CareQuality Commission

Review of compliance

Ms Iolenta Castelino Therese Care Home	
Region:	London
Location address:	144 Gassiot Road Tooting London SW17 8LE
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Therese Care Home provides residential care for three people with a mental health problem. The home has three staff and a manager. It is the only home provided by Ms Iolenta Castelino, who is also the manager.

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

Our current overall judgement

Therese Care Home 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 9 September 2011, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People using the service told us they were happy with the care they received, and got on well with the staff. One person told us that it could be boring, and another told us that there wasn't a lot to do but they liked relaxing. The people we spoke to said they felt safe in the home, and they could speak to the manager if they had any problems.

People's views were supported by much of what we found during our visit. However, there were some areas where we found that improvements were necessary including the management of medicines, care planning, and staff training.

What we found about the standards we reviewed and how well Therese Care Home 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 living in the home are treated with dignity and respect. They are generally able to make decisions about their care, and what they want to do.

Overall, we found that Therese Care Home was meeting this essential standard.

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

The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, people's needs are not always clearly identified and may not always be met.

Overall, we found that Therese Care Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People are happy with the food provided, however they have restricted access to food and drinks some of the time. A lack of staff training may put people at risk.

Overall, we found that Therese Care Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People living in the home appear to be safe and well cared for. However, a lack of staff training may put people are at risk.

Overall, we found that improvements were 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 processes for the management and administration of medication in the home are very poor, and put the people living there at risk.

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

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

People living in the home like the staff and are satisfied with the service they receive. There appeared to be adequate staffing levels during the day, but it was not clear how these were decided at night. There are significant gaps in staff training.

Overall, we found that improvements were 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

People living in the home were generally satisfied with the service they received. However, the arrangements for monitoring the quality of the service were generally informal and not consistently documented.

Overall, we found that Therese Care Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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. Any regulatory decision that CQC takes 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

The people we spoke to said they liked living in the home and got on well with the staff. We saw that people's rooms were personalised with their belongings, and one of the people had their art work on display throughout the home. There is one bathroom and toilet between the three people who live in the home. The woman living in the home said she didn't mind living with two men.

Other evidence

On admission, each of the people using the service had signed a 'personal statement' which confirmed their agreement with the terms of the home and stated some basic preferences. This showed that none of the people living there wanted a key to the house, and all of them can go out alone. One of the files indicated that the person was religious, but did not want to attend religious services.

Staff were observed to be polite and courteous to the people living in the home. The manager said that she spoke to people using the service on a regular basis as she was in the home most days. She said that periodically the people using the service and staff went out for lunch and would discuss any issues in the home, although we did not see any records of this.

Our judgement
People living in the home are treated with dignity and respect. They are generally able to make decisions about their care, and what they want to do.

Overall, we found that Therese Care Home 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

There are minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us they were happy with the care they received at the home. One person told us that it could be boring, and another told us that there wasn't a lot to do but they liked relaxing.

Other evidence
There are no activities provided directly in the home except a television in the lounge/dining room. The people living there are all able to go out alone, and do so to varying degrees. Some of the people have interests that they carry out within the home. The manager said that people were encouraged to engage in activities, and there was some evidence of this in the records.

People's records showed that each person had had a basic assessment completed and a care plan. The care plans should explain what people's needs are and what staff should do to support people to have these needs met. However, the care plans did not fully show what people's current needs were and how the home is working with people to meet them.

A diary is completed by staff that records key events in the home each day. However, staff do not record in people's individual records what has happened to help them meet their needs.

People are able to visit the GP if necessary, and are supported to do this if they are unable to go independently. Records showed that people have had their health

problems addressed and monitored.

Our judgement
The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, people's needs are not always clearly identified and may not always be met.

Overall, we found that Therese Care Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

There are minor concerns with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
The people we spoke to said they thought the food was "okay" or very good. We saw people preparing their own drinks in the kitchen.

Other evidence
A sign in the kitchen says that it is locked at night. Staff confirmed this and said that people did not want drinks at night. It was not clear if this was really the case, or if it was because people had got used to them not being available.

The fridge and freezer temperatures are recorded twice a day, but have read exactly the same temperature for every reading since 2009 which is unusual. The staff member could not find the thermometer in the freezer.

Staff cook all the food in the home, and people eat together in the dining room. Staff have received food hygiene training, but not within the past three years. One member of staff had not had food hygiene training for nearly 8 years.

Staff said that the menu was set by the manager, and the people living in the home were not asked what they wanted to eat. There is a four-weekly menu cycle. The fridge and freezer were well stocked.

Our judgement
People are happy with the food provided, however they have restricted access to food and drinks some of the time. A lack of staff training may put people at risk.

Overall, we found that Therese Care Home was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The people we spoke to said they felt safe in the home.

Other evidence
None of the staff have had safeguarding training within the last three years. Staff said that if they had any concerns they would contact the manager.

The manager said that all people living in the home have their own bank account that their benefits/pension are paid directly into. Some of the people manage their own money. Others have support from the manager, and we saw a book where it was recorded when money had been given to the person and they have signed to say they've received it.

Our judgement
People living in the home appear to be safe and well cared for. However, a lack of staff training may put people are at risk.

Overall, we found that improvements were 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

There are major concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
All the people living in the home had agreed to have their medication ordered, stored and given to them by staff.

Other evidence
Each person's medication is supplied to the home in individual boxes labelled with administration instructions. Once a week a member of staff takes the tablets from the boxes and puts them into a different container. These containers are placed into an envelope marked with the person's name, but the containers themselves are not labelled – nor are the times and days they should be given. Once the tablets are mixed together in the box, it is not clear what they are.

Staff demonstrated the process for managing medication. The medication administration charts for each person are hand written by the manager each month, and staff tick off when they have given the medication. There is a plastic pot labelled with each person's name – these looked worn and dirty.

An out of date bottle of eye drops, with no indication of who this was for or when it was opened, was found in the medicine cupboard. Eye drops should normally be stored in a fridge and labelled with the person they are for, and the date they were opened.

The medicine cupboard was locked, but the keys were stored in an unlocked drawer. The home's policy, which all three staff had signed, said that the keys for the medicine

cupboard should be with a member of staff at all times.

Staff said that people were not prescribed any 'as necessary' medication. When asked what they would do if, for example, one of the people living there had a headache they said that they would give them paracetamol but would not record this anywhere. The home's policy, which all three staff had signed, said that homely remedies were not used in the home. The training records showed only one member of staff had received medication training, and this was over four years ago.

Our judgement
The processes for the management and administration of medication in the home are very poor, and put the people living there at risk.

Overall, we found that improvements were 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 moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People living in the home said they liked the staff, and found them helpful. They said they could speak to the manager if they had any problems. We observed staff speaking to the people using the service in a positive and friendly manner.

Other evidence
There are three staff and the manager (who is also the owner) working in the home. Staff said that they felt supported by the manager, and by the other staff working there.

The staff rota covered 9am-7pm, but staff said that they sometimes came in earlier or left later. We were told by one member of staff that the home is not staffed at night, but another said that it was sometimes staffed at night. The manager said that someone did a sleeping-night in the home more often than not. The manager said that this was based on an assessment of the needs of the people in the home, but acknowledged that this wasn't documented. The manager said that the people living in the home knew how to contact her if they needed support, and contact details were seen on the wall above the phone.

Staff told us that they had had training but it was some time ago. The training records confirmed that two of the staff had not received any training since 2008, and another since 2009 though most of this was provided at another home. None of the staff had had safeguarding training, food hygiene or medication training within the last three years.

Our judgement

People living in the home like the staff and are satisfied with the service they receive. There appeared to be adequate staffing levels during the day, but it was not clear how these were decided at night. There are significant gaps in staff training.

Overall, we found that improvements were 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 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 living in the home said that overall they were happy with the service, and would approach the manager or other staff if they had any concerns.

Other evidence
The manager said that as there were only three people living in the home she speaks with them regularly, and they approach her if they have any concerns or problems. She said that the staff and people living there periodically go out for a meal, so that they can talk about any problems or improvements outside of the home. She said that this used to happen every month, but is now less frequent because of a reduction in fees. The manager said that she has given surveys to family members and visiting healthcare professionals in the past, though the response rate was normally low. She said that she assumes that if there is a problem then people will complain.

There was a complaints and an accident book, but there had been no complaints recorded at all, and no accidents recorded for over 2 years.

Our judgement
People living in the home were generally satisfied with the service they received. However, the arrangements for monitoring the quality of the service were generally informal and not consistently documented.

Overall, we found that Therese Care Home was meeting this essential standard but, to maintain this, we suggested that some improvements were 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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: The people living in the home said that they enjoyed living there, and interactions between them and staff appeared positive. However, people's needs are not always clearly identified and may not always be met.	
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 05: Meeting nutritional needs
	Why we have concerns: People are happy with the food provided, however they have restricted access to food and drinks some of the time. A lack of staff training may put people 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
	Why we have concerns: People living in the home were generally satisfied with the service they received. However, the arrangements for monitoring the quality of the service were generally informal and not consistently documented.	

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 within 7 days of this report being received.

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.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 07: Safeguarding people who use services from abuse</td></tr>
<tr><td colspan="2">How the regulation is not being met:
People living in the home appear to be safe and well cared for. However, a lack of staff training may put people are at risk.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 09: Management of medicines</td></tr>
<tr><td colspan="2">How the regulation is not being met:
The processes for the management and administration of medication in the home are very poor, and put the people living there at risk.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 14: Supporting staff</td></tr>
<tr><td colspan="2">How the regulation is not being met:
People living in the home like the staff and are satisfied with the service they receive. There appeared to be adequate staffing levels during the day, but it was not clear how these were decided at night. There are significant gaps in staff training.</td></tr>
</table>

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 this report being received.

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:

<u>Improvement actions</u>: 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.

<u>Compliance actions</u>: 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.

<u>Enforcement action</u>: 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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