Review of compliance

Ashberry Health Care Limited Holmer Court Residential Home	
Region:	West Midlands
Location address:	Attwood Lane Hereford Herefordshire HR1 1LJ
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Holmer Court is a large Georgian house with modern extensions, situated on the outskirts of the city of Hereford. It is registered to accommodate up to 33 older people whose care needs may arise from frailty due to the ageing process or a dementia illness. All rooms are single, apart from one, which is shared by two people. Twenty rooms have en-suite facilities. There are a range of communal rooms,

	a new conservatory and good-sized established gardens that are accessible for service users.

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

Our current overall judgement

Holmer Court Residential 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 09 - Management of medicines
Outcome 13 - Staffing
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 14 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

There was a calm, peaceful atmosphere in the home with classical music playing in one lounge. We saw that people were settled and staff spoke to them gently and kindly, asking them if they were comfortable. One person who lived at the home said that "it's a good place to be". Another person said that the staff were "kind and always cheerful. They look after me". We spoke with relatives of two people who said that they were very happy with the standard of care given, and that they felt included by staff. They were welcomed at any time.

What we found about the standards we reviewed and how well Holmer Court Residential Home was meeting them

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

Care plans are detailed and highly individual but some records are not always up to date or complete.

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

human rights

We are confident that people who use the service are protected from abuse. Staff were able to demonstrate their knowledge and understanding of their responsibilities to protect people and keep them safe.

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

The recording of prescribed items indicates that people may not always receive their medicines correctly and safely.

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

The provider is compliant in this area. We are confident that staff numbers and training and supervision are meeting people's needs.

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

Care records and documentation are not always up to date or completed in a timely fashion.

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. 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

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
We saw that staff were able to spend time with people, chatting with them and supporting them to take part in activities. We were told by the manager that five people had just returned from a short break in Burnham-on-Sea, accompanied by staff.

The garden had been improved with wider paths for wheelchair access, raised beds and a bigger allotment for growing vegetables. It was large and tidy with plenty of seats. Some people were active in the garden including looking after the chickens. As it was a sunny day, staff were erecting a gazebo for shelter and offering sun hats to people. The Alzheimer's Society, in its report "Home from Home" states "The benefits of a garden can change through the stages of dementia, at first providing opportunities for gardening activities and later promoting stimulation of the senses and awareness outside of the self".

We were told that a Royal Wedding party had been held in April and relatives had brought in hats for everyone to wear.

Other evidence
The manager told us that they were undertaking training in advanced care planning and updating records of important decisions.

We saw that people were calm and settled in the communal lounges. People appeared well cared for and were dressed appropriately. Some had newspapers beside them, and many had individual bowls of cut up fruit next to them. Everyone had drinks brought

to them in clear beakers.

We saw that the cook was taking a tray of late breakfast to a person in their room.

We looked at the care records for four people in detail. Three care plans were comprehensive and up to date with detailed assessments and records. Each care plan included a detailed "living history" and emphasised dignity and individuality, and encouraged independence. They contained good explanations of agitation triggers and calming measures to be used by staff. One care plan did not include detailed information, but staff knew the care that the person needed and showed a good understanding of the person's individual needs and wishes.

All the seven members of staff that we spoke with showed that they had good in-depth knowledge of people living in the home and their need for independence, and were keen to make Holmer Court as homely as possible. They had all received dementia care training.

Our judgement
Care plans are detailed and highly individual but some records are not always up to date or complete.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
One person told us that "the staff are there if I need them".

Other evidence
The manager showed us that the local authority's procedures on the protection of vulnerable people (safeguarding) were available for staff to access.

We were told that all the nursing and care staff and other staff in the home have now received safeguarding training from the local adult safeguarding team in the last few months, and saw the staff training record. We asked seven members of staff about their training. They all showed knowledge and confident understanding of the requirements for reporting safeguarding concerns.

Staff were able to show an understanding of people's best interests. We were told by staff that if people refuse the care that is offered to them, they know that the manager will contact the social workers to alert them.

While we were at the home, we saw that staff were able to manage a person's agitation calmly and effectively by interacting gently with them, sitting and talking about their trip to Burnham-on-Sea.

Our judgement
We are confident that people who use the service are protected from abuse. Staff were able to demonstrate their knowledge and understanding of their responsibilities to

protect people and keep them safe.

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 moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not speak to any people living at the home about their medications.

Other evidence
Most medication was stored within a lockable trolley and the remainder in a lockable wall cupboard. We viewed a sample number of Medication Administration Record (MAR) sheets for both the current and previous month.

Overall we found that the majority of sheets were signed satisfactorily showing that people had received medication. We saw some gaps on the MAR sheets with no explanation as to why medication was either not given or not recorded as given. One sheet showed that an antibiotic had not been administered for one dose with no explanation given.

Doses of medication given were not always accurately recorded. For example, if a dose was a variable dose of either one or two tablets, there was no record to indicate how much had been administered.

Variable dose medications which were prescribed to be given "as required" did not have a template giving indications for doses of the medication.

We saw that one person had not received their diabetes medication for two days with no reason given.

We saw that when a prescription had been transferred to a new MAR sheet, only one person had signed this and it had not always been witnessed by a second member of staff.

Our judgement
The recording of prescribed items indicates that people may not always receive their medicines correctly and safely.

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
Staff told us that there were usually five staff on duty in the morning, four in the afternoon and three or four at night. They felt that this was usually enough and gave them enough time to spend chatting with people and helping with activities. People told us that there were always enough staff to help them when needed. They said that staff were always cheerful and kind.

Other evidence
We were told that communication between staff occurred twice a day at handover, which was held in the morning and afternoon.

The manager said that staff mobile phones were banned whilst on duty and that all staff were aware of the policy.

New staff received an induction pack to work through, and worked under the supervision of another care worker for the first month. Induction training included moving and handling, first aid, food hygiene, fire, safeguarding, infection control. We spoke with staff members who were able to confirm this.

Our judgement
The provider is compliant in this area. We are confident that staff numbers and training and supervision are meeting people's needs.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

There are minor concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We looked at care records for four people who live in the home. Three of the care records were person-centred and showed great attention to detail of people's likes and dislikes, and of their interests.

The care plan of a person who had moved into the home a few weeks previously, was not completed with many entries un-named and undated. There was no 'management of agitation' plan even though we were told that this person was often very agitated and vocal.

Other evidence
The medication administration record (MAR) sheets were not always accurately completed to show that people had received their medication.

The people who live at Holmer Court may not always be able to tell staff about their needs and wishes, due to their dementia. Therefore it is very important that written records are accurate and up to date, so that all staff know how to meet people's individual needs.

Our judgement
Care records and documentation are not always up to date or completed in a timely fashion.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The recording of prescribed items indicates that people may not always receive their medicines correctly and safely.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The recording of prescribed items indicates that people may not always receive their medicines correctly and safely.	
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: Care records and documentation are not always up to date or completed in a timely fashion.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated Activities)	Outcome 21: Records

	Regulations 2010	
	How the regulation is not being met: Care records and documentation are not always up to date or completed in a timely fashion.	

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 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

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