Review of compliance

The Brendoncare Foundation Brendoncare Froxfield	
Region:	South West
Location address:	Littlecote Road Froxfield Marlborough Wiltshire SN8 3JY
Type of service:	Care home service with nursing
Date of Publication:	December 2011
Overview of the service:	Brendoncare Froxfield is a purpose built care home with nursing for up to 44 older people. It is one of a number of care homes that are run by the Brendoncare Foundation in the south of England. The home is located in the village of Froxfield, near to Marlborough. The accommodation is provided in single

	bedrooms and some rooms have en-suite facilities.

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

Our current overall judgement

Brendoncare Froxfield 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 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 10 November 2011, checked the provider's records, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People appreciated the care and support that they received from staff. Staff were described as "very caring" and we saw that people's privacy and dignity were being respected. One of the staff told us "choice is a priority" and we heard about the choices that people could make, for example about what time to get up and where to have their meals.

Relatives told us they were made to feel welcome in the home. A visitor said the staff were "very patient" and we saw staff going about their work in a friendly and approachable manner.

Staff were aware of the importance of providing people with the right support, for example with pressure area care and mobility. We found, however that risk assessments and care plans were not being consistently reviewed and updated. This meant that there was a risk that people would not receive the care they required in order to meet their needs.

People told us that they felt safe in the home. Staff said they felt confident about being able to recognise abuse and report any concerns.

What we found about the standards we reviewed and how well Brendoncare Froxfield was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People can exercise choice in the home and their privacy and dignity are being respected. Activities are being arranged and people are mostly well informed about the home and the service they receive. However, there are shortcomings and information about people's individual circumstances is not being consistently maintained. This is important so that each person can be supported in a person centred way.

Overall, we found that Brendoncare Froxfield was meeting this essential standard but, to maintain this, we suggested that improvements are made.

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

People benefit from the support that they receive from staff with their day to day care needs. However, the standard of care planning and a lack of up to date information puts people at risk of not receiving the care that they require.

Overall, we found that improvements were needed to this essential standard.

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

People are safeguarded from abuse because staff have received training and have a good understanding of the different ways in which people can come to harm.

Appropriate procedures are being followed to ensure that people are only deprived of their liberty when this is in their best interests.

Overall, we found that Brendoncare Froxfield was meeting this essential standard.

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

People benefit from staff who are deployed in sufficient numbers to meet their needs. Staffing levels are being kept under review to ensure that they reflect people's dependency levels.

Overall, we found that Brendoncare Froxfield was meeting this essential.

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

People are being given the opportunity to pass on their views about the home. Systems are in place, which help to ensure that the facilities are safe for people. The provider is identifying ways in which the service can develop and improve, although the monitoring of the home has not been effective in improving the standard of the care plans.

Overall, we found that Brendoncare Froxfield was meeting this essential but, to maintain this, we have suggested that an improvement is made.

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People were provided with information which helped them to understand their rights and make decisions. Information was displayed in the front hall, including guidance about advocacy and specialist services for older people. There were leaflets about making a compliment or a complaint and telling people how they could pass on their views. One person showed us a newsletter that was produced each week. The newsletter was informative, with various articles and details about forthcoming events.

Information was displayed about activities in the home and the various events that were taking place. An activities co-ordinator was reading a newspaper to several people in the lounge when we arrived at the home. People were kept informed of what was happening both in the home and in the wider community. People told us that they had been involved in the planning of a remembrance service which had been arranged for the next day.

However, the information that people received was not all up to date. This included a guide to the home and the home's statement of purpose, which people had been given to keep in their rooms. The documents that we saw had been produced in February 2004; a lot of the information had since changed and was now out of date.

We saw people using the communal areas during the day. Some people met together in the lounge before lunch and enjoyed having a glass of sherry. We met other people who stayed in their own rooms, either through choice or because they were receiving care in bed. People's rooms had been well personalised with pictures and ornaments, which made them look very homely.

One of the staff said "choice is a priority" and we were told how people were supported with making choices. This included people being offered a choice of menus and being asked what clothes they would like to wear. A staff member gave us an example of how a person had told them, on the morning of our visit, that they would like to stay in bed longer; the staff member said that they had changed their routine to fit around the person's wishes. When going around the home we heard another staff member asking someone if they wanted to go to the dining room for lunch or to have the meal in their own room.

People told us that their privacy and dignity were being respected. Staff referred to people by name and talked in a respectful way. We heard one of the staff taking time to compliment someone on their hairstyle and talk to them about what they had done during the day. We saw that people's privacy was being respected, such as when staff drew the window curtains in somebody's ground floor bedroom before providing them with personal care.

People were involved in the planning of their care, with relatives also involved when people could not express their own views directly. The relatives we met during our visit told us they were made to feel welcome in the home and were being kept well informed. Staff said that the involvement of relatives was important, particularly when their family member in the home was receiving end of life care.

Other evidence
Staff told us they worked hard to maintain people's dignity when they were receiving end of life care. Care staff said that they were confident that they would be told about any relevant cultural and religious beliefs which would need to be observed.

People had individual care plans which were easily accessible in their bedrooms. Some of the plans we saw had been dated and signed by the person, or their representative, to confirm their agreement to what was written. However this was not happening consistently.

We saw information in the care plans which helped staff to support people with making choices and decisions. This included information about whether the person was able to make their wishes known. In one care plan we read that the person was unable to express their needs; there was guidance for staff about the need to speak clearly and to observe for non-verbal signs of discomfort. A staff member told us that flash cards and photographs had been used to communicate with one person whose first language was not English.

Some sections of people's plans had not completed. This included, for example, a section for recording a person's getting up time and bedtime. This meant that there were gaps in information about people's individual needs and preferences. We also saw that records of people's daily activities were not being completed consistently, which meant that it was difficult to monitor how well their social needs were being met.

Our judgement
People can exercise choice in the home and their privacy and dignity are being respected. Activities are being arranged and people are mostly well informed about the home and the service they receive. However, there are shortcomings and information about people's individual circumstances is not being consistently maintained. This is important so that each person can be supported in a person centred way.

Overall, we found that Brendoncare Froxfield was meeting this essential standard but, to maintain this, we suggested that improvements are made.

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 moderate 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 met people who received nursing care in their rooms and had a high level of individual needs. They were dependent on staff for support with their personal care and with keeping safe. Staff told us about the support that people received, for example with pressure area care and with eating and drinking to ensure that they had a sufficient amount. The staff members said these areas were given a high priority and they were aware of the risks to people if they did not receive the right level of support.

We heard positive comments about the support that people received, although not everyone was able to express their views directly. One person told us they received a lot of help with their personal care and staff provided the support they needed. They said that staff helped with cutting finger nails and they saw a chiropodist for their feet. We met relatives who said that they thought their family members were well cared for in the home.

We saw that people had drinks in their rooms to help ensure that fluid intake was maintained during the day. There were no unpleasant odours in the accommodation that we saw. A number of people had wheelchairs and we saw these being used with footplates adjusted so that people were comfortable. The people we saw in the communal rooms looked well supported with their personal appearance. During the morning, some people in the lounge were encouraged to take part in some gentle exercises which were designed to help them with their mobility.

People received end of life care at the home. The staff we spoke with told us they had

received training and guidance which helped them to support people and their relatives. We were told that the home was working towards accreditation under the Gold Standards Framework. This is a quality assurance scheme for services that provide end of life care.

People benefited from the involvement of outside health care professionals. Staff said that people received good support from their GPs and from the local health services. We met with a physiotherapist who said they visited the home twice a week. We were told support was also available from an occupational therapist who advised on appropriate aids and equipment for people to use. People received support from specialist nurses in the community, for example the tissue viability nurse, in addition to the home's own nursing team.

Other evidence
People's care was being recorded in individual files. We looked at five people's care records, which included a range of assessment and care plan forms, together with charts for recording the care that people received on a day to day basis. The files themselves looked unhygienic. The paper contents were generally in a poor condition, with loose sheets which made it difficult to ensure that the information was kept securely and in order.

A small number of care plans had been audited by the home's manager and this had identified various shortcomings and improvements that needed to be made. The audit had found that some of the care plans needed to be more personalised, and updated and reviewed. Our findings confirmed that risk assessments and care plans were not being consistently reviewed and updated. There was therefore a risk that people's care plans did not reflect their current needs.

We saw that a lot of information was being recorded by staff about the care they had provided. This helped to ensure that areas such as pressure area care and fluid intake could be monitored and evaluated. However, the daily reporting was not always being clearly linked to up to date care plans and risk assessments.

Changes to people's care plans and risk assessments were not always being clearly recorded, which meant that people were at risk of not receiving the care that they needed. We saw care plans and risk assessments that had been written over five years ago; in a number of cases, changes had been made over time by crossing out the original information and writing in some additional and undated comments. This is poor practice which can lead to misunderstandings about people's current needs and the support that they require from staff.

Our judgement
People benefit from the support that they receive from staff with their day to day care needs. However, the standard of care planning and a lack of up to date information puts people at risk of not receiving the care that they require.

Overall, we found that improvements were needed to this essential standard.

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 told us they felt safe in the home and could talk to one of the staff if they had any concerns. Information was displayed in the home about the different agencies that people could contact for advice and if they had any concerns or complaints. A range of booklets and leaflets were on show in the front hall. These included copies of 'Keeping people safe in Wiltshire', which tells people how any concerns about abuse can be reported and are followed up.

One of the senior staff told us that any concerns about abuse would be referred to the local authority for investigation, in accordance with the local procedures for safeguarding adults. We spoke to four other staff members and each said that they felt confident about being able to recognise abuse and report any concerns.

Staff members told us they had received a copy of the 'No Secrets' booklet, which summarises the local authority's procedures for safeguarding vulnerable adults. They had attended training about preventing abuse and received an annual update. The staff we spoke with were able to describe the different forms that abuse can take, such as financial and psychological. One staff member mentioned the use of inappropriate equipment with people as being a form of abuse. Another said that abusive practice included failing to ensure that sufficient drinks were available to a person who was at risk of poor fluid intake.

One staff member said that whistleblowing was encouraged and other staff confirmed that they were aware of the home's policy on whistleblowing.

Other evidence
The home accommodated people who lacked the capacity to make informed decisions and to give their consent to certain actions. The home has applied to the appropriate authority during the last year to restrict an individual's liberty in the home, in order to prevent them from coming to harm. This shows an understanding of the Mental Capacity Act, which allows for a person who lacks capacity to be deprived of his or her liberty in a proportionate way, if this is assessed to be in their best interests.

Our judgement
People are safeguarded from abuse because staff have received training and have a good understanding of the different ways in which people can come to harm.

Appropriate procedures are being followed to ensure that people are only deprived of their liberty when this is in their best interests.

Overall, we found that Brendoncare Froxfield was meeting this essential standard.

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 appreciated the support they received from individual staff. Staff were described as being "caring" and "very patient". We saw staff going about their work in a friendly and positive manner. Staff were observed carrying out a range of tasks, such as helping people with drinks, assisting with meals, talking to people and giving encouragement with activities. One of the staff told us "we work hard as a staff team for the same aim".

People had call alarms in their rooms which they could use to contact one of the care staff. They told us that staff were available when needed. Staff members said there were enough staff working throughout the day to keep people safe and to meet their needs. This included occasions when people needed the support of two care staff with their personal care tasks. We were told that relief and agency staff were deployed when needed to ensure that staffing was maintained at a consistent level.

Staffing levels were being kept under review to ensure that they were sufficient to meet people's needs. Staff told us that staffing had increased on occasions when people at the home had a higher level of dependency and needed more support. One of the senior staff said that staffing levels were assessed on a weekly basis and a decision made about the need for additional care hours.

The care staff were allocated to work in a particular area of the home at the start of their shifts. This enabled them to work as a team to support a number of people who used the service. Staff said that they also had the opportunity to work in different areas of

the home, which they thought was useful as it enabled them to get to know all the people who used the service.

Staff training was being given a high priority, so that people were supported by competent staff. One staff member commented that they had "never known a place like this for training".

Other evidence
In addition to the home's manager, there was a staff team which comprised team leaders, nurses and care workers. The rota for care staff at the time of our visit included two nurses and seven care workers. A care leader was in charge of the home as the manager was not working at the time. We were told that there could be eight care workers on duty during the day, depending on occupancy and dependency levels. Other staff were deployed to cover catering, maintenance and domestic work, and to support people with activities. The staffing levels reduced at night to reflect the change in workload.

Handover meetings took place during the day so that the staff who came on duty were up to date with the day's events and aware of people's needs.

Our judgement
People benefit from staff who are deployed in sufficient numbers to meet their needs. Staffing levels are being kept under review to ensure that they reflect people's dependency levels.

Overall, we found that Brendoncare Froxfield was meeting this essential.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are minor concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us they would be able to talk to one of the staff team if they had any concerns or they wanted to pass on their views. Comments could also be passed on anonymously using a suggestions box that was in the front hall of the home.

There were also more formal arrangements in place for gaining feedback and monitoring the quality of the service. Meetings were being held every six months to gain feedback from the people who used the service and from their relatives. Annual surveys were also being used; the home's manager told us that this year's surveys had been returned to the provider's head office where they were currently being analysed.

Staff members had the opportunity to pass on their views using a staff forum which met every two months. This involved staff from all the provider's homes and two staff from Brendancare Froxfield attended the meetings. When we met with staff they told us about the developments they had seen in the home, such as the purchase of new electric beds and improvements in how risks were being managed.

We were told that there were plans to upgrade some items of equipment. A staff member said that the hoists in the home were working as they should, but a more modern type of hoist would be beneficial. We saw labels with dates on the hoists and on the portable electrical appliances, confirming that they had been checked for their safety.

Checks of the equipment and facilities were also being undertaken on an in-house

basis. A maintenance person told us that they carried out regular checks of bedrails, wheelchairs and the home environment as a whole. They said they also made weekly tests of the fire alarm system to ensure it was working correctly. We were told that staff reported any repairs and maintenance issues that they found during the course of their work.

Other evidence

We were shown a copy of the provider's business plan for 2012 – 2013, which identified some key developments and areas for improvement. Dementia training was reported to be a priority, as was refurbishment of some areas of the home. It was stated in the plan that staffing levels would be maintained to ensure that they matched dependency levels.

A senior manager from the Brendoncare Foundation visited the home each month, for monitoring purposes and to check on compliance with the standards. They wrote a report of their findings.

At a previous inspection of the home, there had been a discussion about how these visits could be improved. This had included a more detailed review of care plans. This was in order to identify the variability in care planning that was found at the time and to ensure that action was taken to improve the quality of the care plans. The monthly report for October 2011 did not refer to shortcomings in care planning and assessments and there was no action plan for making the improvements that were needed. As reported under outcome 4, there were some significant shortcomings in the standard of the care plans.

Our judgement

People are being given the opportunity to pass on their views about the home. Systems are in place, which help to ensure that the facilities are safe for people. The provider is identifying ways in which the service can develop and improve, although the monitoring of the home has not been effective in improving the standard of the care plans.

Overall, we found that Brendoncare Froxfield was meeting this essential but, to maintain this, we have suggested that an improvement is made.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: People can exercise choice in the home and their privacy and dignity are being respected. Activities are being arranged and people are mostly well informed about the home and the service they receive. However, there are shortcomings and information about people's individual circumstances is not being consistently maintained. This is important so that each person can be supported in a person centred way.	
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
	Why we have concerns: People are being given the opportunity to pass on their views about the home. Systems are in place, which help to ensure that the facilities are safe for people. The provider is identifying ways in which the service can develop and improve, although the monitoring of the home has not been effective in improving the standard of the care plans.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of

compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 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 benefit from the support that they receive from staff with their day to day care needs. However, the standard of care planning and a lack of up to date information, puts people at risk of not receiving the care that they require. Regulation 9 (1) is not being complied with, in that care is not being planned and delivered in a way as to meet people's individual needs and ensure their welfare and safety.	

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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