Review of compliance

Mr & Mrs S Hayat Chandos Lodge Nursing Home	
Region:	South East
Location address:	Blackpond Lane Farnham Common Slough Berkshire SL2 3ED
Type of service:	Care home service with nursing
Date of Publication:	September 2011
Overview of the service:	Chandos Lodge Nursing Home is a care home that provides accommodation for 30 older people who require nursing or personal care.

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

Our current overall judgement

Chandos Lodge Nursing 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 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 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 the staff, felt they met their needs well and the care provided was very good. They said there was enough staff available to help and assist them, both in the day time and during the night.
They said they were able to make decisions about their day to day care and were involved in the reviews of their care. Their wishes were taken into account.
People told us they had the opportunity to visit the home, meet the staff and residents and view the facilities before moving into the home
People told us that they had no concerns but if they did they would either tell their relatives or the manager of the home. They said they felt safe and well looked after.
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What we found about the standards we reviewed and how well Chandos Lodge Nursing Home was meeting them

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

The health and social care needs of each person living in the home was recorded. Risk assessments had been carried out to identify actual or potential risks and how these should be addressed. The records were well maintained, regularly reviewed and updated where necessary.

Overall, we found that Chandos Lodge Nursing Home was meeting this essential standard

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

Staff were knowledgeable about how to respond to any allegations or incidences of abuse. Procedures were in place to manage any safeguarding incidences. Whilst we saw safeguarding certificates on staff files these were not held for staff who worked at Chandos Lodge as their second place of employment. Whilst we were told they had undertaken training at their main place of employment, but there were no records to show they had been followed up and verified.

Overall, we found Chandos Lodge Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable staff. However, the recruitment process did not include undertaking a further Criminal Records Disclosure check on staff who were returning to work in the home after a break in service. The service relied on their previous disclosure which could potentially place people using the service at risk.

Overall, we found Chandos Lodge Nursing Home was not meeting

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

At the time of this visit there were sufficient numbers of staff to meet people's care and welfare needs.

Overall we found that Chandos Lodge Nursing Home was meeting this essential standard.

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

People received care and support from staff who were supervised and whose work was monitored and appraised regularly. Staff were provided with appropriate training to ensure

that they had the knowledge and skills to undertake their role competently.

Overall, we found Chandos Lodge Nursing Home was meeting 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

Whilst there were systems in place to monitor the service, there was no clear documented process to show how the results had been acted upon, by whom and when. It was therefore unclear how the outcomes of these audits were used to improve or develop the service.

Overall, we found Chandos Lodge Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

The provider is compliant 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 liked the staff and felt they met their needs well. They said that they were able to choose how they spend their day, including the time they chose to get up and retire to bed. They told us that individual and group activities were provided for them to take part in if they wished. They said if they preferred to spend some time alone they could choose to sit in a quieter part of the home or their bedroom.
One person visiting their relative told us that they were very happy with the care provided. They said that they were always kept informed of any concerns or changes in their relative's care. They described the staff as 'wonderful' and very kind, patient and consistent. They told us that their relative used to live alone, but following a fall and stay in hospital was transferred to Chandos Lodge Nursing Home. They said that 'mum is always looked after well, she likes it here and there is never a dull moment, whereas previously at home she had very little to do'. They said they had seen a positive change in their mother and that the staff were 'good natured, kind people who took a pride in the home'.

Other evidence
We followed through the care and support that people received at Chandos Lodge Nursing Home. We found that people's care plans were individualised to their particular needs, were detailed, reviewed and updated regularly. We saw that an assessment of any risks had been clearly recorded with actions recorded as to how the risk was to be managed. Examples included assessing the risk of people who could potentially develop pressure sores and risks associated with poor mobility needs such as falling. Plans were in place to address the moving and handling of people with the use of

specialised equipment. We saw assessments in relation to people's nutritional needs where they were at risk of poor nutrition. Records were kept of people's weight, with evidence of referral to their doctors or the dietician if there was any significant weight loss. Where a risk had been identified, a specific plan of care to address the need was documented within the file for staff to follow.

It was evident that people and their families had been consulted with and involved in the care planning and assessment process to ensure their likes dislikes and views had been taken into account.

Where people lacked the capacity to make informed decisions about some aspects of their care and support needs, best interest meetings were held. Best interest meetings consider all relevant circumstances and factors when decisions are being made about or for an individual. This includes consulting with family and other agencies or professionals involved in care and treatment.

People's files contained documentation noting and summarising any visits by other healthcare professionals together with any recommendations that they made. We saw instructions had been added to people's care plans following any recommendations made.

One file that we viewed contained documentation to show that blood tests had been taken and sent to the surgery. However, the documentation had not been completed to advise of the outcome of the tests.

Daily records were completed for each person. Where people were cared for in bed, charts were in place for regular turning, fluid and food intake. We saw that people being cared for in bed looked comfortable, were being repositioned regularly to prevent any discomfort or pressure sores and their fluid and food intake was being recorded appropriately. One such person we spoke to told us that the staff were meeting her needs appropriately.

Procedures were in place to make sure that when people moved between services information was shared sensitively and appropriately to ensure continuity of care. There were transfer forms completed and held in people's files for this purpose.

Throughout our visit the atmosphere in the homewas calm and relaxed. Staff were observed to be interacting with people in a positive and appropriate manner.

Our judgement
The health and social care needs of each person living in the home was recorded. Risk assessments had been carried out to identify actual or potential risks and how these should be addressed. The records were well maintained, regularly reviewed and updated where necessary.

Overall, we found that Chandos Lodge Nursing Home was meeting 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 told us that they had no concerns but if they did they would either tell their relatives or the manager of the home. They said they felt safe and well looked after.

Other evidence
We were aware of a safeguarding incident being investigated by the local authority at the time of our visit. The manager had taken all reasonable precautions and followed the disciplinary procedures whilst the incident was investigated. This was to ensure that people were safe.
We were told that all staff had been provided with safeguarding training during their induction and every two years thereafter. We saw the staff training matrix which showed that the majority of staff had been provided with an update to their training in 2011. Where staff were working at Chandos Lodge Nursing Home, as their second place of employment we were told they had undertaken the training at their main place of employment. There were no safeguarding certificates on their file to check this out and no records to show these had been followed up and verified.
Policies and procedures were in place to inform staff how to report any actual or potential abuse. We also saw that the home had the local interagency policies and procedures in place for staff to refer to. There was documentation which contained staff signatures to show that staff had read these.
The staff we spoke to understood their duty of care and responsibilities in relation to safeguarding people from harm. They told us that there were whistleblowing and safeguarding policies and procedures in place which they would use if the need arose.
We were informed that the home didn't manage peoples monies, that this was

undertaken by their family or representatives. Any services required, such as hairdressing, chiropody, daily newspapers and toiletries were invoced to people's representatives and receipts held.

Our judgement
Staff were knowledgeable about how to respond to any allegations or incidences of abuse. Procedures were in place to manage any safeguarding incidences. Whilst we saw safeguarding certificates on staff files these were not held for staff who worked at Chandos Lodge as their second place of employment. Whilst we were told they had undertaken training at their main place of employment, but there were no records to show they had been followed up and verified.

Overall, we found Chandos Lodge Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 12:
Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are moderate concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We did not speak to people about this outcome area.

Other evidence
During this visit we reviewed the recruitment process and viewed a sample of new staff members files. Each file contained a completed application form, a full employment history, a health declaration statement and two references. The records confirmed that a full and satisfactory Criminal Records Bureau (CRB) check had been received. However, it was noted some references had been supplied on unheaded paper and there was no documentation to show they had been followed up to verify their authenticity.

During discussion with the provider it became evident that a member of staff had left the provider's employment and returned a couple of years later. We looked at the staff member's personnel file and found the provider had not followed a robust recruitment procedure to ensure the welfare of people living in the home. The provider had re-employed the person without undertaking a further CRB check to ensure the person remained suitable to work with vulnerable adults. This potentially placed people using the service at risk.

Job descriptions had been given to staff on appointment which stated their roles and responsibilities and all the files we viewed contained contracts of employment.

Staff we spoke to confirmed they had been required to provide all relevant information

prior to beginning work in the home.

Our judgement
There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable staff. However, the recruitment process did not include undertaking a further Criminal Records Disclosure check on staff who were returning to work in the home after a break in service. The service relied on their previous disclosure which could potentially place people using the service at risk.

Overall, we found Chandos Lodge Nursing Home was not meeting

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People who use the service told us there was enough staff available to help and assist them, both in the day time and during the night.

Other evidence
The staff we spoke with told us they had received an induction and were supported to do their work. They said there was good team working at the home and that the manager was approachable. They had a good knowledge and understanding of people's care needs.

On the day of our visit staffing levels appeared appropriate to meet the needs of people. No one was seen having to wait for assistance. Staff were observed undertaking care related activities with people, spending time talking to people and involving people in social activities.
We were informed that the home employs seven qualified nurses, twelve health care assistants, a housekeeping team of four people, a maintenance worker, a cook and an administrator.
We were told that each shift during the day comprised of a qualified nurse and three or four health care assistants. There was also a full time member of staff working in the communal areas of the home to support the staff in encouraging hydration and assist people with activities. The early morning shift was also supported by an additional 'lead' nurse. During the night, there were two healthcare assistants and a registered nurse.
The manager told us that the home did not use bank staff as they had sufficient number of staff to meet people's care and support needs. Staff we spoke with felt there were

enough staff.

Our judgement
At the time of this visit there were sufficient numbers of staff to meet people's care and welfare needs.

Overall we found that Chandos Lodge Nursing Home was meeting 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

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We did not speak to people about this outcome area.

Other evidence
Staff told us that they were provided with a good level of training to assist them in their roles. We looked at a sample of staff members' personnel files. These contained documentation which showed that staff were provided with appropriate training to give them with the knowledge and skills to undertake their roles competently. The training included an in house induction at the point of employment. During the induction period they worked alongside an experienced member of staff until they felt comfortable and were competent in undertaking their role. Following the in house induction we were told that they then undertook a more in depth induction which covered all the mandatory training. We saw a range of training certificates in staff files which included safeguarding training, food hygiene, health and safety, moving and handling, fire safety, medication training and infection control.
Further training had been provided covering dementia awareness, Parkinson's disease and deprivation of liberty safeguards. We also saw documentation to show that registered nurses had been provided with opportunities to attend clinical skills training.
We were informed that dates had been booked for all staff to attend updates to their fire awareness training. We saw documentation to confirm this had been booked for September 2011.
The training matrix showed that there were some gaps to some staff members training, however we were informed this had been recognised and was being dealt with.

Staff said that they received regular supervision and an appraisal of their work. Staff

meetings were held regularly and minutes were documented. They said they felt well supported in their roles.
All those spoken to were happy to be working at Chandos Lodge Nursing Home and told us there were very good training opportunities. One staff member told us that they had approached the manager for some specific training to further their knowledge and the manager was making arrangements to meet their request. Another member of staff said they found the manager very approachable, that she was always arranging training to enable the staff to develop. They said the training was very helpful and interesting.

Of the twelve healthcare assistants, we were told that nine had attained the National Vocational Qualification (NVQ)in health and social care at level 2 or above. One of the housekeeping staff had also attained their NVQ level 2 in cleaning and support

Our judgement
People received care and support from staff who were supervised and whose work was monitored and appraised regularly. Staff were provided with appropriate training to ensure that they had the knowledge and skills to undertake their role competently.

Overall, we found Chandos Lodge Nursing Home was meeting 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 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
We did not speak to people about this outcome area.

Other evidence
The home had some systems in place to monitor the quality of service that people received. People's views were sought both on an informal and formal basis, through talking to people on a daily basis, during their reviews of care and through the use of quarterly surveys. A comments box was available in the home for people to make any comments and a communications book was in people's rooms for them or their visitors to document any comments about their care and support if they wished. We saw that surveys had been sent out to family members in June 2011 for them to complete with their relatives. Five had been returned, all of which gave positive feedback on the care provided and the staff who delivered the care and support.
We saw documentation of monthly visits undertaken by one of the proprietors, who does not have a constant presence in the home. The purposes of the visits were to assess the care and services provided and where any improvements could be made. The visits included talking to people using the service, staff members and generally observing the environment for any maintenance issues that needed attending to.
Whilst there were systems in place to monitor the service, there was no clear documented process or action plan to show how the results had been acted upon, by whom and when. It was therefore unclear how the outcomes of these processes were used to improve or develop the service.

Our judgement

Whilst there were systems in place to monitor the service, there was no clear documented process to show how the results had been acted upon, by whom and when. It was therefore unclear how the outcomes of these audits were used to improve or develop the service.

Overall, we found Chandos Lodge Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Staff were knowledgeable about how to respond to any allegations or incidences of abuse. Procedures were in place to manage any safeguarding incidences. Whilst we saw safeguarding certificates on staff files these were not held for staff who worked at Chandos Lodge as their second place of employment. Whilst we were told they had undertaken training at their main place of employment, but there were no records to show they had been followed up and verified,	
Diagnostic and screening procedures	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	Why we have concerns: Staff were knowledgeable about how to respond to any allegations or incidences of abuse. Procedures were in place to manage any safeguarding incidences. Whilst we saw safeguarding certificates on staff files these were not held for staff who worked at Chandos Lodge as their second place of employment. Whilst we were told they had undertaken training at their main place of employment, but there were no records to show they had been followed up and verified,	
Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse

	Why we have concerns: Staff were knowledgeable about how to respond to any allegations or incidences of abuse. Procedures were in place to manage any safeguarding incidences. Whilst we saw safeguarding certificates on staff files these were not held for staff who worked at Chandos Lodge as their second place of employment. Whilst we were told they had undertaken training at their main place of employment, but there were no records to show they had been followed up and verified,	
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: Whilst there were systems in place to monitor the service, there was no clear documented process to show how the results had been acted upon, by whom and when. It was therefore unclear how the outcomes of these audits were used to improve or develop the service.	
Diagnostic and screening procedures	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: Whilst there were systems in place to monitor the service, there was no clear documented process to show how the results had been acted upon, by whom and when. It was therefore unclear how the outcomes of these audits were used to improve or develop the service.	
Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: Whilst there were systems in place to monitor the service, there was no clear documented process to show how the results had been acted upon, by whom and when. It was therefore unclear how the outcomes of these audits were used to improve or develop the service.	

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
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable staff. However, the recruitment process did not include undertaking a further Criminal Records Disclosure check on staff who were returning to work in the home after a break in service. The service relied on their previous disclosure which could potentially place people using the service at risk.	
Diagnostic and screening procedures	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	How the regulation is not being met: There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable staff. However, the recruitment process did not include undertaking a further Criminal Records Disclosure check on staff who were returning to work in the home after a break in service. The service relied on their previous disclosure which could potentially place people using the service at risk.	
Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers

	How the regulation is not being met: There was a recruitment process in place, designed to ensure that people who use the service were cared for by suitable staff. However, the recruitment process did not include undertaking a further Criminal Records Disclosure check on staff who were returning to work in the home after a break in service. The service relied on their previous disclosure which could potentially place people using the service at risk.

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
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