that some policies were being developed and should be completed by September 2011.

Our judgement
Suitable arrangements were in place to manage and secure records held about people. However, some personal records relating to peoples' care and welfare were not always accurately maintained and stored.

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 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	Why we have concerns: Systems were in place for people to give consent to their care and treatment. They were not always fully used to ensure that peoples' best interests were promoted and maintained at all times.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	Why we have concerns: People received meals that were generally consistent with their choice, nutritional and cultural needs. Meals were not always served hot in and in this state were unappetising to the people affected by this aspect of the service.	
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 live in an environment that is safe and generally fit for its purpose. Improvements are needed to remove unpleasant odours from all bedrooms in the home.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing

	Why we have concerns: A system was in place to determine the levels and suitability of staff required to meet peoples' care and support needs. However, there were times when peoples' needs were not appropriately met by the numbers of staff on duty.	
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
	Why we have concerns: Systems were in place to monitor and improve the quality of the services that people received. However, the current arrangements for clinical monitoring of the service were not robust and did not always identify weaknesses or gaps related to clinical practice.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	Why we have concerns: Suitable arrangements were in place to manage and secure records held about people. However, some personal records relating to peoples' care and welfare were not always accurately maintained and stored.	

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 within 14 days of this report being received.

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
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: While some aspects of peoples' care and welfare were met, the lack of specialist knowledge, skills and care practices in relation to pressure area care and its management, did not always make it safe for people using the service. Appropriate action must also be taken to effectively manage peoples' non-compliance with their care packages.	
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: Some systems were in place to prevent people from the risk of harm or abuse. The provider needs to demonstrate that appropriate action is taken to promote safe and effective pressure area care in the home at all times.	
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: The level and quality of staff supervision including that of the manager is inadequate to ensure that people receive safe and appropriate care at all times.	

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 28 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

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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