Review of compliance

A Cox and Mrs Z Cox Ashleigh Nursing Home	
Region:	East Midlands
Location address:	17 Ashleigh Road Leicester Leicestershire LE3 0FA
Type of service:	Care home service with nursing
Date of Publication:	February 2012
Overview of the service:	Ashleigh Nursing Home is owned and managed by Mr Ashley Cox & Mrs Zarina Cox. The service is located in Leicester and provides nursing care and support for up to 21 people. It is registered to care for people under the following regulated activities:- Accommodation for persons who require nursing or personal care. Treatment of disease, disorder or injury. Diagnostic and screening

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

Our current overall judgement

Ashleigh 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 26 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

Relatives of people using the service told us that they were happy with the care and support provided by the service and its staff. They told us - "…..can be very difficult but the staff are brilliant, can't be faulted." "Any problems they let me know straight away." "Manager will contact family straight away if there are concerns." "The care is brilliant, very happy with how they look after her. I think it's the care that's keeping her going."

People using the service did not in all instances have their dignity promoted. People's care plans were not always implemented which means that people were not receiving the care and support they needed.

We found that the environment was not well maintained, which had the potential to impact on the health, safety and welfare of people. We found that equipment was not well maintained or cleaned which had the potential to put people at risk from cross infection.

What we found about the standards we reviewed and how well Ashleigh Nursing Home was meeting them

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

People did not experience effective, safe and appropriate care, treatment or support as care plans and records were not comprehensive or always followed. People's privacy and dignity is not promoted or upheld.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People resided in accommodation and used equipment which was damaged, not maintained or cleaned and had the potential to spread infection.

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

People resided in accommodation which was not well maintained and which posed a risk to their health, safety and welfare.

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

The lack of staff supervision and support had a detrimental affect on the care and support people using the service received.

Actions we have asked the service to take

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

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

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

Our findings

What people who use the service experienced and told us
We spoke with visitors who were visiting relatives at Ashleigh Nursing Home. We asked them for their views about the care and support provided to their relative. They told us "…..can be very difficult but the staff are brilliant, can't be faulted." "Any problems they let me know straight away." "Manager will contact family straight away if there are concerns." "The care is brilliant, very happy with how they look after her. I think it's the care that's keeping her going."

Relatives we spoke with expressed satisfaction with the care provided and the attitude and approach of staff. Relatives told us they were contacted if there relative became unwell and they were aware of the care and supported provided.

We sat in the lounge with nine people who resided at Ashleigh Nursing Home. We saw staff interact with some people whilst others received no input from staff. Staff spent time with people looking at magazines and newspapers, whilst others encouraged people to sing along or play a musical instrument to the music which people had chosen to listen to. In the afternoon we saw staff spending time with people in taking part in a game of 'connect 4'.

We observed that the privacy and dignity of people is not always supported or recognised by staff. We saw two members of staff standing up whilst they fed people the lunchtime meal. One person was sitting in the lounge; we asked why they had not been taken through to the dining room. We were told that they 'slipped off' the dining chairs. The person received no interaction from staff during the morning and did not

move from their seat. At lunchtime a member of staff stood at the side of them, feeding them their lunch. There was no eye contact or conversation.

We saw two people who had dementia interact with stuffed soft toys and dolls; this gave them a sense of purpose and brought them comfort and reassurance. One group of visitors we spoke with told us their relative often dressed and fed the baby doll, this provided them with comfort and security.

Other evidence

We looked at the care plans and records of three people. Care plans were specific to each person and detailed the care and support people required with regards to a range of topics which included diabetes, mobility, continence, communication and pressure area care. We found that care plans were not in all cases comprehensive or acted upon. We looked at the care plan for someone with diabetes. It stated that the person had fluctuating blood sugar levels. It did not state the normal blood sugar range for the person or what action staff should take if levels were found to be too high or too low. One person's care plan stated that they needed to be weighed monthly; records showed this instruction had not been acted upon. We discussed these issues with the registered manager who had no explanation as to why care plans did not contain the necessary information or why they had not being followed.

People who resided at Ashleigh Nursing Home require nursing care as they had dementia. Care plans were not comprehensive as to the care and support of people with regards to dementia care. A majority of staff we spoke with said that they had received training in dementia care, however they had limited knowledge as to how the condition affected people or how people should be supported. One person had reverted to speaking in their first language. The person's care plan recorded this; however we found no evidence that the service had considered how they could support this person with regards to isolation, communication or stimulation. We spoke with this person in their first language. They told us that they were happy in the home but found it hard as no one else could communicate with them.

A number of people were cared for and nursed in bed. The registered nurse on duty told us the food and fluid intake of people was not recorded and in there opinion it should. We found people were not weighed with the frequency as detailed in their care plan. A number of people required a soft or pureed diet. Staff we spoke with told us there was not sufficient staff on duty at meal times to feed and support those who can eat independently. On the day of our inspection additional staff were asked to stay on duty whilst we were there.

The provider and registered manager told us that the home uses 'bank' nurses. This means that the nurses were not directly employed by the service. The registered nurse on duty told us they were not responsible for the writing and reviewing of care plans and that this task was undertaken by the registered manager.

We spoke with staff and asked them how often they referred to care plans. Staff told us they looked at care plans every few weeks or months and that they had no input into the writing or reviewing of care plans. We asked how they found about changes to peoples' needs, they told us this information was shared at staff handovers which take place daily.

Our judgement
People did not experience effective, safe and appropriate care, treatment or support as care plans and records were not comprehensive or always followed. People's privacy and dignity is not promoted or upheld.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are major concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We looked around communal areas of the service and some of the bedrooms. We found commodes which had not been cleaned well with dry deposits on the frames which were rusted and corroded. We saw toilets which were not clean. We saw a padded shower chair which was ripped and dirty and bed side protection bumpers which were ripped and dirty. Walls to bedrooms and corridors were stained and dirty. (Refer to outcome 10)

Other evidence
We toured the service with the provider and registered manager and pointed out to them the standard of equipment and lack of general cleanliness. The provider and registered manager were not aware that the equipment was not well maintained or clean.

We spoke with the provider and registered manager who told us no one at the service was responsible for overseeing and taking responsibility for infection prevention and control.

The provider and registered manager told us that the home employed someone to clean the home. There were no cleaning schedules in place or monitoring of the cleanliness of the service by the provider or registered manager.

Our judgement
People resided in accommodation and used equipment which was damaged, not maintained or cleaned and had the potential to spread infection.

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 major concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We spoke with visitors who were visiting relatives as Ashleigh Nursing Home. One relative stated that whilst they were happy with the care provided they had concerns regarding the run down state of the building and accommodation.

We looked around communal areas of the service and some of the bedrooms. We found the décor of communal areas was not well maintained, with wall paper which was torn in places and damaged paint work. Walls, skirting boards and door frames were dirty. The dining room walls were dirty from food and drink spillages. We found that armchairs in corridors and bedrooms were stained.

A majority of the bedrooms at Ashleigh Nursing Home are shared rooms; curtains partitioned the beds to provide privacy. The partitioning curtains in some instances were stained and dirty. We found two bedrooms had large stains to the ceiling. The provider told us this was caused by water damage from the roof, they were not aware that a second bedroom had a damaged ceiling. One bedroom in addition to having a stained ceiling had two cracked window panes and had free standing plug in heaters, we asked the registered manager for an explanation. They told us that the central heating system had 'air pockets' and additional heating was required in the bedroom.

We noted that the carpet on the first floor presented a trip hazard as it was not fitted well, we were told by the provider this had been caused by water damage from the roof. Carpets in some bedrooms were stained.

Other evidence

The provider and registered manager told us that the home employed someone to clean the home. There were no cleaning schedules in place or monitoring of the cleanliness of the service by the provider or registered manager. The provider and registered manager were not aware of all of the maintenance issues and were not able to provide a plan detailing a schedule of works to bring about improvement.

Our judgement
People resided in accommodation which was not well maintained and which posed a risk to their health, safety and welfare.

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 major concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We spoke with visitors who were visiting relatives at Ashleigh Nursing Home. We asked them for there views about the attitude and approach of staff. Visitors told us that staff were kind and friendly and looked after there relatives well. Visitors' comments included, "Very caring staff, very supportive." "Very good, very good indeed very caring and helpful."

Other evidence
We spoke with the provider and registered manager about the support staff received and looked at records. We found staff were not regularly supervised and records detailing staff supervisions showed that some staff had not been supervised for over a year. Supervision sessions are an opportunity for the registered manager and a staff member to meet on a one to one basis to talk about work practices, training needs, care and welfare of people using the service and other issues which impact on their role.

The provider and registered manager told us that a staff meeting had been planned but acknowledged that staff meetings had not routinely take place.

Staff we spoke with said if they had concerns they would speak with the registered manager and were confident that issues would be listened to. Staff we spoke with said they had raised concerns about staffing levels especially around meal times; however no action had been taken.

Staff training records were not up to date. The office wall had a range of training

certificates which reflected the training provided, however it did not detail which staff had taken part. The provider and registered manager did not have a system to review whether the training staff received had a positive impact on people using the service.

Staff we spoke with told us that they had access to training. One staff member we spoke along with a colleague had received training in topics which included, first aid, moving and handling, infection control and health and safety.

Our judgement
The lack of staff supervision and support had a detrimental affect on the care and support people using the service received.

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: People did not experience effective, safe and appropriate care, treatment or support as care plans and records were not comprehensive or always followed. People's privacy and dignity is not promoted or upheld.	
Diagnostic and screening procedures	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: People did not experience effective, safe and appropriate care, treatment or support as care plans and records were not comprehensive or always followed. People's privacy and dignity is not promoted or upheld.	
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: People did not experience effective, safe and appropriate care, treatment or support as care plans and records were not comprehensive or always followed. People's privacy and dignity is not promoted or upheld.	
Accommodation for persons who require nursing or personal care	Regulation 12	Outcome 08:

	HSCA 2008 (Regulated Activities) Regulations 2010	Cleanliness and infection control
	How the regulation is not being met: People resided in accommodation and used equipment which was damaged, not maintained or cleaned and had the potential to spread infection. The service did not have a system for the management of infection control.	
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: People resided in accommodation and used equipment which was damaged, not maintained or cleaned and had the potential to spread infection. The service did not have a system for the management of infection control.	
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: People resided in accommodation and used equipment which was damaged, not maintained or cleaned and had the potential to spread infection. The service did not have a system for the management of infection control.	
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: People resided in accommodation which was not well maintained and which posed a risk to their health, safety and welfare. The service	

	does not have a maintenance plan.	
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 service does not have a system to ensure staff receive upto date training reflective of the needs of people using the service. Staff are not supervised or appraised as to there competency.	
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: The service does not have a system to ensure staff receive upto date training reflective of the needs of people using the service. Staff are not supervised or appraised as to there competency.	

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

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

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

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

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

What is a review of compliance?

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

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

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

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

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

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

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

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

Information for the reader

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