Review of compliance

Whitehaven Rest Home Limited Whitehaven Residential Home	
Region:	South East
Location address:	22 Whitehaven Horndean Waterlooville Hampshire PO8 0DN
Type of service:	Care home service without nursing
Date of Publication:	February 2012
Overview of the service:	Whitehaven Rest Home is a home for older people offering support and care for people with dementia. The home is situated in a residential area.

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

Our current overall judgement

Whitehaven Residential Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 24 January 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

During our visit we spoke with three people who live at the home, one relative, two staff and the provider.

People at the home told us that they liked living at the home and that the staff were helpful with nothing being too much trouble and the staff were easy to talk to. There were cats living at the home, and people liked having the cats as extra company. Relatives we spoke with told us that the home was 'homely' and spoke about the provider with high regard and said they could also speak freely with staff. The staff conducted themselves in a caring and professional manner.

We observed lunch being served and how staff interacted with people and ensured choice about daily issues such as where to sit. One person told us about the activties and games available, the activities on the day of our visit was a quiz and flower arranging.

Staff told us they received regular training, were supported by the management of the home and that they could speak with senior staff about any concerns they had about the running of the home.

What we found about the standards we reviewed and how well Whitehaven Residential 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 were asked about the help and support needed and felt they were able to make decisions. People and or their representatives are involved in planning their care on an ongoing basis and had been given opportunities to discuss what could improve the quality of care and support provided to them. People's right to privacy, dignity and independence was respected. On the basis of the evidence provided we found the service to be compliant with this outcome.

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

The majority of the records showed that people consistently received safe care that met their needs. Staff had responded to people's needs and taken action to minimise the risks to people who use the service in timely manner. However there are some areas where further work is needed. Overall, we found that Whitehaven Rest 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

The provider had arrangements in place to safeguard people who use the service from the risk of abuse. Staff had received training and were aware of the actions to take if they suspected that any abuse had occurred. On the basis of the evidence provided we found the service to be compliant with this outcome.

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

Whitehaven Rest Home ensured the necessary pre-employment checks had been carried out on staff prior to them starting work in the home. However there are some areas where work is needed. Overall, we found that Whitehaven Rest Home was meeting this essential standard but to maintain this, we suggested that some improvements were made.

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

Although the provider had ensured that people who use the service were safe and that the quality of care provision was risk managed, there was no record of any improvements that had been made to the service. Overall, we found that Whitehaven Rest 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. 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
Most people at the home have memory difficulties and did not know about their care plan. Relatives confirmed that they were kept well informed about their relative when there had been concerns. They told us how the senior staff had travelled to where their relative lived to met them and discuss tehir concerns to ensure that their needs could be met at Whitehaven.

Staff were observed to knock on doors before entering to ensure privacy. People, relatives and our observations confirmed that people were treated with dignity and their privacy was respected.

Other evidence
Most people living in the home had family members involved in their care who supported them when necessary to make decisions. People confirmed they were able to make decisions about their day to day care such as when to get up and go to bed, to spend time alone or join in groups and where to have their meals. One relative talked about the sorts of discussions they had with staff about their relative's care needs and the decisions agreed.

We observed staff interacting with people who use the service and spoke with staff.

Staff told us that people were asked about they type of support they needed virtually every time support was offered or given. This was because people sometimes changed their minds, or it was to enable people to partake in decisions about their care. Visitors told us that they had seen staff asking people what they wanted or what they would like to do.

Our judgement
People were asked about the help and support needed and felt they were able to make decisions. People and or their representatives are involved in planning their care on an ongoing basis and had been given opportunities to discuss what could improve the quality of care and support provided to them. People's right to privacy, dignity and independence was respected. On the basis of the evidence provided we found the service to be compliant with this outcome.

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 who we spoke with who were able to express their opinion, told us they had the help they required. No one we spoke with was aware of their care plan.

One relative said they were happy with their care and that staff did everything they could to minimise the disruption that happens sometimes.

Our observations confirmed people had their own individual routines which were respected. The atmosphere was relaxed and people interacted with each other, the home's cats and with staff. Staff were observed to be kind and caring in their approach to people.

Other evidence
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Our observations confirmed people had their own individual routines which were respected. The atmosphere was relaxed and people interacted with each other, the home's cats and with staff. Staff were observed to be kind and caring in their approach to people.

Other evidence

The provider told us that over the last eight months they had been moving care plans and all associated records to a computer database system. Each staff member had an individual "log on" and password. Only senior staff were able to edit records. We saw that if a care plan was needed, for example if someone went to hospital, then the staff printed a copy of the care plan which was sent with them.

We looked at three care plans and saw that for each individual there was information for staff about how to support them. The records included risk assessments where risks were apparent and the assessments included actions to take to reduce the identified risk. There were also monitoring tools in place for particular issues such as if a person was known to be at risk of falling.

We saw care plans had been reviewed regularly and they had been updated when people's needs had changed.

Visitors we spoke with said they had no concerns about the care their relative received.

When people had been ill or had an accident, daily reporting records by staff showed appropriate referrals had been made to health professionals and any action taken as a result.

We saw that where there were concerns about a persons' ability to make decisions for themselves, a mental capacity assessment had taken place. We saw paper records for these assessments. The staff had not put these assessments on the computer yet. We spoke with staff about the assessments we saw as they had not been reviewed since they had been done, one had been completed in 2008. Staff said that people were able to make choices about their daily lives such as, when they wanted to go to bed and what they wanted to eat. However, they had difficulty with "big" decisions related to their lives. We discussed the assessments with the provider as they did not reflect what capacity the person had, and indicated they were not able to make a choice about anything related to their life.

Our judgement
The majority of the records showed that people consistently received safe care that met their needs. Staff had responded to people's needs and taken action to minimise the risks to people who use the service in timely manner. However there are some areas where further work is needed. Overall, we found that Whitehaven Rest 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

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 speak with people who use the service about this outcome.

Other evidence
Staff told us they had received training in safeguarding vulnerable adults, the Mental Capacity Act and Deprivation of Liberty Safeguards. The training records we saw confirmed this. There were policies and procedures to support staff after they had had the training.

Staff gave examples of the types of issues that might occur and would constitute abuse. All of them were aware of the safeguarding protocols and said they would report incidents according to the procedure in the home. They gave us an example of an incident that had been reported by staff. They explained what had happened with the information and the subsequent actions following the closure of the investigation.

Our judgement
The provider had arrangements in place to safeguard people who use the service from the risk of abuse. Staff had received training and were aware of the actions to take if they suspected that any abuse had occurred. On the basis of the evidence provided we found the service to be compliant with this outcome.

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 minor concerns with Outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us
We did not speak with people who use the service about this outcome.

Other evidence
We looked at the records of five staff who had been recruited in the last eighteen months. We saw that four records had evidence of safety checks for example Criminal Records Bureau check(CRB), however on one file there was only one reference. The provider believed they had received a second reference and that they may have misfiled it. Another record had two references however one was dated January 2012 and the employee had been in post since April 2011. The manager told us that they had spilt coffee on the original reference and had had to get a replacement.

Staff we spoke with told us about their interview and what checks they knew had been carried out for example CRB and references. They also gave examples of their induction of 'shadowing' other members of staff and the training they had had.

The provider said they had recently changed the method of obtaining criminal records and independent safeguarding authority checks for staff. They now received written confirmation in the form of an email.

Our judgement
Whitehaven Rest Home ensured the necessary pre-employment checks had been carried out on staff prior to them starting work in the home. However there are some areas where work is needed. Overall, we found that Whitehaven Rest Home was

meeting this essential standard but to maintain this, we suggested that some improvements were made.

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
We did not speak with people who use the service about this outcome.

Other evidence
The communication between the provider, staff relatives and people living at the home was open and enabled people to receive the support and care they needed.

The provider showed us copies of surveys that had been returned from relatives of people living at Whitehaven and from staff which were sent out in the last six months. The provider said that they regularly send out surveys usually yearly. The comments from relatives were all positive for example how happy they were with the care.

We saw that comments in surveys made completed by staff had been about staff meetings and how beneficial they would be; training needs and what they wanted or needed as individuals and what they had felt about their induction. We asked what action had been taken as a result of these comments. The provider explained what they had done, but they had not assessed the results and comments or made a plan about any changes they intended to make.

The provider explained that they had some monitoring tools in place at the home for example cleaning schedules. They believed they had some work to do to ensure they can monitor the quality of the service and make any changes that are required.

Our judgement

Although the provider had ensured that people who use the service were safe and that the quality of care provision was risk managed, there was no record of any improvements that had been made to the service. Overall, we found that Whitehaven Rest 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 majority of the records showed that people consistently received safe care that met their needs. Staff had responded to people's needs and taken action to minimise the risks to people who use the service in timely manner. However there are some areas where further work is needed.	
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 12: Requirements relating to workers
	Why we have concerns: Whitehaven Rest Home ensured the necessary pre-employment checks had been carried out on staff prior to them starting work in the home. However there are some areas where work is needed.	
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: Although the provider had ensured that people who use the service were safe and that the quality of care provision was risk managed, there was no record of any improvements that had been made to the service.	

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.

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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