Review of compliance

Apple Tree House Residential Care Home Apple Tree House Residential Care Home Limited	
Region:	Yorkshire & Humberside
Location address:	31 Norwood Beverley East Riding of Yorkshire HU17 9HN
Type of service:	Care home service without nursing
Date of Publication:	August 2011
Overview of the service:	Apple Tree House is a Victorian terraced property in a residential area, close to the centre of the market town of Beverley. It is situated adjacent to a main road offering easy access to public transport, and within walking distance of the local shops and markets. On the ground floor there is a conservatory/dining area, lounge, kitchen and one bedroom. Further bedrooms and bathrooms are on the on

	the first floor. There are three self-contained flats in the courtyard area.

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

Our current overall judgement

Apple Tree House Residential Care Home Limited 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 06 - Cooperating with other providers
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 09 - Management of medicines
Outcome 10 - Safety and suitability of premises
Outcome 11 - Safety, availability and suitability of equipment
Outcome 12 - Requirements relating to workers
Outcome 13 - Staffing
Outcome 14 - Supporting staff
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 17 - Complaints
Outcome 21 - Records
Outcome 24 - Requirements relating to registered managers

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 10 June 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 said they enjoyed living at the home as it was a nice place to live. They said that they were encouraged to be as independent as possible with the support of the staff. They enjoyed swimming and going to the gym and were looking forward to going on holiday in the summer. People told us that they were happy with their rooms and the cleanliness of the home. However, one person did tell us that the Hoover keeps them awake at night. Another said the kitchen was always being cleaned.

We spoke with one relative who told us that they were happy with the support provided to their daughter. One person said that they hadn't settled at Apple Tree and that they were hoping to live in a flat soon.

What we found about the standards we reviewed and how well Apple Tree House Residential Care Home Limited 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

We found that the provider did not involve people or their representatives in the planning of their care, treatment and support.

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

The provider did not meet outcome 2. People who used this service were not protected from inappropriate care by staff seeking their consent.

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

The provider did not meet this outcome as we did not find personalised care and treatment provided through coordinated assessment and planning.

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

Overall people were supported to have adequate nutrition and hydration. We were concerned that nutritional risk assessments and regular weight assessment were not used for people at risk of inadequate nutrition.

Outcome 06: People should get safe and coordinated care when they move between different services

People received co-ordinated care and support from other professionals.

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

The provider did not protect people who used this service from abuse or the risk of abuse.

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

People were supported to live in a home that was a clean and appropriate environment facilitating the prevention and control of infections.

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

We were concerned to see medication left unattended; that one person had run out of their medication and that staff had considered using medication belonging to another person at the home.

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

Fire drills do not take place at regular intervals.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

People had safe and suitable equipment to meet their needs.

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

The provider was not compliant with this outcome. The employment history for prospective employees was not checked thoroughly and people had commenced work prior to the provider receiving their CRB.

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

We were concerned that during the weekend, when the majority of the people were at home, that there were only two members of staff on duty.

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

The provider did not meet this outcome. Staff had not received regular training in fire safety, health and safety, food hygiene and safeguarding people from harm. Staff did not receive formal supervision with the manager at regular intervals.

We were also concerned that staff had not received specialist training in the needs of the people who live at the home such as Autism and Asperger's Syndrome.

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

The provider did not meet this outcome. The provider did not have a system for auditing and demonstrating the quality of care and treatment provided by the service.

Outcome 17: People should have their complaints listened to and acted on properly

The provider did not meet this outcome. The provider did not have a system in place for identifying, receiving, handling and responding to complaints or comments made by people who used the service or their representative.

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

Records about the care, treatment and support of people who used this service were not clear, factual or accurate. The records were not regularly monitored to ensure that they were fit for purpose. Risk assessments were not in place for each person who used the service.

Outcome 24: Services must be managed by people who are honest, reliable and trustworthy. They must also have the right skills, experience and qualifications to do the job

This outcome was not met. The provider did not have a registered manager in place who could ensure that people who used the service had their needs met.

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

There are major concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
When we talked to people who used this service they said that they were encouraged to be as independent as possible with the support of the staff. They enjoyed swimming and going to the gym and were looking forward to going on holiday in the summer.

Other evidence
Individual relationships between the staff and the people who lived in the home were friendly and relaxed. We observed people chatting in a relaxed manner, sharing jokes and laughing together. People utilised different areas of the home, using the karaoke machine in the conservatory, watching the television, using the computer and sitting in the garden.

We saw that people had various jobs to do around the home including watering the plants in the garden and helping in the kitchen. Apple Tree had a very homely atmosphere and people who lived at the home were interacting over everyday issues such as putting out the washing and tidying the bedrooms. Opportunities for leisure activities were available and we saw that there were plans for a holiday for four days in July. One person was undertaking his Duke of Edinburgh award at Hull College and two people had been to the gym earlier in the day.

However, when we looked at people's files we found only limited evidence that people were consulted about their care. One example was that one person had attended a care review with the Local Authority and another when one of the residents was involved in a specialist medical appointment. There was limited evidence of people being involved in the planning, reviewing and assessment of their care. However, we did find that care plans included details of people's preferences regarding food and some of the details of how their finances were managed.

We found that people were supported to undertake activities of their choice. Some people attended a local youth club and went swimming every week. One person attended work experience and several attended a day care facility. While we were visiting Apple Tree relatives were coming and going in preparation for the weekend.

We saw that meetings took place in the home for people who live there. We were concerned to note that some of the issues discussed were not appropriate for an open forum. For example, on one occasion the group had discussed an individual's personal relationship which was not appropriate and did not respect their privacy. Please refer to outcome 7.

Staff at the home explained that most of the people needed structure to their daily routine. This included quiet time after 10.30pm when they were encouraged to get ready for bed and perhaps watch television in their rooms. This was described as a way of helping them realise their responsibility when they needed to get up in the morning for work and to attend day care.

We were concerned to note that one person had been told that they should return home by a certain time each evening without their agreement being sought and recorded in their care plan.

Our judgement
We found that the provider did not involve people or their representatives in the planning of their care, treatment and support.

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 major concerns with Outcome 02: Consent to care and treatment
Except in respect of Accommodation for persons who require nursing or personal care, where there are minor concerns.

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
We visited Apple Tree in response to a safeguarding concern that had been brought to our attention. This information had also been relayed to the Local Authority safeguarding adult's team who had been advising the provider and had commenced an investigation. The concern brought to the attention of the Care Quality Commission was of a safeguarding nature but also concerned when consent should be sought. The provider did not ensure that people gave consent, where they were able to, before their photograph was taken. Please refer to outcome 7: safeguarding.

The provider was not able to demonstrate that people who used the service received care and treatment that they had agreed to. Clear procedures to obtain consent were not in place to ensure that the risks, benefits and alternative options were discussed.

Some of the people who lived at Apple Tree did not have the capacity to make decisions and consequently their parents acted as their advocates. We saw one example where a best interest meeting had been held to assist in making a decision on the person's behalf. However, in the majority of files we saw limited evidence that

people were involved in discussions about their care and that risks were explained to them. Although each person had a 'rights' file in their bedroom and there was a form for people to confirm whether they wished to be checked upon during the night.

We talked to the new manager at Apple Tree who told us that staff had not received training on the Mental Capacity Act (2005) or Deprivation of Liberty safeguards, which could assist them when supporting people to understand consent.

Our judgement
The provider did not meet outcome 2. People who used this service were not protected from inappropriate care by staff seeking their consent.

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 one relative who told us that they were happy with the support provided to their daughter. One person said that they hadn't settled at Apple Tree and that they were hoping to live in a flat soon.

Other evidence
We saw that peoples care files contained a variety of information about their individual needs. However, these files were not well organised, resulting in repetition of information, and the storage of out of date documents that made it difficult to view people's latest needs. People who used this service had weekly planners but these were not up to date. In one file we saw three versions of a form to record the time the key worker spent with the person.

The provider did not have any risk assessments or management plans in place to support people with daily living tasks or with identified needs. For example, assisting with and monitoring mental health needs. This placed people at risk as it was unclear what level of support they required to be safe. Although one person had a specific plan in place to monitor their mental health needs, this had not been completed in recent months.

The manager had developed health files for the people who live in the home and these were well organised and clear. Although we noted that one person was allergic to penicillin, this information had not been transferred into the health file.

The manager told us that she is qualified in first aid and we saw first aid boxes were available in the home.

Our judgement
The provider did not meet this outcome as we did not find personalised care and treatment provided through coordinated assessment and planning.

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 who used this service did not comment on this outcome.

Other evidence
The provider had a large kitchen where people could help prepare the meals and keep the kitchen clean. We saw one person helping staff when the evening meal was being prepared. The meal consisted of chicken casserole and vegetables which was freshly prepared. The temperature of hot food was checked with a food probe and we saw notices displayed about kitchen hygiene.

The provider had a fridge and freezer for the storage of food which were both clean with food appropriately covered. Temperatures for the fridge and freezer were checked twice a day.

People's likes and dislikes regarding their diet were available within their care files. People were generally coming in and out of the kitchen helping themselves to drinks and snacks. We saw one care file for someone who was a fussy eater. Staff recorded the diet and fluids taken by this person and how much they had eaten. What was not clear however was whether a nutritional risk assessment had been completed and a management plan devised to promote adequate nutrition.

Some of care files showed that people were weighed as a means of assessing their health and nutrition. However, this had been carried out inconsistently and consequently was not very useful.

Our judgement
Overall people were supported to have adequate nutrition and hydration. We were concerned that nutritional risk assessments and regular weight assessment were not used for people at risk of inadequate nutrition.

Outcome 06:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:
* Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant with Outcome 06: Cooperating with other providers

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
When we reviewed the care files it was evident that the provider liaised with Social Services regularly regarding care of people at the home. The care plans devised by Social services were included in the assessment of the individual. In addition we saw that the provider worked with a variety of other professionals to maintain the health and well being of people who live at this service. The care files included letters from other professionals who liaised with the home and supported some of the people who live there.

The provider talked to us about how people access their local GP and the good support they receive. We also saw that records in the files included details of the phone calls to and from the GP such as advice for no further swimming after a diagnosis of epilepsy.

Some of the people who used this service were not able to make decisions about their lives on their own. As a consequence a 'best interest' meeting had been held with Humber NHS Mental Health Trust. This had been attended by the individual themselves, the community psychiatric nurse and the home manager. In this way a decision about future treatment in hospital was made.

The staff had recently benefited from the expertise of the local community learning disability nurse, when epilepsy training was held.

Our judgement
People received co-ordinated care and support from other professionals.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
We were able to see and speak to all the people who lived at the home. At the time of our visit people were attending a day centre, work experience and one person was attending a hospital appointment.. Some people were able to access the community independently. However, it was unclear what assessments and safeguards had been undertaken to ensure that this was a positive and safe experience.

The manager described the safeguarding training she had undertaken. We were concerned that referrals to safeguarding had not been made appropriately. For instance, there had been two recorded incidents where people had physically assaulted other people in the home which had not been forwarded to the Local Authority safeguarding team for investigation.

We saw records of the meetings held for people who live at the home and noted with concern that one person had disclosed information of a safeguarding nature that had not been handled according to the correct procedure. We discussed this situation with the manager at the time of the visit and in response the information has now been shared with the Local Authority safeguarding adult's team who will decide if further action is required.

We saw evidence of cooperation between the provider and Humber Mental Health NHS

Foundation Trust. The home worked closely with the community learning disability nurses and the community psychiatric nurses. A 'best interest' meeting had been held concerning one person's dental health and the requirement for anaesthetic in hospital. In this way when a person could not make an informed decision themselves a group of health professionals would consider what was in their best interest.

We visited this provider after receiving information of concern. At our visit it was evident that safeguarding procedures had not been followed. Some of the staff had acted inappropriately in their care of the vulnerable people who lived at this home. Consequently two members of staff had been suspended from duty pending an investigation by the local safeguarding team. This was ongoing at the time of our visit. The provider did not have systems that clearly assessed whether a person could give consent. Consequently, individuals were not able to decline having their photograph taken when this was inappropriate. In this way the provider did not protect people who used the service from unsafe or inappropriate care.

Our judgement
The provider did not protect people who used this service from abuse or the risk of abuse.

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

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We spoke to two of the people who lived in the home. They told us that they were happy with their rooms and the cleanliness of the home. However, one person did tell us that the Hoover keeps them awake at night. Another resident said the kitchen was always being cleaned.

Other evidence
We found that the manager was an infection control trainer and was arranging updates for staff in infection control as part of their overall training package. She planned to provide the training herself and told us that she is proactive in promoting good hygiene. There was evidence of posters promoting the prevention of infection. For example, there were posters on hand hygiene displayed in the downstairs toilet to prevent infections.

We inspected recent records for cleaning rotas, completed cleaning records, fridge and freezer temperatures and records for testing temperature of hot water taps. The manager stated she was going to add 'flushing through to the water outlet' checks to enhance protection against Legionella.

The shared toilet near the communal lounge had a normal towel for hand washing and the manager stated the intention to replace this with disposable paper towels. Antimicrobial hand gel was available in various locations and we saw a sign near the visitors' book asking people to use gel when entering and leaving the premises. However, the dispenser was not available at the time of the inspection.

A cleaner was employed by the home to undertake domestic duties in addition to those

undertaken by the staff and the people who live in the home.

Our judgement
People were supported to live in a home that was a clean and appropriate environment facilitating the prevention and control of infections.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

There are minor concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
People we spoke to during this visit did not comment on this outcome.

Other evidence
Each person had a locked medication cupboard in their room. The manager stated that two members of staff visit each person carrying their medication administration record (MAR) and keys to the cupboard. We inspected records for the ordering of prescribed medicines and these appeared to be satisfactory. At the back of the file containing the MAR charts, there were copies of certificates of training for appropriate staff.

We saw copies of six monthly audits of MAR charts. This audit was a check that charts had been completed correctly. The manager explained that where a prescription offers choice, for example, "one or two tablets as required" that the dose administered was recorded in order that stock can be fully accounted for. At the time of inspection there were no-one taking controlled drugs but the provider had a policy in place and through their medications contract can acquire suitable storage if required.

When we were carrying out this inspection we observed that medication was on one occasion left unattended in the office of the home. In addition we saw a letter from a staff member, informing the management that one person's medication had run out and they were questioning if they could use medication belonging to another person living in the home. There were no records of the response to this request or how the situation was handled to ensure the needs of the individual were met, including ensuring that

they received all of their prescribed medication. There was also no evidence that the staff member concerned had received further training in administration of medication.

Our judgement
We were concerned to see medication left unattended; that one person had run out of their medication and that staff had considered using medication belonging to another person at the home.

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 said they enjoyed living at the home as it was a nice place to live.

Other evidence
When we visited the home was clean, tidy and very well presented. Each person had their own bedroom which they personalised as they wished. There were also three bungalows at the rear of the property which had ensuite bathrooms. One of the bedrooms that was part of the main house was accessed by an external staircase and did not connect internally with other rooms in the house.

The local environmental health officer had inspected the home in 2010 and an external company had inspected the home the previous week. They had made some recommendations to the home which included revisions to the fire exits. The home had an action plan in place to meet these recommendations. When we discussed fire safety with the provider we were told that fire drills do not take place. This would be a good idea so people know what to do in the event of a fire.

The provider checked the functioning of the fire alarms in the home at weekly intervals. The temperature of the water from hot taps was also checked weekly to ensure safety.

Our judgement
Fire drills do not take place at regular intervals.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
* Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

The provider is compliant with Outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
We were shown a recent report testing the fire safety and alarm systems, together with portable appliance testing (PAT) for the premises. The provider stated that the fire safety inspection should have been completed in April but their contractor has only just carried this out. The report did not highlight any ongoing concerns.

For the most part the people who used this service did not require equipment for their individual needs. One person with physical disabilities required the use of a hoist. We asked about the use and maintenance of this lifting hoist, a washing machine and a fridge. The manager spoke about the safe use, service and health and safety considerations of this equipment.

Temperature recordings of fridges and freezers were available and these were up to date.

Our judgement
People had safe and suitable equipment to meet their needs.

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
People who used this service did not comment on this outcome.

Other evidence
Staff files were held within the home and included the recruitment and induction details for staff. There was a recruitment process within the home and application forms and checks were undertaken on potential new staff. Application forms included a check that people were physically fit for the role and recorded their past work history. However, the provider did not ask for start and finish dates for previous employments. Consequently, it was unclear if people had any gaps in their employment that should have been questioned.

References were requested for prospective employees, although character references had been accepted by the manager and references were not verified.

Details in two of the staff files showed that criminal record bureau (CRB) checks had not been received for the individuals prior to them commencing employment in the home. One of these people was on the rota to work with only one other staff member. Due to the layout of the home and the needs of the people living there it was not possible for this person to work 'supervised' prior to their CRB being received and this placed people at the potential risk of harm.

Our judgement
The provider was not compliant with this outcome. The employment history for

prospective employees was not checked thoroughly and people had commenced work prior to the provider receiving their CRB.

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
We received comments from people who said that the staff were 'OK'.

Other evidence
There were duty rotas in place that showed that there were two staff on duty during the day until 10.20 pm in the evening every day of the week with two staff also on duty throughout the night. The provider also used twilight shifts with an additional member of staff working between 7pm and 10.30pm. This third member of staff was able to assist people with activities, to have some social time and to get ready for the next day.

When discussing staffing with the owner she stated that she was additional to the staff that were on duty to care for the people who live at the home. The manager was also supernumerary. We were told that staff at the home worked flexibly and were happy to do additional hours when required.

At the time of our visit three members of staff were suspended. This meant that the home was short of staff the following weekend. The provider stated that agency staff would be used. Two senior carers at the home had recently left employment so the home was currently advertising for replacements.

Throughout the week people attended a variety of activities away from the home including work placements, and were at home during the weekend. However, there were only two staff throughout the day during the weekend with no additional staff on duty and it is recommended that this is re-assessed by the home.

Our judgement
We were concerned that during the weekend, when the majority of the people were at home, that there were only two members 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 major concerns with Outcome 14: Supporting staff
Except in respect of Accommodation for persons who require nursing or personal care, where there are minor concerns.

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
Staff files included details of the training that they had received, including induction and ongoing training. The manager had plans to develop individual portfolios with the staff and an example showed a formal and organised system for recording and assessing staff needs.

Of the files we looked at we found that the amount of training people had received varied greatly. Some staff had received training in only one or two areas, whereas other staff had received a variety of training, although some of this was out of date.

Of the five files examined two people had received training in epilepsy, safeguarding people from harm, food hygiene, infection control, health and safety, and equality and diversity. Three had received training in moving and handling and medication awareness. We did not find any evidence that people had received training in the Mental Capacity Ac t (2005), Deprivation of Liberty safeguards, fire training or any specialist courses, such as Autism. However, some staff had received epilepsy training from the learning disability specialist nurse.

The manager told us that she had booked the following training: safeguarding people from harm, equality and diversity, and medication awareness. She confirmed that all staff needed to renew their food hygiene and health and safety training and that all staff

were trained to National Vocational Qualification (NVQ) level 2 with some staff currently working towards an NVQ level 3.

Staff files had only limited evidence of supervision with the manager, reflecting that these were not taking place regularly. The manager confirmed that these sessions had not taken place.

Our judgement
The provider did not meet this outcome. Staff had not received regular training in fire safety, health and safety, food hygiene and safeguarding people from harm. Staff did not receive formal supervision with the manager at regular intervals.

We were also concerned that staff had not received specialist training in the needs of the people who live at the home such as Autism and Asperger's Syndrome.

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 major 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 who used this service did not comment on this outcome.

Other evidence
People's files included only limited evidence of formal reviews, with one file containing the minutes of a meeting with the Local Authority. We did not see any evidence of monthly or six monthly reviews of people's needs or reviews of these files by the management of the home.

The owner of the home told us that she did not use a formal quality assurance system and that this had been the case for the last six months.

We looked at the accident book which contained one incident for April 2011 and one for May. Incident forms were also seen. However, this information was not collated by management or fed back to staff.

Our judgement
The provider did not meet this outcome. The provider did not have a system for auditing and demonstrating the quality of care and treatment provided by the service.

Outcome 17:
Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:
* Are sure that their comments and complaints are listened to and acted on effectively.
* Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

There are major concerns with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
When we asked to examine the complaints 'log' or records we were informed that there was not one in place. When this was discussed a member of staff made a complaints book.

We did not see a complaints procedure on display in the home or other information to support people in raising concerns.

Our judgement
The provider did not meet this outcome. The provider did not have a system in place for identifying, receiving, handling and responding to complaints or comments made by people who used the service or their representative.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are moderate concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
We reviewed the care files for four of the people who used this service. The new manager at the home reported that she had reviewed the content of approximately half of the care files. Health records for each person were retained in a separate file and were generally in a good order as the manager had been able to review these.

The documents seen in the care files included the admission assessment, care planning from the Local Authority (LA) commissioning team and reviews of the planned care. However, the LA review documentation was sporadic. One care file showed the transition plan that had been put in place by the LA when a person was being transferred to the provider. We saw specific care identified for people such as triggers for certain behaviours and mood and behaviour charts. Weight charts were present but were not filled in. The key worker for each person was identified but there was more than one document for the key worker to complete which was confusing and had been poorly completed. This should be streamlined.

Patient passports had been developed recently and were of a good standard. These assist when people go into hospital as they provide information to other professionals and ensure continuity of care.

Risk assessments were carried out but these were general and were not included in the individual files. We saw a risk assessment folder that related to all the people who used this service regarding risks such as striking, throwing, and access to toiletries and sharp objects.

Our judgement
Records about the care, treatment and support of people who used this service were not clear, factual or accurate. The records were not regularly monitored to ensure that they were fit for purpose. Risk assessments were not in place for each person who used the service.

Outcome 24:
Requirements relating to registered managers

What the outcome says

This is what people who use services should expect.

People who use services:
* Have their needs met because it is managed by an appropriate person.

What we found

Our judgement

There are major concerns with Outcome 24: Requirements relating to registered managers

Our findings

What people who use the service experienced and told us
People who used this service did not comment on this outcome.

Other evidence
The manager for this service was not registered with the Care Quality Commission (CQC) and there had not been a registered manager in post for some time. The need for a registered manager was discussed with the owner of the home as there were a number of pieces of work required in order for outcomes to be fully met.

Our judgement
This outcome was not met. The provider did not have a registered manager in place who could ensure that people who used the service had their needs met.

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: We were concerned that staff felt it was appropriate to take photographs of people who used this service without their permission. We were concerned that staff who care for people who may not be able to give consent, had not received training in the Mental Capacity Act (2005) or Deprivation of Liberty safeguards.	
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: We were concerned that nutritional risk assessments and regular weight assessment were not used for people at risk of inadequate nutrition.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	Why we have concerns: We were concerned to see medication left unattended; that one person had run out of their medication and that staff had considered using medication belonging to another person at the home.	
Accommodation for persons who require nursing or personal	Regulation 15 HSCA	Outcome 10: Safety and

care	2008 (Regulated Activities) Regulations 2010	suitability of premises
	Why we have concerns: We were concerned that fire drills do not take place at regular intervals.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: We were concerned that during the weekend, when the majority of the people were at home, that there were only two members of staff on duty.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: We were also concerned that staff had not received specialist training in the needs of the people who live at the home such as Autism and Asperger's Syndrome.	

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 7 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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider did not involve people or their representatives in the planning of their care, treatment and support which may affect their lifestyle and quality of life.	
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 02: Consent to care and treatment
	How the regulation is not being met: The provider did not ensure that there are systems in place for people, where they are able; to give consent to the examination, care, treatment and support they receive.	
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: The provider did not ensure that people who use this service have treatment and support based on an assessment of their individual needs, identifying and managing risks, and centred on them as an individual.	
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse

	How the regulation is not being met: The provider did not meet this outcome as they did not safeguard the people who used this service from abuse. Staff were behaving inappropriately and the provider did not have systems in place to report safeguarding concerns to the local safeguarding adults team. In addition the provider did not ensure that people, where they were able to, gave their consent to photographs being taken.	
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: We were concerned that the employment history for prospective employees was not checked thoroughly and people had commenced work prior to the provider receiving their CRB.	
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: Staff did not receive regular training in fire safety, health and safety, food hygiene and safeguarding people from harm. Staff must receive formal supervision with the manager at regular intervals.	
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
	How the regulation is not being met: The provider did not use a system for auditing and demonstrating the quality of care and treatment provided by the service.	
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA 2008 (Regulated	Outcome 17: Complaints

	Activities) Regulations 2010	
	How the regulation is not being met: The provider did not have a system in place for identifying, receiving, handling and responding to complaints or comments made by people who use the service or their representative.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The provider did not ensure that records about the care, treatment and support of people who use this service are clear, factual and accurate. The records must be monitored regularly to ensure that they are fit for purpose and must include risk assessment for each person.	
Accommodation for persons who require nursing or personal care	Regulation 6 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 24: Requirements relating to registered managers
	How the regulation is not being met: The provider did not ensure that the service has a manager who is registered with CQC and has the qualifications, skills and experience to manage the service.	

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

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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