Review of compliance

Sudera Care Associates Limited Highbury Residential Care Home	
Region:	East Midlands
Location address:	38 Mountsorrel Lane Sileby Loughborough Leicestershire LE12 7NF
Type of service:	Care home service without nursing
Date of Publication:	September 2012
Overview of the service:	Highbury Residential Care Home is registered to provide accommodation and personal care for up to 27 older people and those with dementia. The home is situated in the village of Sileby with access to local shops, cafes and other facilities. It can be reached by public transport and there is parking in the grounds.

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

Our current overall judgement

Highbury Residential Care Home was not meeting one or more essential standards. Action is 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 15 August 2012, 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

As part of our inspection on this service we spoke to three people using the service, five members of staff working at the service and the relatives of two people using the service.

The people using the service we spoke to were generally happy with the care they received at the home. They commented that they enjoyed the food provided at the home. One person using the service told us that there was not sufficient staff on to meet people's needs, stating that, "It is chaotic at lunch-times. There is not enough staff on. Definitely not." Another person using the service told us, "There are not a lot of activities but I do get plenty to eat and drink."

We spoke to relatives of people using the service. One relative was concerned that clothes were being given to the wrong people. The relative commented that, "The home is very good. The only complaint is that the laundry is confused. We often find her wearing other people's clothes. She sometimes comes out and doesn't look like herself. We buy new clothes and don't see them again." Another relative we spoke to told us, "I think for the girl's sake they could do with more staff."

Staff working at the service told us that they struggled at times to meet people's needs. One staff member told us, "There are not enough staff on to meet people's needs. We've not had a coffee or lunch-break today." Another staff member commented, "I personally don't think there are enough staff on." Staff did tell us that they felt supported by the management at the home and felt they would address issues if needed.

What we found about the standards we reviewed and how well Highbury

Residential Care Home was meeting them

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

The provider was not meeting this standard. We judged this had a moderate impact on people using the service.

People did not experience care, treatment and support that met their needs or protected their rights.

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

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

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

The provider was meeting this standard.

People who use the service were being protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider was not meeting this standard. We judged this had a minor impact on people using the service.

The provider has not taken steps to provide care in an environment that is suitably designed and adequately maintained.

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

The provider was not meeting this standard. We judged this had a moderate impact on people using the service.

There were not enough qualified, skilled and experienced staff to meet people's needs.

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 was not meeting this standard. We judged this had a minor impact on people using the service.

The provider did not have an effective system to regularly assess and monitor the quality

of service that people receive.

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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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 non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people living at the home who were complimentary about the care provided by the staff working there.

All of the people we spoke to told us there was very little offered by the home in terms of activities for people. One person told us, "There are not many activities. Sitting and sleeping – that's it."

One person using the service told us that they did not believe there were enough staff on duty to meet people's needs. They told us, "My worst complaint is that there is a shortage of staff and it is very chaotic at meal-times."

Other evidence
We reviewed four care records at the home. These were not presented in an orderly fashion and key documents were missing from them. The home was unable to produce Do Not Resuscitate (DNR) forms for people using the service and the care plans we looked at were chaotic and difficult to follow.

We reviewed the nutritional screening process used at the home. Records showed that one person using the service had lost 7kg in weight in a period of one month. The home had recorded this weight loss but had not taken any action to address it. The home explained that this may have been due to an error in the weighing equipment. The home had not taken any further action either in relation to the weight loss recorded or to

the possible fault in the weighing equipment. This indicated that the provider was not ensuring that care was being planned and delivered to ensure the safety and welfare of people using the service.

The home had produced a hospital grab sheet for people using the service but these were not completed for any of the people using the service and were shown to us as template documents. This documentation should have been completed for each person using the service and formed part of people's care plans to ensure safe delivery of care.

During our visit there were no activities provided at the home. We were told that activities did take place, however, we saw no evidence of this. The home was unable to produce a schedule of activities. People we spoke to living at the home told us there was little offered in terms of activities. We observed people sitting for long periods of time with little to stimulate them.

Staff we spoke to told us they lacked time to sit with residents due to the number of staff on duty and the needs of the people using the service. We observed staff failing to meet the needs of people using the service. At one point during our inspection there was one staff member looking after 12 people. The staff member was not able to meet people's individual needs. This meant that the care was not being delivered safely to ensure the welfare of people using the service.

We did observe health professionals visiting the home during our visit and saw evidence that the home was making referrals to health practitioners when required.

Risk assessments were in place for people using the service and these were reviewed on a regular basis.

Our judgement
The provider was not meeting this standard. We judged this had a moderate impact on people using the service.

People did not experience care, treatment and support that met their needs or protected their rights.

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

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The people using the service we spoke to told us that they had enough to eat and drink. They told us that the home provided a choice of meals and that snacks were offered throughout the day and into the evening. One person commented that, "The food here is fine. Quite alright." Another told us that, "The food is very good."

A relative of someone using the service told us, "They have kept her nutrition up. She says she enjoys the meals."

Other evidence
The home produced a weekly menu and we were shown an example of this during our visit. This menu provided evidence that the provider was offering a choice of nutritious meals in sufficient quantities. There was a hot breakfast offered each day and hot options offered for lunch, tea and supper.

Each day residents were asked what they would like to eat from the menu offered. The provider did not display a menu in the dining room or have menus out on the tables so that people could see what was on offer. The provider may find it useful to note that displaying a menu in the dining room, and on the tables, would assist people in choosing from the dining options.

The people we spoke to who use the service were happy with the quantity of food being offered. We did observe people asking for water which was not provided in a timely manner on two occasions. However, we did see a drinks trolley being taken around the home on a regular basis.

We saw evidence that people at the home were offered a wide range of snacks throughout the day and that drinks were being offered on a regular basis. People were being provided with a choice of suitable and nutritious food and drink.

The home provided evidence that they have been using a nutritional screening tool and that this was being used to assess people in terms of their nutritional risk.

Our judgement
The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

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
People using the service told us they felt safe at the home and with the carers looking after them. Nobody we spoke to told us about concerns related to abuse.

Other evidence
The home was able to evidence incidents which had occurred in the home in relation to safeguarding vulnerable adults. The provider was also able to evidence actions taken in relation to these. We found that the home had made timely notifications to the relevant authorities since the new manager had been in post. We also saw evidence that these incidents had been clearly documented and risk assessments put in place in relation to these.

As part of our inspection we reviewed the safeguarding policy in place at the home. This did have details of how to report incidents of safeguarding and had been recently updated.

The staff we spoke to at the home had a good understanding about safeguarding vulnerable adults. They were able to name the difference types of abuse and could tell us how they would report any incidents of abuse both internally and outside of the home.

We reviewed the training schedule at the home and saw evidence that safeguarding training had recently been undertaken by the majority of the staff working at the home. This training was reflected in staff's knowledge around this area.

We observed notices to staff and people living at the home about the definitions of abuse and how to report these. This provided evidence that the provider had taken The home was able to evidence incidents which had occurred in the home in relation to safeguarding vulnerable adults. The provider was also able to evidence actions taken in relation to these. We found that the home had made timely notifications to the relevant authorities since the new manager had been in post. We also saw evidence that these incidents had been clearly documented and risk assessments put in place in relation to these.

As part of our inspection we reviewed the safeguarding policy in place at the home. This did have details of how to report incidents of safeguarding and had been recently updated.

The staff we spoke to at the home had a good understanding about safeguarding vulnerable adults. They were able to name the different types of abuse and could tell us how they would report any incidents of abuse both internally and outside of the home.

We reviewed the training schedule at the home and saw evidence that safeguarding training had recently been undertaken by the majority of the staff working at the home. This training was reflected in staff's knowledge around this area.

We observed notices to staff and people living at the home about the definitions of abuse and how to report these. This provided evidence that the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

All staff files contained CRB checks and references along with copies of identification documents taken prior to employment.

Our judgement
The provider was meeting this standard.

People who use the service were being protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider is non-compliant with Outcome 10: Safety and suitability of premises. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
People we spoke to were generally happy about the environment in which they were living. Nobody we spoke to had any concerns about the safety and suitability of the home. They told us that they thought the home was clean and tidy.

Other evidence
During our visit we observed the home to be safe and secure for people living there. There was a secure locking system to the front door of the building and the windows were secured to protect the safety of people living at the home.

We were told that maintenance staff worked at the home from Monday through to Friday and saw evidence of this on the staff rotas we were shown.

We looked at the bedrooms people were occupying at the home. These were all in need of redecoration. Some of the wallpaper in the rooms was peeling off the walls and the skirting boards were chipped. The furniture was dated and some of it was not of a decent standard.

The bedrooms were not being maintained to ensure the welfare of the people living in them. One room, occupied by a person using the service, had furniture and mattresses stored in them which were not in use. We observed wires which were exposed and not taped down in another occupied bedroom.

We observed equipment being stacked in areas which were not safe for people using the service. Wheelchairs were stacked in one of the hallways in the home and were in a

hazardous position for people living there.

Equipment and furniture not currently in use was not being stored appropriately to protect service users against the risks of unsafe or unsuitable premises.

We saw evidence that the lift in place at the home was regularly serviced and that the home had fire safety procedures and checks in place.

We observed that the grounds of the home were adequately maintained and these were secure enough for people living at the home to access safely.

Our judgement
The provider was not meeting this standard. We judged this had a minor impact on people using the service.

The provider has not taken steps to provide care in an environment that is suitably designed and adequately maintained.

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 non-compliant with Outcome 13: Staffing. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to a number of staff working at the service about staffing levels at the home. They all told us that they thought there were not sufficient staff on duty to meet the needs of people living at the home. One staff member commented, "The kind of residents we've got need a lot of attention and we don't have enough time to give them what they need." Another staff member said, "The night girls are really concerned about it. They struggle to cope at night."

People using the service told us that they had confidence in the staff looking after them and told us that they thought the staff were well trained and qualified to deliver their care. However, people using the service did tell us they did not think there were enough staff on to meet their needs. One person said, "It takes them a long time to get round to things. I think it's a shortage of staff."

The relatives we spoke to were quite happy with the abilities of the staff working at the home. One relative did not think there was enough staff to meet people's needs.

Other evidence
At the time of our inspection there were three carers on duty, one senior carer, a cook and a cleaner, as well as the manager of the home. During the night there were two members of staff working at the home. There were 20 people living at the home at the time of our visit. The majority of the people living at the home had some form of dementia.

During our visit we observed staff failing to respond to requests from people for drinks and struggling to move and handle people appropriately.

The home could not supply any evidence of how they had determined staffing levels in relation to the needs of the people using the service. The level of need we observed during our visit was high in some cases and we did not see any evidence that this was being managed effectively by the staff on duty.

People using the service told us that the buzzers often were not answered in a timely manner and that they often had to wait for a drink when they requested one. We saw evidence of this whilst at the home. People's needs were not being met due to lack of staff numbers in relation to the needs of people using the service.

We observed lunch being served at the home at the time of our inspection. We witnessed people having to wait for food, people being moved and handled inappropriately, and staff struggling to meet people's needs during this time. This indicated that there were not sufficient staff on duty at this time.

We reviewed the training schedule for staff working at the home. This schedule showed that several members of staff had not received training in key areas of delivering safe and appropriate care. There were several gaps in the training schedule and some of the training needed to be refreshed.

Staff files we reviewed contained the relevant CRB checks, references, training records, ID documents and supervision records. We saw evidence of some staff supervisions which were documented. These staff supervisions were not done on a regular basis and there was no annual appraisal system in place.

The gaps in staff training and staffing levels at the time of our inspection indicated that there was not enough adequately qualified and skilled staff to meet the needs of the people using the service.

Our judgement
The provider was not meeting this standard. We judged this had a moderate impact on people using the service.

There were not enough qualified, skilled and experienced staff to meet people's needs.

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

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We did not speak to people using the service about this outcome. We did, however, speak to the manager of the service about recent satisfaction surveys and audits undertaken by the service.

Other evidence
At the time of our inspection the service was unable to produce any evidence of any satisfaction surveys that had been carried out by the service. The service had no evidence of a feedback process which had been documented.

We did not see any evidence of residents meetings held by the service which could have provided an opportunity for people using the service to feedback to management on how things could be improved on. The manager told us that this was something the home was looking to do but that it had not been done recently.

There was a complaints policy in place at the service. There was no documentation related to any complaints having been received by the service. We were told that this was because the service had not received any.

We did not see any evidence of a quality monitoring policy or evidence of how the service intended to seek the views of people using it in order to measure its quality.

We did see evidence of some audits carried out by the service in relation to infection

control, medication and maintenance. These were satisfactory and had been carried out on a regular basis.

Our judgement
The provider was not meeting this standard. We judged this had a minor impact on people using the service.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

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 care, treatment and support that met their needs or protected their rights. The provider did not provide evidence that care was being planned and delivered to ensure the welfare and safety of people using the service. Care plans were chaotic and key documents missing from them. There was a lack of stimulation for people living at the home.	
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: The provider has not taken steps to provide care in an environment that is suitably designed and adequately maintained. Equipment was being stored inappropriately in communal areas and in bedrooms. The home was in need of redecoration.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met:	

	There were not sufficient numbers of staff on duty to meet the needs of the people using the service. People's needs were not being met. The training schedule showed gaps in key areas of delivering safe care.	
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 service did not have systems in place to measure the quality of the service being provided. There were no residents meetings being held and little evidence that the views of the people using the service were being taken into account.	

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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
Copyright	

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