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:	August 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. 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 to check whether Newstead House had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 09 - Management of medicines
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 9 July 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

We have carried out six inspections at Newstead House since May 2011. At each inspection we have identified shortfalls which meant that the home was not complying with the essential standards of quality and safety. We have begun to see some improvements, but the pace of change has been slow.

We spent a day at the home carrying out an unannounced inspection of some aspects of the care provided for people. This included observing staff as they supported people. We spoke with six people who were living at the home, relatives who were visiting, staff and the manager. People were positive about the home. One person told us "it's the most wonderful place I've been in since I got ill" and "I can't speak highly enough about it".

Many people stayed in their bedrooms for most of the time, so we spent time visiting people in their rooms and talking with them. Many of the people who were living at Newstead House had a dementia type illness, and so were not always able to talk to us about the care and support provided. We spent time in some of the communal areas of the home so that we could see how staff supported people.

Although some people told us that they enjoyed the food at the home, other people said

"it's not to my taste" and "I never remember what I've ordered". There was a lack of meaningful choice of food for people with dementia. This was because people were asked to make their selection up to a week in advance. Kitchen staff were not aware of some people's specialist dietary needs.

Medication was managed safely at the home. Arrangements were in place for the safe and secure storage of people's medicines. Appropriate arrangements were in place to ensure that medicines were available and checks could be made.

There were enough staff on duty to meet people's needs. People told us that the staff were "lovely", "really kind" and "always willing".

The home's systems for monitoring the quality of the service were not effective. This meant that some risks were not identified and managed appropriately. Some records were inaccurate and inconsistent, and this could have meant that staff did not have the information they needed to provide the care that people needed.

Although the provider had not made all the improvements which were necessary in order for the home to be compliant with the Regulations, we have seen that the home had slowly improved over the past months. We have been sharing information with Herefordshire Council and the Primary Care Trust (PCT) under local multi agency procedures for protecting vulnerable adults. The PCT has carried out assurance visits to the home. The information from these visits, together with our own evidence, indicated that people were not at imminent risk of harm and that in general, outcomes for people were good. However, the shortfalls we have identified indicate a risk of poor outcomes for people. We have decided to reissue compliance actions as the most proportionate way for the home to achieve compliance with Regulations.

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 meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

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

The provider was not meeting this standard. People were not always protected from the risks of inadequate nutrition and dehydration. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider was meeting this standard. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

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

The provider was meeting this standard. There were 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. The provider's system for regularly assessing and monitoring the quality of service that people receive was not effective. The provider's system for identifying, assessing and managing risks to the health, safety and welfare of people using the service and others was not effective. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider was not meeting this standard. People were not protected from the risks of unsafe or inappropriate care and treatment, because records were not accurate and fit for purpose. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

Our findings

What people who use the service experienced and told us
Over the past year we have inspected the home on several occasions. When we visited the home in May 2012 we found that people were still not always experiencing care, treatment and support that met their needs and protected their rights. At this inspection, we found that further improvements had been made to ensure that people's care needs were being met.

We saw that staff were kind and respectful when they supported people. People described the staff as "very good", "there when you need them" and "such kind people".

Each person had a chart in their bedroom, which staff were completing to show the care and support that had been provided. We saw that these charts had been completed and that other records were being kept to monitor aspects of care such as repositioning for people at risk of pressure damage to their skin. The provider might find it useful to note that some of these charts were not completed in accordance with the care plans.

We saw that one person was at high risk of developing a pressure ulcer. Records showed that staff had provided them with pressure relieving equipment. We saw that this equipment was being used in accordance with the care plan and in line with good practice guidance. Care records showed that the home had requested advice from a specialist nurse about this person's needs. This meant that the home was ensuring that they followed best practice to make sure that people were protected from the risk of

pressure damage.

Other evidence
We looked at the care records for five people who were living at the home. Each person had a care plan which had been regularly reviewed. Some of the information in the care plans did not reflect what staff told us about people's care needs. Staff told us that they received the most up to date information about people's needs at the handover at the beginning of each shift. This meant that staff had a good knowledge of people's needs, although the care records were not always accurate.

Our judgement
The provider was meeting this standard. People experienced care, treatment and support that met their needs and 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 non-compliant with Outcome 05: Meeting nutritional needs. 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
At our inspections over the past year we have continued to find shortfalls in the way that the home was managing people's nutritional needs.

Although some people told us that they enjoyed the food at the home, other people said "it's not to my taste" and "I never remember what I've ordered". Staff told us that people made their menu choices on a Wednesday for the whole of the following week.

When we looked at the menu for the current week, we saw that the vegetarian option on one day was cauliflower cheese and on the next day it was cauliflower bake. The provider might find it useful to note this lack of variety for people who are vegetarian. Staff told us that people could ask for alternative meals, such as jacket potatoes and omelettes, but that these were not routinely offered unless people said that they did not want what they had previously chosen.

Many people living at the home had short term memory loss or a dementia illness. This means they might not remember a choice made a week before or that they could ask for an alternative meal.

We saw that lunch was served on trays to people, most of whom were eating in their bedrooms. The hot pudding of fruit pie and custard was served at the same time as the main course. This meant that the pudding might not have been hot when people finished their first course.

Staff were supporting some people to eat, and this was done sensitively and in an

unhurried manner, allowing people plenty of time to eat each mouthful. People had drinks available to them at all times, and staff were making sure that these were within reach.

Other evidence
We looked at the fluid charts for three people who were having their fluid intake and output monitored. These showed that staff were recording when drinks were offered. Some records showed low fluid intake and output. For example, the records for one person indicated that they had drunk less than one litre of fluid every day for the past eight days. The care records showed that staff were aware of the low fluid intake, but there was no clear information to show how this was being monitored as part of the person's overall health needs.

Records showed that people were being weighed regularly and that any significant weight loss was being reported to the local GP.

Kitchen staff had a good knowledge of people's individual likes and dislikes, and told us that snacks were available at all times if people requested them. We asked about people at risk of weight loss and they were not sure which people these were. They told us that they used cream and milk powder to fortify food such as porridge and mashed potatoes, and that this was done for everyone living at the home. Records showed that some people living at the home were overweight, so it would not be good practice to be providing extra 'hidden' calories for these people.

The kitchen staff told us that they were not sure how many people had diabetes. They said that they relied on the nursing staff to tell them how to manage the dietary needs of people with diabetes. Records showed that not everyone with diabetes had an individualised nutritional care plan in place.

We looked at the food stocks and noted that much of the food was processed, such as powdered soup and packets of powdered milk desserts. The stocks of fresh fruit were low, and the kitchen staff told us that fresh fruit salad was provided once a week. They said that fresh fruit was not routinely offered at other times, although people could have it if they asked.

Our judgement
The provider was not meeting this standard. People were not always protected from the risks of inadequate nutrition and dehydration. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
The safe handling of medicines was assessed by a pharmacist inspector. Our inspection of 10 January 2012 found that people were not fully protected against the unsafe use of medicines. At this inspection we spoke with three members of staff and looked at 12 people's medicine records. We saw that the arrangements for the handling of medicines had improved.

Nursing staff and health care assistants we spoke with were knowledgeable about individual people's medicine requirements. This means that people were given their medicines by staff who understood their health requirements.

Other evidence
Arrangements were in place for the safe and secure storage of people's medicines. Medicine storage was neat and tidy which made it easy to find people's prescribed medicines. The provider may find it useful to note that some medicines which were not currently in use were stored in the medicine trolleys. This may increase the risk of a medicine error and we highlighted this to staff during the inspection. The medicine storage room and medicine refrigerator temperatures were recorded daily to ensure medicines were stored within safe temperature ranges. This means that people's medicines were stored securely and within recommended storage temperatures.

We looked at the arrangements and storage for controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements. The provider

may find it useful to note that we found other items which were not classed as controlled drugs incorrectly stored in the controlled drugs cabinet. We had informed the service of this at our last inspection on 10 January 2012. This increases the risk of unnecessary access to controlled drugs. We were told that this should not happen and staff would be reminded of correct controlled drug procedures.

Appropriate arrangements were in place to ensure that medicines were available and checks could be made. We looked at these arrangements including records of receipt, medicine balances and dates of opening of medicines. We found that medicines were in stock, and that containers were labelled with the dates when they were opened.

Our judgement
The provider was meeting this standard. People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

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
People told us that the staff were kind and caring. One person told us "they're all so good" and "I can't sing their praises enough". We saw that staff were attentive to people's needs. They went about their work cheerfully and calmly.

When we arrived at the home, there was only one registered nurse on duty, with a team of health care assistants to support her. The nurse was carrying out the medication round and we saw that she was interrupted on several occasions. The provider might find it useful to note that this could increase the risk of errors occurring. Later in the morning another registered nurse came on duty. The manager told us that the home was currently recruiting new nurses.

We saw that people did not have to wait for support when they needed it. One person told us "if I need them, they come straight away". Staff were checking people on a regular basis to make sure they had everything they needed.

In one of the nursing units there were two health care assistants on duty to provide care for the eight people living there. The provider might find it useful to note that when both staff were attending to people in their bedrooms this meant that there were no staff in the unit to support the other people.

Other evidence
The manager told us about her plans to use staff more flexibly within the home. This included allocating some care staff to do activities under the guidance of the activities

co-ordinator. She was also planning to give staff who worked on the residential unit opportunities to develop their skills on the nursing units.

Staff told us that they had been provided with a range of training opportunities to give them the skills and knowledge they needed.

Our judgement
The provider was meeting this standard. There were 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 moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to people using the services but their feedback did not relate to this standard.

Other evidence
Over the past year we have had concerns about the effectiveness of the provider's processes for monitoring the quality of the service. At this inspection we found that there had been some improvements, but that there were still areas that needed addressing.

The provider's internal quality assurance systems had not identified the fact that care plans did not always contain accurate information about people's care needs. The lead nurse told us that care plans were being audited regularly, but our evidence showed that these audits were not effective in identifying inaccuracies and inconsistencies.

Some staff who were using the home's computerised care planning system were not familiar with how to use the system. When we asked one member of staff to locate some information about a person's care on the computerised system, they were unable to find it. A second member of staff was called from another unit. They accessed the required information quickly and easily. This meant that not all staff who were involved with people's care were able to access the required information.

We found evidence that communication systems within the home were not always effective. Staff did not always make sure that important information had been passed

on in line with the provider's policies and procedures.

The provider had been sending us regular action plans to update us on progress with improvements. The action plan was not always reflected in our evidence. For example, the most recent action plan stated "Training matrix in use and delivering effect". We asked to see the training matrix (a chart which shows all the training provided for staff). The matrix which was shown to us was not up to date, and did not include all the training which staff had attended. We asked to see staff training records. We were given two box files full of certificates. These were not in order and we were not easily able to find out what training the staff on duty that day had undertaken. This meant that it would be difficult for the new manager to carry out an analysis of staff training needs.

The home had appointed a new manager, who had shown her commitment to the service by registering with the Commission. She told us about her plans for the future of the home. She had already identified some of the concerns which we found at the inspection, and was able to tell us how she was planning to make the necessary improvements.

Although the provider had not made all the improvements which were necessary in order for the home to be compliant with the Regulations, we have seen that the home had slowly improved over the past months. We have been sharing information with Herefordshire Council and the Primary Care Trust (PCT) under local multi agency procedures for protecting vulnerable adults. The PCT has carried out assurance visits to the home. The information from these visits, together with our own evidence, indicated that people were not at imminent risk of harm and that in general, outcomes for people were good. However, the shortfalls we have identified indicate a risk of poor outcomes for people. We have decided to reissue compliance actions as the most proportionate way for the home to achieve compliance with Regulations.

Our judgement
The provider was not meeting this standard. The provider's system for regularly assessing and monitoring the quality of service that people receive was not effective. The provider's system for identifying, assessing and managing risks to the health, safety and welfare of people using the service and others was not effective. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 21: Records. 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 using the services but their feedback did not relate to this standard.

Other evidence
Some of the care records did not contain accurate information about people's care needs. One person's care plan stated that they had serious mental health conditions which staff confirmed they did not have. Another person's care plan contained a list of medications which the person was taking, but elsewhere in the care plan it stated that the GP had stopped all the person's medications.

When people were given their medicines, this was being recorded onto medicine administration record (MAR) charts printed by the supplying pharmacy. We looked at 12 people's medicines and their MAR charts. Five people's MAR charts had not always been signed to show the administration of a prescribed medicine. In some cases, there was no code documented to explain why the medicine had not been given. Some MAR charts did have a code recorded when a medicine was not given, but the code had not been further explained on the back of the MAR chart to show why the medicine had not been given as prescribed. This means that it was not always possible to know if a medicine had been given, or the reason why a prescribed medicine had not been given.

The daily records for one person stated that they had recently had episodes of behaviour which could have put them or other people at risk of injury. There was no care plan in place to tell staff what could trigger this behaviour or effective ways to support the person. It is important that accurate information is available to inform staff about people's care needs, especially for people who are unable to communicate verbally.

Our judgement
The provider was not meeting this standard. People were not protected from the risks of unsafe or inappropriate care and treatment, because records were not accurate and fit for purpose. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

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 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Choice was not offered in a way which was meaningful to people living at the home. There was insufficient information about people's dietary and hydration needs.	
Diagnostic and screening procedures	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Choice was not offered in a way which was meaningful to people living at the home. There was insufficient information about people's dietary and hydration needs.	
Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	How the regulation is not being met: Choice was not offered in a way which was meaningful to people living at the home. There was insufficient information about people's dietary and hydration needs.	
Accommodation for persons who require nursing or personal care	Regulation 10	Outcome 16: Assessing

	HSCA 2008 (Regulated Activities) Regulations 2010	and monitoring the quality of service provision
	How the regulation is not being met: Internal monitoring systems had not identified risks associated with inaccurate record keeping and poor communication. Systems for managing the home were not effective.	
Diagnostic and screening procedures	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: Internal monitoring systems had not identified risks associated with inaccurate record keeping and poor communication. Systems for managing the home were not effective.	
Treatment of disease, disorder or injury	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: Internal monitoring systems had not identified risks associated with inaccurate record keeping and poor communication. Systems for managing the home were not effective.	
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 and medication records were not accurate and did not always reflect people's needs. Records were inconsistent and did not provide appropriate information in relation to the care and treatment provided to people.	
Diagnostic and screening procedures	Regulation 20 HSCA 2008 (Regulated	Outcome 21: Records

	Activities) Regulations 2010	
	How the regulation is not being met: Care and medication records were not accurate and did not always reflect people's needs. Records were inconsistent and did not provide appropriate information in relation to the care and treatment provided to people.	
Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Care and medication records were not accurate and did not always reflect people's needs. Records were inconsistent and did not provide appropriate information in relation to the care and treatment provided to people.	

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

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