Review of compliance

Mrs Sandra Smith The Owls Care Home	
Region:	North West
Location address:	168 St Annes Road Blackpool Lancashire FY4 2BL
Type of service:	Care home service without nursing
Date of Publication:	July 2012
Overview of the service:	The Owls care home is registered to provide personal care for a maximum of fifteen people living with dementia. The accommodation comprises of eleven single bedrooms and two double bedrooms. some with en-suite facilities, a lounge. There are additional lounge and dining areas as well as bathing and toilet facilities within easy access for people living at the home. A passenger lift enables access to the first floor

	without assistance. The home is located in a residential area of Blackpool.

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

Our current overall judgement

The Owls Care Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 May 2012, carried out a visit on 25 May 2012, 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

Due to the level of people's cognitive and memory impairment we did not always receive specific comments about their care. We relied on our observations, discussions with relatives, staff and professionals.

We visited The Owls and we spoke to several people. Due to the ageing process and level of memory impairment of some people living at the home we observed how people interacted with each other and with staff on duty. Some people were no longer able to use words but we were able to observe their care. We saw that staff took the time to use people's preferred names and ask them if they wanted anything. Staff asked people to do things rather than tell them when they required support with personal care.

A family member of a person living at the home said that their relative was respected by staff. They said, "Mum's loved and cared for. I know she's happy and I'm happy".

We were told that staff were patient when providing personal care and people's dignity was promoted by staff at the home. A relative said, "Attention to detail and care is so good. If she spills a drink or gets her meals on herself she's changed immediately. Mum likes to look nice and always does". The relative said that their famil member could make themself understood when they did not want to do some thing and that staff respected their choice. They said, "She's nearly 90 and tired and doesn't want to do much. I have asked that she doesn't join in the activities. She doesn't wants to and staff say she gets more agitated. Staff know her well".

What we found about the standards we reviewed and how well The Owls 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

The provider was meeting this standard. People who used the service were able to influence decisions about their care and support. Their privacy, dignity and independence were respected.

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

The provider was not meeting this essential standard. We judged it had a moderate impact on people using the service and action was needed for this essential standard.

People were not protected against risks associated with their health conditions as information was missing about the health needs of people. This meant care and treatment was not consistently planned and delivered when risks to health were identified or information was missing.

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

The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

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

The provider was not meeting this standard. We judged that this had a major impact on people using the service. Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete.

People were not protected against the risks associated with medicines because arrangements to manage medicines safely were not fully implemented and consistently adhered to.

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

The provider was meeting this essential standard. There were enough qualified and experienced staff to meet people's needs.

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

The provider was not meeting this standard. We judged that this had a moderate impact

on people using the service and action was needed for this essential standard.

The provider's quality monitoring system was ineffective as this did not regularly assess all the systems that contributed to the quality of service people received.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take. We will check to make sure that this action has been taken.

We have taken enforcement action against Mrs Sandra Smith.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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
We visited The Owls and we spoke to several people. Due to the ageing process and level of memory impairment of people living at the home we observed how people interacted with each other and with staff on duty. Some people were no longer able to use words but we were able to observe their care. We saw that staff took the time to use people's preferred names and ask them if they wanted anything. Staff asked people to do things rather than tell them when they required support with personal care.

We observed daily living. Some people in the main lounge were watching television. Others were reading newspapers and magazines. We did not see staff were engaged with people. We arrived at 09:00 and could see that staff were busy. We observed people's care throughout the morning. In the conservatory and quiet lounge area we saw people sleeping for long periods. Staff acknowledged and spoke to some people in passing or if they were assisting them into the dining area for breakfast. Later after lunch staff engaged in some recreational activities with people that involved throwing a ball to one another. We saw how people enjoyed this activity and there was much laughter and more conversation.

A family member of a person living at the home said that their relative was respected by staff. They said they had chosen the home on behalf of their relative as they had

received a warm welcome and said, "Mum's loved and cared for. I know she's happy and I'm happy". The family member said their relative could get distressed when staff were providing personal care but staff treated them with respect at all times and said, "Attention to detail and care is so good. If she spills a drink or gets her meals on herself she's changed immediately. Mum likes to look nice and always does". The family member said that their relative could make themself understood when they did not want to do some thing and that staff respected their choice. They said, "She's nearly 90 and tired and doesn't want to do much. I have asked that she doesn't join in the activities. She doesn't wants to and staff say she gets more agitated. Staff know her well".

Other evidence
We looked at personal records of four people who had lived at the home, referred to as pathway tracking. This is a method we use to look at how people were involved in their admission to the home and how they were cared for. It helped us establish if people's admission was the right option for them and their care and support matched their wishes and expectations.

We looked at the information gathered about the needs of one person that had recently moved into the home. The home had not completed the form they use to gather information from people about their needs. We could not see the person had been involved in their decision to move to the home. We saw that due to the person's restricted capacity to consent to their care and treatment the home had involved their relative in agreeing to the person moving to the home but had not highlighted the person's lack of capacity. There was a care and support plan in place but we could not see that the person had been involved in this. This meant that the home had not sought a relative or advocate to act for or supported the person to agree to their plan of care. The provider may find it useful to note that seeking support from relatives, advocates or professionals where people lack capacity gives then an opportunity to make decisions about how they want their care to be provided to them.

The deputy manager told us that there were no regular meetings held at the home which involved people living there. This was said to be due to the age and level of memory impairment of the people living at the home. We saw that the home used questionnaires for relatives, visitors and visiting professionals to comment on the quality of care that people received at the home. We saw that relatives and a professional visitor to the home had made positive comments about the quality of care that people received.

Our judgement
The provider was meeting this standard. People who used the service were able to influence decisions about their care and support. Their privacy, dignity and independence were respected.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
When we arrived at the home we spoke to several people and a relative. People engaged in conversation with us where possible and a relative provided a balanced view of their experience of the care and support their family member received. We spoke to as many people as possible as well as staff working at the home. To make sure their views were represented fairly we made observations of their care and their care records. Where people did not use words we saw that they smiled, waved, shook and nodded their head or gave a thumbs up to give an answer when we spoke to them.

We found that people who were mobile and able to express their views experienced good interactions from staff. Staff spoke to them respectfully, communicated well and appropriately, and offered assistance when needed. Some people had no interaction with staff as they were asleep or sat very quiet.

We spoke to a relative, district nurse, community mental health nurse and social worker about access to health care. A relative said they were involved in their family members reviews of care with health professionals and at the home. They said that the home was good at making them aware of any health problems their family member had and that the community mental health services were actively involved in monitoring their family member's care.

Other evidence

Information gathered about the health needs of people was not always consistent. We looked at four care and support plans of people living at the home. Information was gathered about the nutritional, mobility and safety needs of people. This included information to identify if people were at risk of falling, malnutrition or developing pressure ulcers. Some information was gathered by staff at the home visiting the person at hospital before they moved to the home. Staff had made no record of this or of other important supplied at the discharge meeting. This meant that information provided by the hospital was not followed up so important information about the person's needs was missed.

We saw that there were inconsistencies in information provided about prescribed medicines. This meant that the home did not have the correct medicines for a person who was prescribed anticoagulant therapy and pain relief medication. The discharge information identified the person needed to have regular blood tests so their anticoagulant therapy could be monitored. The home had followed this up to see if the dosages they were given at discharge were correct but had not recorded the information on the person's medicine administration record or care plan. This meant that the information was not available to staff to ensure they were given the correct dose of medicines. Information about the person's pain relief had been provided on discharge but the information could not be found so the home was unsure when the medication needed to be renewed. The person in charge had to be advised to follow this information up.

Care and treatment was not planned and delivered in a way that ensured people's safety and welfare. We saw that care plans were incomplete. One person's pre admission assessment had not been completed when they were recently admitted to the home. Care and support plans had been drawn up for people so staff had some guidance on providing care to these people. However care and support plans were not completed for all the identified needs of people. For example there were care plans in place to monitor and manage people's mental health need but these lacked guidance and detail in managing people's individual needs. We saw care and support plans that identified where people needed support to maintain their oral hygiene, assistance with personal care and mobility but the reviews of these did not say if outcomes for people were being met. Monthly reviews recorded 'continue as above'. This meant that person centred care was not being planned in a way that included people in the decision making process about their care.

We spoke to the district nurse visiting the home. They said they were one of three district nurses visiting the home and over the last year relationships with the home had improved. They said there was also a twighlight service that the home used or contacted for advice ad guidance. They said due to the proactive approach of staff at the home the monitoring and treatment of skin tears had improved and their visits to the home had reduced. They said that this was due to training the staff had from the district nurses. Staff had been shown how to use first aid to treat skin tears. They said they had taken wound dressings (non medical) into the home and showed staff how to apply these with the correct pressure. This mane that if a skin tear happened staff knew how to apply pressure correctly and dress the wound. So appropriate first aid was used. They said, "The staff know now how to apply good first aid practice to skin tears. They (skin tears) are treated sooner so heal quickly. We just monitor their progress through staff. This has vastly improved". They said due to this approach the numbers of people they were visiting at the home had reduced. The district nurse said that staff always

sought advice if they were concerned about the health of people living at the home and used the service appropriately. They said they thought that people living at the home had a good standard of care and said, "I have a lot of confidence in the care resident's receive. We visit here twice a week and have a two hour window. We see staff spending time with residents. There's regular activities, ball games, reading newspapers and talking. Most of these residents here don't have capacity to make complex decisions from my point of view. They have fluctuating capacity but will say what they like. They tell me the foods always good. They always seem happy and smile".

We spoke to a social worker and community mental health nurse from the local community mental health team. They told us that they were involved in the care of several people living at the home and that the home would seek advice and guidance on managing people's mental health. We were told that the owner and deputy manager recently attended the discharge planning meeting of a person they had placed at the home. They said that the home were provided with all relevant information about the needs of the person and they had done a seven day follow up on the first day of our inspection. The social worker and community mental health nurse both said they had confidence in the home to provide care to people living with dementia with support form the relevant community mental health professionals.

Our judgement
The provider was not meeting this essential standard. We judged it had a moderate impact on people using the service and action was needed for this essential standard.

People were not protected against risks associated with their health conditions as information was missing about the health needs of people. This meant care and treatment was not consistently planned and delivered when risks to health were identified or information was missing.

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 observed people in the home were relaxed around staff. They were able to express themselves freely and openly.

Other evidence
We saw staff training records that confirmed all but one staff had completed safeguarding training in the last two years. We saw that there were arrangements made for staff to attend refresher training on safeguarding adults. We saw the home's safeguarding adults' policy. We saw this was updated regularly as the provider used an organisation that updated policies and procedures as guidance and laws changed. The deputy manager had also requested a copy of the revised Blackpool Council safeguarding adults' policy.

We spoke to two staff about their knowledge and understanding of the safeguarding process and they were able to demonstrate they would take the appropriate action to protect people. We saw that a care worker had recognised that a person who had recently moved into the home made reference to their experience of being cared for in an NHS hospital. The person said they experienced poor care and the care worker clarified this and reported their concerns to the deputy manager who said they would make a safeguarding referral.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the

possibility of abuse and prevent abuse from happening.

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

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a major impact on people who use the service.

Our findings

What people who use the service experienced and told us
Many people living at The Owls were unable to directly express their reviews about medicines handling due to a variety of complex needs. We observed that patient support was offered when people needed assistance in taking their medicines.

Other evidence
We saw that the home's medicines policy was available for reference. However, thorough written audits of medicines handling were not completed to check adherence to the homes policy.

We looked at how people's medication needs were considered on admission to the home. We found that appropriate arrangements were not in place in relation to checking and confirming people's current medicines on first admission to the home. For example, care workers had not confirmed when the next dose of a once weekly medication was next needed. Similarly, where people's medicines changed, written confirmation from the prescriber was not promptly sought.

Arrangements for the safe administration of medicines were not consistently adhered to. We saw that on occasion medicines were taken from their original pharmacy labelled containers and placed into a monitored dosage system (MDS). This is also known as 'secondary dispensing' and due to the risks involved is contrary to current good practice guidance. Additionally, we were told that medicines were only normally administered by day staff. This means that where doses of the same medicines are

repeated throughout the day there is a risk they will be given too closely together. This practice also reduces the choice and flexibility in the times that medicines are given.

Appropriate arrangements were not in place in relation to the recording of medicines. We found errors in the medicines administration records that meant it was not possible to tell whether medicines had been administered as prescribed. Some handwritten records were not fully dated to include the month and year. Records were not completed to show the use of prescribed nutritional supplements. Controlled drugs handling was not consistently recorded in the controlled drugs register.

Our judgement
The provider was not meeting this standard. We judged that this had a major impact on people using the service. Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete.

People were not protected against the risks associated with medicines because arrangements to manage medicines safely were not fully implemented and consistently adhered to.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People we spoke to said that staff were kind and helpful. Words used in reference to staff were, "Angels", "The girls are so lovely" and "They're my friends".

A relative and visiting professional said said that staff were patient and respectful. The visiting professional said that people were cared for "As a family".

Other evidence
We saw evidence from the staff roster that the home had adequate numbers of staff to provide care and support to people living at the home. Care staff were busy providing personal care as well as attending to laundering clothes. Staff were expected to launder, dry and put clothing away. We saw that staff also made and served drinks and served and assisted people with meals. Staff engaged in group activities in the afternoon. Staff did not raise concerns about staffing but from our observations we could see there were long periods of time when people were not engaged by staff and were sleeping. One staff member said that if they did not have to undertake laundry duties they would have more time to spend time in social and recreational activities with people living at the home. They said, "We don't have laundry assistants. The washer is going all day and it takes each of us an hour to do". The provider may find it useful to note that when staff employed to provide personal care were taken away from these duties they were not engaged with people living at the home. This meant that staff were not available to provide recreational and social care as they were involved in domestic duties.

Our judgement
The provider was meeting this essential standard. There were enough qualified and experienced staff to meet people's needs.

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

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
People living at the home did not comment directly on assessing and monitoring the quality of service provision.

Other evidence
The home had a quality assurance system that would have been compliant with the Health and Social Care Act 2008 if it applied to this legislation. The quality assurance system we saw in place referred to the previous regulatory framework The Care Standards Act. The quality assurance system in place was based on monitoring national minimum standards. The quality assurance system would have been useful if it had been used. We saw evidence that the manager monitored some areas of the quality of care delivered in the home. We identified concerns with the process for gathering and following up information about the care and wellbeing of people were risks to their health were identified. See Outcome 4.

The owner had completed some quality assurance audits of accidents in February and March 2012. However the results of the accidents audits was not used to identify if there were areas of the home that were unsafe or if accidents related to risk associated with individuals.
The provider had not completed an audit of medicines as referred to in outcome 9. Care and support plans were audited but this was by the person who was responsible for writing them so there was no objective assessment of the quality of the care and support plans in place. Fire logs were completed and signed for.

We were told the views of the people living at the home were not sought through meetings to discuss the service being provided as people living at the home could not contribute to them due to their memory impairment. We saw that the home used satisfaction surveys which had been completed by family members of people living at the home and visiting professionals. Comments we saw were "All staff are always pleasant. The home clean and tidy. I cannot fault anything about the Owls", "The staff are very good to patients and visitors. They have been very good if I have phoned for information" and "I have found the staff very kind and helpful. Nothing is too much trouble for them". A visiting professional commented, "The staff are helpful and friendly. They are approachable and willing to make changes to improve the care of residents. A really good team who care for 'their' family."

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

The provider's quality monitoring system was ineffective as this did not regularly assess all the systems that contributed to the quality of service people received.

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.

<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 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">How the regulation is not being met:
The provider was not meeting this essential standard. We judged it had a moderate impact on people using the service and action was needed for this essential standard.

People were not protected against risks associated with their health conditions as information was missing about the health needs of people. This meant care and treatment was not consistently planned and delivered when risks to health were identified or information was missing.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 16: Assessing and monitoring the quality of service provision</td></tr>
<tr><td colspan="2">How the regulation is not being met:
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

The provider's quality monitoring system was ineffective as this did not regularly assess all the systems that contributed to the quality of service people received.</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 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

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

Enforcement action we have taken

The table below shows enforcement action we have taken because the service provider is not meeting the essential standards of quality and safety shown below. Where the action is a Warning Notice, a timescale for compliance will also be shown.

Enforcement action taken			
Warning notice This action has been taken in relation to:			
Regulated activity	**Regulation or section of the Act**	**Outcome**	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines	
	How the regulation or section is not being met:	**Registered manager:**	**To be met by:**
	The provider was not meeting this standard. We judged that this had a major impact on people using the service. Where areas of non-compliance have been identified during inspection they are being followed up and we will report on any action when it is complete. People were not protected against the risks associated with medicines because arrangements to manage medicines safely were not fully implemented and consistently adhered to.		29 June 2012

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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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