Review of compliance

Methodist Homes Exning Court	
Region:	East
Location address:	Cotton End Road Exning Newmarket Suffolk CB8 7PF
Type of service:	Domiciliary care service Extra Care housing services
Date of Publication:	December 2011
Overview of the service:	Exning Court is registered for Personal Care. They provide this service only to people living in their own flats within Exning Court.

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

Our current overall judgement

Exning Court was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

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

Outcome 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

During our visit people using the service were positive about the staff and how they were cared for. A relative told us they had helped to write a plan of care when their relative first started to use the service. Another person said they liked the staff and they were "kind and thoughtful".

What we found about the standards we reviewed and how well Exning Court was meeting them

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

The service is non compliant in this outcome area.

The needs of people using the service are not fully considered by the service when deciding upon sufficient staffing levels.

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 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 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 minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People who use the service (or their relatives) were very positive about the staff at Exning Court. One person said they couldn't find fault with the staff, saying, "they are exceptionally good" and "they seem happy working here".

A relative we spoke with said that staff were hard to find but if they needed them they would pull the emergency call cord in the flat to speak with someone.

Other evidence
We visited the service on 27 October 2011 after receiving information which raised concerns about staffing levels. Some of those concerns were being looked into by the local authority and we were unable to comment on them in this review because they were still being investigated. The service is based in Exning Court (sheltered accommodation) and registered to provide "Personal Care" to people living in their own homes.

People can choose to live in sheltered accommodation because it helps maintain independence, with their own flat, but with the added security of care staff being available to provide care and support when it is needed (often called flexible care packages). At Exning Court we found people with various needs including those living with dementia and/or limited mobility.

When we arrived two members of staff were on site. One was in the front hall working on their training with a National Vocational Qualification (NVQ) Assessor. Another was

booking in and organising medication. They told us there were no scheduled visits to people's flats at that time, but if someone pulled their emergency call cord they would visit and find out what they needed. They confirmed staff were available 24 hours a day to respond to emergencies outside of their normal scheduled visits.

The Assistant Housing with Care Manager told us there were no specific times that carers visited people because there had been problems in the past when staff were late because the previous visit or visits had overrun. Staff worked to a "job card" which listed the order of visits. Staff told us that they assisted people flexibly, for example they often went to help with medication, then returned later to help the person to get up when the medication had had time to work.

People living in Exning Court were assessed as needing a minimum of six hours care a week. On this basis rotas showed there were enough staff hours to cover this. However it was not clear how many hours of care were actually being provided. The Assistant Housing with Care Manager told us some people received less than six hours and some had more. No other information was provided about how staffing hours were assessed and monitored against staffing levels.

The local authority told us that during a recent visit, they found records showed some people received less care hours than they had been assessed for. This could have been because they were not needed but may also mean that staff were not spending enough time with people.

Staff told us additional hours were provided for "well being" visits and people could "buy" extra hours for other services. The rota showed that the majority of the time there were two care staff on duty during the day and one at night. The night carer had an 'on call' staff member to contact if they needed help. They told us staff lived nearby and it took around ten minutes for someone to arrive. It was not clear how this level of staffing would cope appropriately with the amount of potential variation of the hours of the care packages. For example, if more than one person, at the same time, required help during the night or at peak times of the day when more people needed care in a short period of time. The "job card" for the night carer showed that there were visits that were important to attend to promptly. One entry said 'As soon as (person) buzzers you must attend as this could be vital". Some of the tasks required on other visits meant they would be unable to leave for an additional visit, for example if they were assisting with a shower and/or personal care. Staff carried a phone that linked to the call system so they were able to advise people how long they may be.

We saw two carers were needed for a visit but it did not appear on both carers "job cards". We were told this then affected one carer's timings for the following scheduled visits.

People living with dementia had flats in one area of Exning Court. We were advised that there was no member of staff allocated solely to this area during shifts. If the people living there chose to go out staff may not have known they had gone. Because Exning Court is not a care home concerns about this did not fall within our remit to review. However, it was not clear if people who used the service, their relatives, staff and others understood the limitations of the service provided in that particular environment.

The Assistant Housing with Care Manager told us that since Exning Court had opened

there had been a decrease in the amount of staff on site. They said that there were still enough care staff to provide the care needed but people remembered there used to be more. They were advertising for two new carers to fill vacant hours.

Our judgement
The service is non compliant in this outcome area.

The needs of people using the service are not fully considered by the service when deciding upon sufficient staffing levels.

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
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The needs of people using the service are not fully considered by the service when deciding upon sufficient staffing levels.	

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.

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA