Review of compliance

Somerset Redstone Trust Newstead House	
Region:	West Midlands
Location address:	43 Venns Lane Hereford Herefordshire HR1 1DT
Type of service:	Care home service with nursing
Date of Publication:	May 2012
Overview of the service:	Newstead House is located in Hereford and provides nursing and residential care for up to 46 people.

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

Our current overall judgement

Newstead House was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 to check whether Newstead House had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 2 May 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We visited Newstead House to check whether the home had made the improvements we required following an inspection on 10 January 2012. We visited the home on 6 March 2012 and 2 May 2012. At these visits we found that there had been significant improvements in the way in which the home managed people's care and welfare needs. We shall return to the home again to check that improvements have been made in other areas. This report only refers to Outcome 4: Care and welfare of people who use services.

We spoke with three people who live at the home and a relative who was visiting. We spent some of our time sitting in the lounges. This was so we could see how people spent their time and how staff provided care and support. People were positive about the staff and described staff as "approachable and discreet" and said "they really do their best and work very hard". One person told us how pleased they were with the recent improvements. Comments included "very, very positive changes", "it's brilliant" and "overall, really happy now".

Some care records contained inconsistent or misleading information. This meant that there was a risk that staff might not have the information they needed to ensure that people received care which met their needs.

What we found about the standards we reviewed and how well Newstead House 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 that this had a minor impact on people using the service and action was needed for this essential standard. People did not always experience care, treatment and support that met their needs and protected their rights.

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

In a previous review, we found that improvements were needed for the following essential standards:

- 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
- Outcome 05: Food and drink should meet people's individual dietary needs
- Outcome 09: People should be given the medicines they need when they need them, and in a safe way
- Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare 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

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

There are minor 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 three people who lived at the home and a relative who was visiting. People were positive about the staff and said that they felt confident that the nurses and care staff knew how to care for them.

We spent time in two of the lounges to see how people spent their time and how staff supported them. People were wearing clothing which was clean and tidy, and they were wearing footwear which was well fitting and would help to reduce the risk of falling. We saw that some people were enjoying a game of dominoes and others were watching an old film on DVD. Everyone, including people who stayed in their bedrooms, had drinks within reach, and we saw that staff were encouraging people to drink. Staff told us that they knew that some people were at risk of not drinking enough fluids, so they made sure that they offered drinks every half hour. Anyone who was at risk of dehydration was having their fluid intake recorded, and we saw that staff were completing these records every time a drink was offered.

We saw that staff were kind and caring in the way they supported people, and took time to reassure people. At lunchtime, we watched staff supporting people who needed assistance with eating, and this was done sensitively and respectfully.

We knew from a previous visit that one person had had some damage caused by pressure on vulnerable parts of their body. This is known as a pressure ulcer. Records showed that the ulcer had improved since our last visit, and we saw that there was clear information for staff about how to prevent any further pressure damage. People who

were at risk of pressure damage were using appropriate equipment such as pressure relieving cushions and mattresses. There was clear information for staff about how to use this equipment safely.

We found that care and treatment was not always planned and delivered in a way that ensured people's safety and welfare. For example, one person had been assessed as being at high risk of malnutrition. A recent entry in the care records stated "I am steadily gaining weight … my charts should be stopped for now". The weight records showed that the person had not been gaining weight steadily, but had actually lost weight over the past three months, although there had been a slight gain in weight when they were last weighed. Their Body Mass Index (BMI) was extremely low. When we mentioned this to senior staff at the home, they assured us that they would begin to monitor the person's food intake again.

Another person had been assessed as being at high risk of developing pressure area damage, but the records stated "no need to monitor". A week later the person had developed a pressure ulcer. The pressure ulcer had subsequently healed, but regular monitoring is important. This is so that the early signs of pressure damage can be acted upon to prevent the development of an ulcer.

One person told us that they had noticed some major improvements recently, and told us that they had seen some "very, very positive changes".

Other evidence
During our inspection on 10 January 2012 we found that people were at risk of not having enough to drink, and that pressure area damage was not managed safely. This meant that the home had not always been meeting people's needs. We met with the provider on several occasions, and they produced a detailed action plan. This stated how they would make sure that people would receive care that met their needs. We found that the improvements in the action plan had almost all been put in place, and therefore the home was providing care which usually met people's needs.

We observed the meeting when the morning staff handed over to the afternoon staff. The handover included detailed information about people's individual needs. Staff showed a good awareness of each person's needs and preferences.

We checked the care records for five people who lived at the home. We wanted to see if the records included accurate and relevant information. We found that some records were inconsistent, and therefore it would have been difficult for staff to know how to provide the right care and support. This was especially important as the home uses agency staff who might not know people and would expect to find information in the care records. For example, one person's records said "I am at low risk as I have been deemed to have mental capacity" but also said "I am at high risk as it has been deemed that I have limited mental capacity". The care records also stated that this person was at "extreme risk", and needed an independent advocate as they were not able to make decisions for themselves. When we asked staff about this conflicting information they told us that the person did not need an independent advocate. This meant that it would have been difficult for staff to know how able the person was to make their own decisions.

Our judgement

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People did not always experience care, treatment and support that met their needs and protected their rights.

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: The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People did not always experience care, treatment and support that met their needs and protected their rights.	
Diagnostic and screening procedures	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard. People did not always experience care, treatment and support that met their needs and protected their rights.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was	

	needed for this essential standard. People did not always experience care, treatment and support that met their needs and protected their rights.

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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