Review of compliance

Mr M Madhewoo **Bevan House**	
Region:	London
Location address:	Bevan House 104 & 106 Coldharbour Road Croydon Surrey CR0 4DW
Type of service:	Care home services without nursing.
Publication date:	June 2011
Overview of the service:	Bevan house is a care home that provides accommodation and personal care to five people with learning disabilities.

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

What we found overall

We found that Bevan House was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

- Respecting and involving people who use services
- Meeting nutritional needs
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Requirements relating to workers
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Requirements relating to registered managers.

We received an anonymous complaint about the service. This information was passed onto Croydon Social Services Safeguarding team and a strategy meeting involving people who use the services care managers was held. Croydon Social Services Safeguarding team are currently investigating the allegations made in the anonymous complaint and further safeguarding meetings are planned in line with their “service level concern” (also known as serious concerns about a provider) protocol.

How we carried out this review

We reviewed all the information we hold about this provider, two Care Quality Commission compliance inspectors carried out an unannounced visit on the 2nd June 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider’s records, and looked at records of people who use services.

What people told us

Due to their needs and limited communication skills not all the people who use the service who we met during the visit were either willing and/or capable of sharing their views about their experiences of life at Bevan House.

One person who uses the service told us “I keep myself to myself, I like to stay in my room and play computer games, the staff are okay, they treat me well, the food is okay” they also told us “I know how to complain if I need to and I think staff would listen to any complaint I make”.

Throughout the course of the visit we observed staff interacting with the people who use the service in a very kind, respectful and professional manner.

What we found about the standards we reviewed and how well Bevan House was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found that the registered provider was not making sure that the people who use the service received a full schedule of weekly activities as agreed with and funded by their placing authorities.

We found that the registered provider was not making sure that people who use the service were given the opportunity to take part in meaningful activities both within and outside of Bevan House.

We found that the people who use the service are not provided with information on what the service is providing in a format that they can understand.

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

Outcome 5: Food and drink should meet people’s individual dietary needs

We found that the registered provider had not taken appropriate steps to ensure that people who use the service are protected from the risk of poor food hygiene and poor food handling procedures.

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

Outcome 7: People should be protected from abuse and staff should respect their human rights

We found that safeguarding procedures were not fully understood by staff that had not been trained on safeguarding adults from abuse. The registered provider was not making sure that appropriate steps were taken to ensure that people who use the service were safeguarded from the risk of being abused, harmed and/or neglected.

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

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

We found that the registered provider was not making sure that the people they support are protected from the risk of infection because staff had not being trained on infection control.

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

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

We found that people could not be sure that their medication is properly managed because the registered provider had not taken the steps to make sure that medicines were managed safely, securely and appropriately.

People who use the service were being placed at risk of abuse and harm because some of the staff that handles medication had not had the appropriate training with regards to dispensing, storing and recording of medicines.

There were no clear guidelines for staff follow for dispensing PRN medication.

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

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

We found that the seating in the lounge was badly worn and damaged and uncomfortable to sit on and needed to be replaced.

We found that one persons room was extremely cluttered with personal belongings, this left very limited floor space for them walk on and even access their bed. This person would be a risk in the event of a fire.

We found an old bed in one person's bedroom and ladders and rubble in the garden that needed to be removed.

We found that water temperatures in the bathroom were unsafe.

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

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

We found that Bevan House relied heavily on foreign students without any previous qualifications or experience of working in care, the staff turnover was high. People

who use the service were not being offered a consistent approach to their support and care needs.

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

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

Due to staff shortage we found that some staff worked excessively long hours, this placed them in the position where they may experience fatigue. Their ability to make sound and rationale judgments could be adversely affected and could ultimately have a negative impact on the standard of care and support they are able to provide to people who use the service.

- 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

We found that people who use the service were being placed at risk of harm and abuse because the staff team were not receiving basic important training and supervision that would enable to carry out their duties as support workers. The registered provider had not taken the appropriate steps required to ensure that people were being supported at all times by a sufficiently qualified and skilled staff.

- 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

We found that monthly quality audits were being carried out at the home however issues of concern were being dealt with by the management team and were not being reported to the proper authorities.

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

Outcome 24: People should have their needs met because it is managed by an appropriate person.

We found that Bevan House had had three managers in charge of the service since transition from the Care Standards Act to the Health and Social Care Act, October 2010. A new acting manager had recently been appointed.

Bevan House did not have a manager registered with the Care Quality Commission. Previous managers had not been able to establish themselves, develop good working practices in order to offer the people who use the service a consistent approach to meeting their needs.

Action we have asked the service to take

We have asked the provider to send us a report within 10 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.

We have referred our concerns to Croydon Social Services Safeguarding team. We will check to make sure that 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.

Please see previous review reports for more information.

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 1:
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 moderate concerns with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us

On this occasion we did not speak to people about this outcome area.

Other evidence

The social activities people could choose to participate in each evening were conspicuously displayed on an information board in the dinning room. The acting manager and operation manager both acknowledged that not everyone who lived at Bevan House would be able to understand the evening activity schedule. Activities included dominoes night (at the home), movie night (at the home or cinema), form a word, family game centre, music night pub or club, meals out and bingo.

We looked at two peoples care plans; both were written in plain language and illustrated with various pictures and photographs to enable these documents to be understood by the people who use the service.

The service needs to develop far more easy to read “user friendly” documents to

ensure everyone who lives at Bevan House has access to all the information they may wish to know about how their home operates and what choices they have. E.g. The service should have far more easy to read menus, social activities schedules, complaints procedure, satisfaction surveys, and staff duty rosters (i.e. photos of all the staff on shift).

During a tour of the premises we found lots of games, puzzles, DVDs and books kept on a shelf in the lounge. However these were not accessible to the people who use the service because two large arm chairs that were placed directly in front of the shelf. Furthermore, not only were a lot of the games, puzzles, films and books for young children (i.e. large Lego bricks, Noddy puzzle ect.), but some were damaged or had pieces missing. None of the puzzles we looked at contained all the pieces to complete them. The service needs to obtain better quality games and in-house entertainment that reflects the age and interests of the people who use the service.

All but one of the people who currently live at Bevan House went out or participated in any meaningful social activities during the visit. Most people were observed sitting quietly in either the main lounge or dinning room doing very little.

We cross referenced weekly daytime activity schedules for two individuals against daily records kept by staff regarding what people who use the service do each day. Contrary to the weekly activity plans, which looked quite interesting on paper, daily diary notes indicated that watching television and going on walks around the local community were the extent of what most people did each day.

The operations manager told us various local authorities who had placed people at Bevan House were paying the service for their ‘clients’ to have 20 hours 1 to1 time a week for staff to ensure their ‘clients’ enjoyed a variety of meaningful and interesting social activities both within the home and in the wider community. The operations manager and the services new acting manager both acknowledged that due to staff shortages this 1 to 1 social time was not happening on a regular basis as agreed with the various funding authorities.

One of the people who use the services care manager had recently completed a review, a reassessment of their “clients” needs. We were forwarded a copy of the review. The care manager recorded that Unicorn Projects, of which Bevan House is part of, is meant to provide their client with a full schedule of weekly activities inclusive of their fees. Their client is meant to receive 4 hours of 1:1 support for activities of their choosing and the rest of their activities should be facilitated by shared staffing. When their client accesses the community for activities, they are meant to receive 2:1 support. However, due to staff shortages, the schedule has not been fully implemented.

Our judgement
We found that the registered provider was not making sure that the people who use the service received a full schedule of weekly activities as agreed with and funded by their placing authorities.

We found that the registered provider was not making sure that people who use the service were given the opportunity to take part in meaningful activities both within and outside of Bevan House.

We found that the people who use the service were not provided with information on what the service is providing in a format that they can understand.

Outcome 5:
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 moderate concerns with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
The meals the people who use the service could choose to eat at lunchtime were displayed on the weekly menu pinned to the wall in the kitchen. The acting manager and the operation manager both acknowledged that not everyone who lived at Bevan House would be able to understand the weekly menu on display in the kitchen.

We observed a number of people who use the service helping themselves to water from the kitchen on several occasions. The kitchen door remained unlocked and therefore accessible throughout the visit.

It was positivley noted that there was a lot of Afro-Carribbean style cuisine on the menu and food in the freezer, which reflected the ethnic origins and tastes of a number of the people who live at Bevan House. The Carribbean style rice dish which staff prepared one individual who uses the service for their lunch on the day of this visit looked and smelt appertising.

We found a number of food items stored in the fridge to be passed their best before dates. We asked staff to dispose of some cauliflower, broccoli, peppers, a stale hot

cross bun and some pots of yogurt. Some mouldy fruit was also found in a bowl in the kitchen which staff also thrown away on request.

The operations manager told us in the provider compliance assessment that staff are trained in food hygiene and are inducted as to what a balanced diet is which includes a diet a high fibre, fresh fruits and vegetables and meat. Staffs are trained to ensure that food is prepared in accordance to requirements of Food Safety Act. However when we spoke to two members of staff both told us they had not received any training on food hygiene or the Food Safety Act.

There was some badly damaged wooden flooring in the kitchen, this needs replacing as a matter of urgency. Surface's that are not impermeable in areas where food is stored and prepared represents an environmental hygiene hazard. Furthermore, the storage units in the kitchen looked very worn and shabby and these should be also replaced. Time specific action plan needs to be agreed for this environmental work to be completed.

Our judgement

We found that the registered provider had not taken appropriate steps to ensure that people who use the service are protected from the risk of poor food hygiene and poor food handling procedures.

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 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
We received an anonymous complaint about the service. This information was passed onto Croydon Social Services Safeguarding team and a strategy meeting involving people who use the services care managers was held. Croydon Social Services Safeguarding team are currently investigating the allegations made in the anonymous complaint and further safeguarding meetings are planned in line with their “service level concern” (also known as serious concerns about a provider) protocol.

During this visit we found safeguarding concerns about the administration of PRN medications. **See Outcome 9 Management of medicines.** An incident of abuse or suspected abuse had been identified however was not reported to the appropriate agencies.

We observed a document regarding safeguarding in the dining with contact information of Croydon Social Services Safeguarding team and the Care Quality Commission.

We spoke to two members of staff; both told us they had not received any training on safeguarding adults from abuse.

Staff we met confirmed physical intervention is not permitted at Bevan Home. The operations manager showed us documentary evidence that demonstrated the registered provider who trained staff at Bevan in the use of Non Crises Intervention had refreshed his training in the last twelve months in line with recognised best practice.

Our judgement
We found that safeguarding procedures were not fully understood by staff that had not been trained on safeguarding adults from abuse. The registered provider was not making sure that appropriate steps were taken to ensure that people who use the service were safeguarded from the risk of being abused, harmed and/or neglected.

Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

There are moderate concerns with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
The operations manager showed us the services policy on infection control. They told us that all staff had attended training on infection control.

We spoke to two members of staff; both told us they had not received any training on infection control.

We showed the operations manager a copy of the Department of Health's Code of practice on the prevention and control of infections and related guidance; they told us they did not have a copy.

The impact of the new legislation was explained to the operations manager. We advised that in order to comply with the Department of Health's Code of practice on the prevention and control of infections a suitably trained member of staff should be nominated to be the homes Infection Prevention and Control (IPC) lead. The IPC lead would be responsible for overseeing the homes infection prevention and control arrangements that includes an annual statement about Bevan House infection prevention and control: risk assessments; quality audits and monitoring systems; cleaning schedules; policies and procedures; reporting; and staff training.

As stated in outcome 5 we found a number of food items stored in the fridge to be

passed their best before dates, mouldy or stale. The two members of staff we spoke to told us they had not received any training on food hygiene or the Food Safety Act.

Our judgement
We found that the registered provider was not making sure that the people they support are protected from the risk of infection because staff had not being trained on infection control.

Outcome 9:
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 9: Management of medicines

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
The operations manager told us in the provider compliance assessment that Bevan House had very strict policies in relation to management of medicines to protect people who use the service against the risks associated with the unsafe use and management of medicines. All staffs that dispense medication have the appropriate qualifications and training with regards to dispensing, storing and recording of medicines. Staffs are trained on how and why to dispense PRN medication and how to record and document it. For extra safety, on each shift, all medication are counted and signed for by the shift leader.

Daily dairy notes we looked at indicated that 'as required (PRN) behavioural modification medication' had been administered 21 times in April 2011 to one particular person who uses the service, mostly by the same member of staff. The operations manager told us they had, picked this up during the monthly quality audit for April 2011. They had been surprised by the frequency of its use in April 2011 and steps were taken to transfer the staff concerned to the other Unicorn project home. There was no recorded evidence of PRN medication being administered to the

same person in May 2011.

However the operations manager had not informed the Croydon Social Services Safeguarding team or the Care Quality Commission. We advised the operations manager that we be informing the safeguarding team about the administration of PRN medication and advised them that they should contact the safeguarding team with their findings in the monthly quality audit for April 2011.

We made a safeguarding referral to Croydon Social Services Safeguarding team during the course of the visit. The safeguarding coordinator subsequently confirmed that the operations manager had contacted them with this information following our visit. Following the referral the member of staff involved was suspended from their duties.

There were guidelines in place for staff to follow when administering PRN medication, but they do not make it explicitly clear that staff must always seek authorisation from the services management before administering this type of medication and that it should only ever be given as a 'last resort' when all other methods have failed.

We spoke to two members of staff. One member of staff, who had worked at Bevan House since September 2010, told us they had not received any training on medication administration or the administration of PRN medications.

The operations manager told us that medication had been audited monthly by the previous managers. We advised the operations manager that stocks and balances of medication should be audited weekly by the manager.

Our judgement
People cannot be sure that their medication is properly managed because the registered provider had not taken the steps to make sure that medicines were managed safely, securely and appropriately.

People who use the service were being placed at risk of abuse and harm because some of the staff that dispenses medication had not had the appropriate training with regards to dispensing, storing and recording of medicines.

There were no clear guidelines for staff follow for dispensing PRN medication.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
During a tour of the communal areas we noted lots of colourful photographs of the people who use the service and pictures hung on walls in the dinning room and lounge.

There were plenty of cushions scattered on all the chairs and sofas in the dinning room and lounge. The seats on all the white leather sofas and chairs in the lounge had been badly worn and damaged making them uncomfortable to sit on. Furthermore, the leather on a number of the chairs was torn and discoloured.

The operations manager showed us two people's bedrooms; these contained appropriate furniture and appeared to reflect the person's personality. Each room had a shower and a toilet. One person had a new bed and the old bed was propped up against the wall. The operations manager told us that they were waiting for this to be taken away.

The services boiler has now been in-cased as recommended by the London Fire and Emergency Planning Authority. Fire safety records indicate fire evacuation drills

are rountinely carried out on a monthly basis.

The temperature of hot water emanating from a tap attached to a bath on the ground floor was found to be an unsafe 47 degrees Celsius when we tested it at 11.20am. Furthermore, the daily records kept by staff of hot water temperatures used in baths indicated that it never exceeded 38 degrees. The new acting manager could not account for this discrepancy and told us they would look into this matter.

One bedroom we viewed with the permission of the current occupant was extremely cluttered with the individual's personal belongings, which left very limited floor space for them walk on and even access their bed. We advised the operations manager that a best interest meeting with all the relevant people, including the individual concerned, should be convened at the earliest convenience in order to ensure this persons safety.

The garden had some tables and chairs for people to sit, however there was some ladders and rubble that needed to be removed. The operations manager told us they planned to tidy up the garden.

Our judgement
We found that the seating in the lounge was badly worn and damaged and uncomfortable to sit on and needed to be replaced.

We found that one persons room was extremely cluttered with personal belongings, this left very limited floor space for them walk on and even access their bed. This person would be a risk in the event of a fire.

We found an old bed in one person's bedroom and ladders and rubble in the garden that needed to be removed.

We found that water temperatures in the bathroom were unsafe.

Outcome 12:
Requirements relating to workers

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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

There are moderate concerns with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
The operations manager told us the service had experienced high rates of staff turnover in the past six months and the service relied heavily on foreign students. They told us it had been difficult to recruit staff and they needed to recruit another three members of staff.

Two of the students were studying accountancy and none of the students had any qualifications or previous experience of working in care with people high support and challenging needs. The operations manager agreed that it was unlikely that students who come to the UK to study had knowledge of the English culture or the local community.

The operations manager told us they had carried out a number of interviews for new staff. They selected three people to employ; they told us they were waiting for references for one applicant another applicant could not start work until August 2011, the other applicant did not accept the post.

We looked at the pre-employment checks the service had carried out in respect of

its two most recently recruited staff. Both their personal staff files contained up to date and satisfactory Criminal Records Bureau checks and two written references from their previous employers.

Throughout the course of the visit we observed staff interacting with the people who use the service in a kind, respectful and professional manner.

Our judgement
We found that Bevan House relied heavily on foreign students without any previous qualifications or experience of working in care, the staff turnover was high. People who use the service were not being offered a consistent approach to their support and care needs.

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

There are moderate concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

On this occasion we did not speak to people about this outcome area.

Other evidence

Throughout the course of the visit we observed staff interacting with the people who use the service in a very kind, respectful and professional manner.

As previously stated we found that we found that Bevan House relied heavily on foreign students without any qualifications or previous experience of working in care, the staff turnover was high. The operations manager told us it was difficult to recruit staff and they wanted to recruit another three members of staff.

We looked at the staff duty rosters for the past four months; we found that some staff had moved between the registered provider's two care homes. The duty roster also indicated that contrary to the European time directive re staff working hours a number of staff had worked excessively long hours on consecutive shifts without taking sufficient time off. We found four instances where staff had worked four shifts in a row without anytime off since March 2011 (i.e. early, late, sleep-in, early).

Our judgement

Due to staff shortage we found that some staff worked excessively long hours, this placed them in the position where they may experience fatigue. Their ability to make sound and rationale judgments could be adversely affected and could ultimately have a negative impact on the standard of care and support they are able to provide to people who use the service.

Outcome 14:
Supporting workers

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 major concerns with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
The operations manager told us in the provider compliance assessment that all staffs receive regular supervision from their manager. Staff is given opportunities for training and professional development. All staffs get a complete induction before being allowed to work on their own. Induction takes place for three days and new employees work under supervision of a senior member of staff on shift for at least a week. Staffs training needs are identified during supervision. Training is delivered by a competent trainer, internal as well as outside agencies. Learning and development takes place as and when required if there are changes in clients' needs. Staff are encouraged to voice their concerns in supervision and if staff are not satisfied, they are encouraged to go to the operations manager or finally to the provider.

The new manager told us they planned to ensure each member of staff received a one to one supervision session at least once every 6 weeks.

We looked at all the training certificates held by the service in respect of its current workforce. It was positively noted that certificates were made available on request that showed us the vast majority of staff had achieved an NVQ in care - level 2 or above. However, not all the files we looked at in depth contained evidence that these staff had received up to date training in core areas of support worker practice

such as fire safety, moving and handling, food hygiene, first aid, managing challenging behaviour and safe medication handling.

There was no information about what inductions the services two most recently employed staff had received. Furthermore, it was not clear what infection prevention and control training staff had received.

Only one staff meeting had been held in 2011, the operations manager told us this was something they expected the new manager to address. The new manager told us they planned to reinstate monthly staff meetings starting in June 2011.

We spoke to two members of staff. One member of staff told us they had been working at Bevan House for three weeks. They had been moved across from the registered providers other care home, Unicorn House. They had been employed by the registered provider for four months. They told us they had completed training on medication and the administration of PRN, fire safety and non violent crises intervention during the period they worked at Unicorn House.

They told us they had completed a two day induction and training on epilepsy since their move to Bevan House. We asked them if they had received training on the following areas at Bevan House. Food hygiene, first aid, health and safety, moving and handling, infection control. They told us that they had not received any training for any of the above. They told us they had not received any formal supervision at Bevan House. They told us that at Bevan House the staff are friendly and work well together however there was a need for more staff.

The other member of staff told us they had worked at Bevan House since September 2010. They had completed a one week induction and training on epilepsy. We asked them if they had received training on the following areas at Bevan House. Fire safety, food hygiene, first aid, health and safety, moving and handling, infection control, safeguarding adults from abuse, medication administration and the administration of PRN. They told us that they had not received any training for any of the above. They told us that they had received regular formal supervision from the previous manager. When we asked them what improvements the service could make they told us they would like to see people who use the service getting out a bit more and staff could have training on autism.

The operations manager was not able to confirm if overseas students had received any of the above training.

Our judgement

People who use the service were being placed at risk of harm and abuse because the staff team were not receiving basic important training and supervision that would enable to carry out their duties as support workers. The registered provider had not taken the appropriate steps required to ensure that people were being supported at all times by a sufficiently qualified and skilled staff.

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
One person who uses the service told us “I keep myself to myself, I like to stay in my room and play computer games, the staff are okay, they treat me well, the food is okay” they also told us “I know how to complain if I need to and I think staff would listen to any complaint I make”.

Other evidence
During our visit the operations manager told us they carried out monthly quality audits, they had picked up the issue regarding the administration of PRN medication during the monthly quality audit for April 2011. **See Outcome 9**. This was dealt with by the management team and was not reported to the proper authorities, Croydon Social Services Safeguarding team or the Care Quality Commission.

The operations manager and new acting manager found it difficult to locate all the records we requested during the site visit. Both managers conceded that there was significant room to improve the services filing systems and to make them far more accessible.

Our judgement

We found that monthly quality audits were being carried out at the home however issues of concern were being dealt with by the management team and were not being reported to the proper authorities.

Outcome 24:
Requirements relating to registered managers.

What the outcome says

This is what people who use services should expect.

This is what people who use services should expect.

People who use services:

- Have their needs met because it is managed by an appropriate person.
- Have a registered manager who:
- is of good character
- is physically and mentally able to perform their role
- has the necessary qualifications, skills and experience to manage the regulated activity.

What we found

Our judgement

- **There are minor concerns** with outcome 24 Requirements relating to registered managers. However a new acting manager had recently been appointed.

Our findings

What people who use the service experienced and told us
On this occasion we did not speak to people about this outcome area.

Other evidence
A manager was registered with the Care Quality Commission during transition from the Care Standards Act to the Health and Social Care Act. The registered provider notified the Care Quality Commission in February 2011 that the registered manager stepped down from their post. This person still works at the home as a full time senior carer. The registered provider told us that they were in the process of recruiting and appointing a new registered manager.

A new acting manager was appointed; this manager had previously worked at the

care home from which three people who use the service had recently been placed at Bevan House. This manager was dismissed from their post on the 25th of May 2011. A new acting manager was appointed on the same day.

The new acting manager told us that they had eight years experience working with adults with learning disabilities as a manager in residential care settings. They had also achieved the registered manager's award and a degree in management.

Our judgement
We found that Bevan House had had three managers in charge of the service since transition from the Care Standards Act to the Health and Social Care Act, October 2010. A new acting manager had recently been appointed.

Bevan House did not have a manager registered with the Care Quality Commission. Previous managers had not been able to establish themselves, develop good working practices in order to offer the people who use the service a consistent approach to meeting their needs.

Action
we have asked the provider to take

Compliance actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care.	Regulation number 17	Outcome 1 Respecting and involving people who use the service.
	How the regulation is not being met: We found that the registered provider was not making sure that the people who use the service received a full schedule of weekly activities as agreed with and funded by their placing authorities. We found that the registered provider was not making sure that people who use the service were given the opportunity to take part in meaningful activities both within and outside of Bevan House. We found that people who use the service were not provided with information on what the service is providing in a format that they can understand.	
Accommodation for persons who require nursing or personal care.	Regulation number 14	Outcome 5 Meeting nutritional needs
	How the regulation is not being met: We found that the registered provider had not taken appropriate steps to ensure that people who use the service are protected from the risk of poor food hygiene and poor food handling procedures.	
Accommodation for persons	Regulation number 11	Outcome 7 Safeguarding.

who require nursing or personal care.	**How the regulation is not being met:** We found that safeguarding procedures were not fully understood by staff that had not been trained on safeguarding adults from abuse. The registered provider was not making sure that appropriate steps were taken to ensure that people who use the service were safeguarded from the risk of being abused, harmed and/or neglected.	
Accommodation for persons who require nursing or personal care.	Regulation number 12	Outcome 8 Cleanliness and infection Control.
	How the regulation is not being met: We found that the registered provider was not making sure that the people they support are protected from the risk of infection because staff had not being trained on infection control.	
Accommodation for persons who require nursing or personal care.	Regulation number 13	Outcome 9 Management of medicines.
	How the regulation is not being met: We found that people could not be sure that their medication is properly managed because the registered provider had not taken the steps to make sure that medicines were managed safely, securely and appropriately. People who use the service were being placed at risk of abuse and harm because some of the staff that dispenses medication had not had the appropriate training with regards to dispensing, storing and recording of medicines. There were no clear guidelines for staff follow for dispensing PRN medication.	
Accommodation for persons who require nursing or personal care.	Regulation number 15	Outcome 10 Safety and suitability of premises.
	How the regulation is not being met: We found that the seating in the lounge was badly worn and damaged and uncomfortable to sit on and needed to be replaced. We found that one persons room was extremely cluttered with personal belongings, this left very limited floor space for them walk on and even access their bed. This person would be a risk in the event of	

	a fire. We found an old bed in one person's bedroom and ladders and rubble in the garden that needed to be removed. We found that water temperatures in the bathroom were unsafe.	
Accommodation for persons who require nursing or personal care.	Regulation number 21	Outcome 12 Requirements relating to workers.
	How the regulation is not being met: We found that Bevan House relied heavily on foreign students without any previous qualifications or experience of working in care, the staff turnover was high. People who use the service were not being offered a consistent approach to their support and care needs.	
Accommodation for persons who require nursing or personal care.	Regulation number 22	Outcome 13 Staffing.
	How the regulation is not being met: We found that some staff worked excessively long hours, this placed them in the position where they may experience fatigue. Their ability to make sound and rationale judgments could be adversely affected and could ultimately have a negative impact on the standard of care and support they are able to provide to people who use the service.	
Accommodation for persons who require nursing or personal care.	Regulation number 23	Outcome 14 Supporting workers.
	How the regulation is not being met: We found that people who use the service were being placed at risk of harm and abuse because the staff team were not receiving basic important training and supervision that would enable to carry out their duties as support workers. The registered provider had not taken the appropriate steps required to ensure that people were being supported at all times by a sufficiently qualified and skilled staff.	
Accommodation for persons who require nursing or personal care.	Regulation number 10	Outcome 16 Assessing and monitoring the quality of service provision.

<table>
<tr><td></td><td colspan="2">How the regulation is not being met:
We found that monthly quality audits were being carried out at the home however issues of concern were being dealt with by the management team and were not being reported to the proper authorities.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care.</td><td>Regulation number 6</td><td>Outcome 24 Requirements relating to registered managers</td></tr>
<tr><td colspan="2">How the regulation is not being met:
We found that Bevan House had had three managers in charge of the service since transition from the Care Standards Act to the Health and Social Care Act, October 2010.

Bevan House did not have a manager registered with the Care Quality Commission. Previous managers had not been able to establish themselves, develop good working practices in order to offer the people who use the service a consistent approach to meeting their needs.</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 10 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:

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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