Review of compliance

Meadowview Care Ltd Allens Mead	
Region:	South East
Location address:	11 Allens Mead Gravesend Kent DA12 2JA
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	Allens Mead is a residential home providing care and support for up to two people with a learning disability. The service is part of a group of homes managed by Meadowview Care Ltd.

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

Our current overall judgement

Allens Mead 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 1 December 2011, checked the provider's records, 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

People told us, or indicated that they liked the home and the staff.

People told us about the activities they liked doing and said that staff helped them with these.

We saw that staff gave support in a kind and sensitive manner so that it promoted individual independence. For example, we saw that staff supported one person to choose what activity they wanted to do.

What we found about the standards we reviewed and how well Allens Mead 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 were treated with respect and dignity and were supported to make choices about the way they lived their lives.

 Overall, we found that Allens Mead was meeting this essential standard.

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

The care and support that the people received was specifically tailored to their individual needs.

 Overall, we found that Allens Mead was meeting this essential standard.

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

The service had policies and procedures for safeguarding vulnerable people and staff understood their responsibility to report concerns appropriately.

 Overall, we found that Allens Mead, was meeting this essential standard

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

The daily management of medications supported people with their needs. However the lack of medicines management, security and safety in the way medicines were stored put the people who used this service at risk.

 Overall we found that improvements are needed for this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

There were sufficient numbers of staff to meet the needs of the people who used this service. However the programme of training did not ensure that all staff had completed all of the training they required to fulfil their role and responsibilities as set by Skills for Care.

 Overall we found that improvements are needed for this essential standard

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

There were some systems in place to monitor the quality of the service; however a lack of formal documentation made it difficult to see how information had been used to identify areas for improvement and how these were to be delivered and achieved.

 Overall we found that improvements are needed for this essential standard

Outcome 27: The service must tell us how they will manage the service safely when the person in charge is away

The provider organisation failed to provide requested information for the requirements relating to notifications of absence for the registered manager.

 Overall we found that improvements are needed for this essential standard

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People told us that they were happy in the home and that they could choose what do. Comments included, "I like it here;" and, "I can have what I want to eat".

People told us that staff were helpful and supported them in the home. One person said, "I like to bake cakes…staff help me with this".

We were unable to discuss this outcome in detail with people living in the home but we observed that staff treated people with dignity and respect.

Other evidence
We observed that staff communicated well with the people who used this service and demonstrated a good understanding of individual needs and preferences. We saw that staff were respectful and gave assistance in a kind and supportive manner that focused on individual independence.

We saw that staff understood how to engage with people that used the service. Care plans clearly explained how individuals were able to communicate and we saw staff using this information to interact with people. The use of pictures in the care plans helped people to communicate their preferences and, a variety of information was

displayed in pictorial format throughout the home so that people were given information in a way they could understand. For example, instructions on how to make a cup of tea were displayed in pictures in the kitchen area and the shower area was signposted with a picture so people could communicate their needs.

Care plans included behavioural guidelines. These guidelines clearly identified people's individual preferences, triggers for behaviours and how individuals communicated different emotions. We saw that staff recognised individual signs of distress or happiness and actively responded to this, following information in the behavioural guidelines. We saw that one person who showed signs of anxiety received a positive response from the support staff that mirrored guidance in the care plans.

The staff we spoke with understood the importance of promoting independence and offering choice so that people could take as much control of their lives as possible.

Care plans emphasised the importance of choice and how to offer it in a way that could be understood. We saw that there were activity planners in place that had individualised pictures of various activities. We saw that one person used this planner to show staff what they wanted to do. Staff explained that planners were reviewed with the individual to see if their preferences had changed. We examined one planner and saw it was last reviewed in January 2011. One person told us that they liked baking cakes and making jigsaws and we saw that these activities were recorded on their activity planner.

The people using the service were offered choice at mealtimes. There were monthly menu planners so people could show what they wanted to eat. Staff explained that they had worked with each person to develop these to make sure they included their likes and dislikes and addressed dietary requirements. People using the service told us that they were able to choose what they wanted to eat.

We saw that staff used picture questionnaires to ask people if they were happy in the home and what activities they wanted to do. Staff told us that each person had a key worker who worked with each person and their family to make sure that their needs were being met. This included a six month care review which involved staff, family and care managers.

Our judgement
People were treated with respect and dignity and were supported to make choices about the way they lived their lives.

 Overall, we found that Allens Mead was meeting this essential standard.

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
People told us that they, "Liked living in the home"; and that they, "Liked staff".

People said that they liked. "Doing jigsaws and making cakes with staff". They told us that staff helped them with other daily chores such as laundry.

We were unable to discuss this outcome in detail with people living in the home but observed positive interactions between people and staff. Observation showed that people using the service were mostly content and enjoyed taking part in activities inside the home.

Other evidence
There was a variety of activities available within the home. We saw that an activity planner was used to help people decide what they wanted to do. This included things such as watching a DVD, jigsaws, puzzles baking and a walk. There was also an option of, 'My Choice', if the person wanted to do something that was not on the planner. During the visit we saw staff supporting people with their Christmas Cards.

We also saw that people were supported with activities in the home such as meal preparation, cleaning and ironing. We saw that staff followed the information in the care plans about how to support these activities. People were encouraged to be as independent as possible, for example, we heard staff encouraging independence with their personal care that followed the guidance in that person's care plan.

The care plans were personalised and gave clear guidance about people's individual needs, including clear information about things such as personal care, mobility, nutritional needs and health and social care needs. The care plans described what was important to each person and there was clear guidance about all aspects of care and how care and support should be provided for each person. Pictures and an easy read format had been used in parts of the care plans. This meant that people could understand what their care plans said.

There were detailed assessments for areas of risk such as laundry and bathing and clear instructions for staff so that they were able to give appropriate and safe care. The staff we spoke with had a clear understanding of individual care needs.

There was written guidance to help staff give positive behavioural support to people. We found evidence to show that this had been developed in conjunction with a clinical psychologist and was reviewed regularly. Staff told us that they worked closely with the clinical psychologist to manage behaviours in a positive way.

Care plans were easy to follow and staff told us that they used them often. The daily records mirrored the information in the care plan but some updates and reviews of support plans were hard to follow as there was duplication of information For example we saw double entries of support plans for behaviour completed at different times but there was no indication as to what plan staff should follow. This could be difficult for new or agency staff who were not familiar with individual needs.

Records showed that appropriate health and social care professionals, such as psychologists, GP, dentists and care managers, were accessed on behalf of the individual.

Our judgement
The care and support that the people received was specifically tailored to their individual needs.

 Overall, we found that Allens Mead was meeting 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
We did not obtain information from people living in the home about this standard.

Other evidence
Staff received training in safeguarding and prevention of abuse. We looked at the training records for the service. This showed us that staff had received up to date training and new staff were booked onto a course for the month following this visit.

The staff we spoke with demonstrated a clear understanding of the safeguarding policies and procedures including whistle-blowing. They said that they would be confident in promptly reporting any abuse to management and felt that their concerns would be effectively acted on. Although written information regarding whistle blowing was given to staff this required updating.

There were procedures in place to protect people's money. We saw that regular checks and audits of personal monies were made.

We saw that families and/or representatives were included in decision making, care planning and reviews.

Our judgement
The service had policies and procedures for safeguarding vulnerable people and staff understood their responsibility to report concerns appropriately.

 Overall, we found that Allens Mead, was meeting 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

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not obtain information from people living in the home about this standard

Other evidence
A local pharmacy supplied the medication to the home and a Monitored Dosage System (MDS) was used for most medicines. There were no controlled drugs in use at the home at the time of our visit.

Medication was kept in a lockable cabinet in the staff office located on the ground floor of the home. On entering the home we saw that people living in the home had access to the office. We saw that the office was left unlocked. Staff showed us that the key to the medication cabinet was kept on the top shelf of the office. This was not a secure place for the key to be kept and could have been accessed by people living in the home as they had access to the office. We alerted the deputy manager to this lack of security as an area of immediate risk to safety.

The storage of medication was disorganised. Medication was stored in the cabinet alongside other items including paperwork. We found some medicines stored at the back of the cabinet that were not detailed on the individual Medication Administration Records (MARs). Some medication was two years old and staff confirmed that these medications were no longer in use. Staff said that they had systems for checking medicines in the home but admitted that they had not been thorough in this task for the out of date medications found.

Temperatures for the storage of medication were not being recorded and therefore it was not possible to ensure the safety and quality of medications that required specific storage temperatures.

The Medicines Administration Records (MARs) were in good order. A detailed care plan for when and how to administer medication was in place for each person. Information sheets were provided outlining relevant medication guidance, for example, when and how to administer medication that was only need occasionally. A list of staff signatories was in place.

Staff who administered medicines had received medication training. We saw evidence that the deputy manager performed an annual medication assessment with each staff member to check that they were competent in the safe administration and management of medicines. The staff we spoke with demonstrated an awareness of safe practice in administrating medication.

We saw that people using the service had regular medication reviews and had been assessed for self medication. Currently no one self medicated in the home.

Our judgement
The daily management of medications supported people with their needs. However the lack of medicines management, security and safety in the way medicines were stored put the people who used this service at risk.

 Overall we found that improvements are needed for this essential standard.

Outcome 14:
Supporting staff

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 competent staff.

What we found

Our judgement

There are minor concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People we spoke with told us that they, "Liked staff", and that they helped them with things they wanted to do around the home.

We observed positive interactions between people and staff.

Other evidence
The staff rota that showed support workers worked flexible hours to provide the necessary support, that provided twenty four seven one to one support for the people who used this service.

We were told that the staff team was supported by a deputy manager and registered manager. However we found that the registered manager was on emergency leave at the time of our visit. We were told that the deputy manager was on call and that shifts had been altered to ensure there was adequate cover.

We were told that there had been an unusually high staff turnover in the last few months following the departure of two permanent staff. The home had used relief support workers from other residential homes provided by the organisation to help with this. The home was still recruiting to fill the vacancies at the time of our visit.

The deputy manager spoke about the recruitment procedures. They told us that people would complete an application form and attend an interview. Staff were subject to a criminal records bureau (CRB) and reference checks. We requested CRB checks in relation to the recruitment policies of the home. We saw that these were in order.

Staff we spoke with told us that they had plenty of opportunities for training and that they found the courses useful and informative. Each member of staff had a training plan that was overseen by the deputy manager. We saw records for training in things such as fire safety, medication, managing challenging behaviours, food safety and infection control. The expiry dates for training and necessary refresher courses were not clearly recorded on these records. This made it difficult to see if all staff training was up to date. We saw that staff had not received manual handling training and the deputy manager was unclear as to whether this was a statutory need for the home.

Staff told us that they had regular supervisions which were recorded. We saw that supervisions addressed individual training needs as well as addressing challenges and setting actions. We were told that the deputy manager observed staff practice as part of their supervision process. We found evidence that staff who administered medicines had annual competency assessments.

Staff said that there were regular staff meetings where they could discuss any concerns or training needs. Staff we spoke with told us that they felt the management in the home was, 'Very supportive,' and that the deputy manager was always available and helpful if they had any concerns. Staff told us that they were happy working in the home. They said they thought the staffing levels met the needs of people using the service.

Our judgement
There were sufficient numbers of staff to meet the needs of the people who used this service. However the programme of training did not ensure that all staff had completed all of the training they required to fulfil their role and responsibilities as set by Skills for Care.

 Overall we found that improvements are needed for this essential standard

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 moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not obtain information from people living in the home about this standard

Other evidence
There were a number of processes and audits for checking the quality of service provided. We saw some evidence that the home conducted internal checks, for example in food safety and infection control however there was not always written evidence that issues identified from these audits had been addressed.

The Area Manager also visited the service to perform regular quality checks and identify areas for improvement. The deputy manager told us that action plans were developed in response to this and progress reviewed at management meetings.

We saw there was a handover process that highlighted any incidents or behaviours that had been recorded for that shift as well as checks on finances. This was done to ensure that correct care had been given and that new staff on shift were up to date on care needs. Staff explained that there was allocated time for handover and that it worked well.

The deputy manager told us that care records were reviewed on a regular basis. This included a review of the accident and incident forms and record of behaviours that were completed by staff. There was a lack of formal documentation in relation to these reviews which made it difficult to see how information was being monitored and analysed.

There was no formal recording of patterns of incidents of behaviour that challenged. This meant that there was no way of monitoring the frequency and severity of such incidents so that individual progress could be identified and plans for improvement developed. We were told that management of behaviours of people who used the service were addressed verbally in staff meetings, staff supervisions and that information was shared with the clinical psychologist.

We were told that regular spot checks were carried out on staff practice but that these were not formally recorded. We were told that any issues identified were discussed immediately or in staff meetings and staff supervisions. However, as there were no records of these spot checks we could not ascertain if there had been any concerns noted at these spot checks and if any appropriate action had been taken if concerns were identified

There were monthly staff meetings where issues such as training, safeguarding, health and safety, care plans and behaviour management were discussed. The notes of these meetings identified actions to be taken.

We saw that staff used picture questionnaires to ask people if they were happy in the home and what activities they wanted to do. Staff explained that this was used to help inform the six month care reviews. We saw evidence that the person using this service was involved in these regular care reviews. We saw that the last review was in May 2011.

We were told that the complaints process was made available to all families of people using the service. Staff told us that they worked closely with families and kept them informed of people's care and any organisational change. The organisation had a nominated lead to regularly contact relatives to ensure they are happy with the service. However we were unable to see records of this.

We were informed that the registered manager was on emergency leave at the time of our visit, and that this was expected to last less than 28 days. When asked about the reporting structure of the service, the staff we spoke with told us that they would approach the deputy manager if they had any concerns. Staff confirmed that the deputy manager was readily available. They said that staff meetings were held and that they could put forward any ideas or concerns at these meetings.

Our judgement
There were some systems in place to monitor the quality of the service; however a lack of formal documentation made it difficult to see how information had been used to identify areas for improvement and how these were to be delivered and achieved.

 Overall we found that improvements are needed for this essential standard

Outcome 27:
Notifications – notice of absence

What the outcome says

This is what people who use services should expect.

People who use services:
* Can have confidence that, if the person(s) in charge of their service is absent, it will continue to be properly managed and be able to meet their needs.

What we found

Our judgement

There are minor concerns with Outcome 27: Notifications – notice of absence

Our findings

What people who use the service experienced and told us
We did not obtain information from people living in the home about this standard

Other evidence
At the time of our visit we were informed that the registered manager was on emergency leave. We had not received notification of this absence. We asked the nominated individual to confirm the expected return of the registered manager. We were told that she was expected to return on the 15th December 2011. At the time of writing this report this information had not been received. This meant it was unclear as to whether the registered manager had been absent for longer than the 28 days, that requires notification to CQC

Our judgement
The provider organisation failed to provide requested information for the requirements relating to notifications of absence for the registered manager.

 Overall we found that improvements are needed for this essential standard

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 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: There were sufficient numbers of staff to meet the needs of the people who used this service. However the programme of training did not ensure that all staff had completed all of the training they required to fulfil their role and responsibilities as set by Skills for Care	
Accommodation for persons who require nursing or personal care	Regulation 14 CQC (Registration) Regulations 2009	Outcome 27: Notifications – notice of absence
	Why we have concerns: The provider organisation failed to provide requested information for the requirements relating to notifications of absence for the registered manager.	

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 7 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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: The daily management of medications supported people with their needs. However the lack of medicines management, security and safety in the way medicines were stored put the people who used this service at risk.	
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: There were some systems in place to monitor the quality of the service; however a lack of formal documentation made it difficult to see how information had been used to identify areas for improvement and how these were to be delivered and achieved	

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 7 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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