# Review of compliance

| Barchester Healthcare Homes Limited<br>Lucerne House | |
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| **Region:** | South West |
| **Location address:** | Chudleigh Road<br>Alphington<br>Exeter<br>Devon<br>EX2 8TU |
| **Type of service:** | Care home service with nursing |
| **Date of Publication:** | September 2011 |
| **Overview of the service:** | Lucerne House Care Centre is a purpose-built home providing nursing care a for up to 75 people accommodated in three units - Shillingford, Ide and Alphinbrook. All these areas have communal facilities, and the majority of bedrooms are for single occupancy, all with ensuite facilities. Areas for those people who live in Shillingford, where people with |

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| | dementia are cared for, are secure, for their safety. There are various level-access areas outside with seating and shade. |

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

## Our current overall judgement

**Lucerne House 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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse

## How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 25 July 2011, 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

We carried out this inspection at the request of the coroner under Rule 43 of the Coroner's Rules. The coroner asked us to look at how the risks to people who are assessed as being at risk of choking were being managed. Concerns were also raised with us that safeguarding procedures were not being followed.

We carried out the inspection on Shillingford Unit where people with dementia are cared for. We identified three people who had been assessed as being at risk of choking due to swallowing problems. We read their care records, spoke with them, and/or observed their care over a mealtime period, and talked to staff about their needs.

During our visit the majority of people living here could not speak with us directly. However, we observed staff interacting with people in a kindly, discreet, calm and respectful way. We were told by one person that they enjoy the meals here and we saw people enjoyed their food. We also saw that people had choices about what to eat, including both hot and cold food choices. We saw that the mealtime in the dining room was managed in a skillful way ensuring that all people were attended to and that the experience for people was calm and relaxed. People are receiving a nutritious diet.

We found that staff knew people's needs well. However some records relating to people's

fluid and food intake were not completely accurate and therefore could not always demonstrate that people were receiving the appropriate care. We also found that some plans in place to manage people's risk of choking were not being completely followed, which meant that this risk was not being fully managed. We saw that some people were eating some foods or food and drink combinations which were associated with an increased risk of choking.

We found that people are not fully safeguarded because actions that were to be taken against a member of staff had not been actioned, and locally agreed safeguarding procedures had not been followed.

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

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

Some risks to people's health and welfare are well managed. However, risks to people from choking are not managed adequately enough to ensure their safety.

- We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

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

People are receiving a nutritional diet in a pleasant and calm environment. However, the risks to people from receiving inappropriate foods are not being sufficiently well managed to adequately mitigate these risks.

- We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

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

People may be at risk from being cared for by inappropriate staff if safeguarding procedures are not followed.

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

## 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.

We have taken enforcement action against Barchester Healthcare Homes Limited.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

## Other information

Please see previous reports for more information about previous reviews.

# What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

**Compliant** means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

# Outcome 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 major concerns with Outcome 04: Care and welfare of people who use services

**Our findings**

**What people who use the service experienced and told us**
We found from people's records and other sources that they had received appropriate care. We met with one person who was being cared for in bed. Records and staff told us that this decision had been made because this person had developed two areas of pressure damage whilst sitting in their chair. We saw that pressure relieving equipment was in place and we saw records showing that this person was being repositioned in bed to relieve the pressure on different areas of their body.

However, records also indicated a risk that people would not always receive required care or receive this in a timely way. Records stated that this person had a dressing. However, there was no specific care plan relating to this, as there should be. We saw this person being sat up for their meal whilst we were in the home. Yet records suggested that this person was not always put into sitting position for their meals, as they should be according to their care plan to help prevent choking. We saw that on one occasion staff completed the repositioning chart before they had taken this action.

We found that the majority of people's needs are well known, and are met by staff. For example, staff told us about one person's needs and clearly knew this person and their needs well. Care records show that staff had asked the doctor to visit due to a change in the person's behaviour which they recognised might be because the person was in pain. Accurate records had been kept in relation to this. We also saw that this person had recently had an eye test, which would help to ensure that their communication needs weren't unnecessarily affected by sight difficulties. We noted that their call bell was not within their reach.  Staff explained that this person was unable to use the call

bell to call for help, so they checked on them every 15 minutes. Whilst we visited this person, we saw that staff looked in at regular intervals.

Records showed that this person had been assessed as being at high risk of choking or aspirating. We saw records showing that this person had been assessed by the Speech and language therapist (SLT) on two occasions, who had provided advice on how to manage this risk. Part of the management plan was that this person should have a mousse diet and thickened fluids. We saw that these actions were being taken by staff to help reduce the risk of this person choking.

Another person was assessed as being at high risk of choking and we saw that they were being supported to eat and drink. Staff were sensitive, kindly and discreet. We read the detailed care plan written by the SLT. We saw that whilst staff followed the majority of this plan, they also supported this person to have a drink whilst they were eating, which, according to the plan, they should not do. The plan also said that this person should not lie down for up to 30 minutes after eating. Staff told us that this person had been lying down in bed watching television within 20 minutes after eating. We spoke with a member of nursing staff and with a member of care staff about this person's plan of care. They said they were not aware that the person should not have a drink whilst eating, although this information was written in the care plan.

**Other evidence**
Staff told us that they had received training from the Speech and Language Therapist in relation to supporting people with swallowing difficulties to eat.

**Our judgement**
Some risks to people's health and welfare are well managed. However, risks to people from choking are not managed adequately enough to ensure their safety.

- We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

# Outcome 05:
# Meeting nutritional needs

## What the outcome says

This is what people who use services should expect.

People who use services:
* Are supported to have adequate nutrition and hydration.

## What we found

**Our judgement**

There are major concerns with Outcome 05: Meeting nutritional needs

**Our findings**

**What people who use the service experienced and told us**
We saw that meal times for people with dementia are well managed. We observed the tea time meal taking place and saw that people could eat where they chose. If people moved from one place to another whilst eating, staff ensured that they moved their food. When some people became distracted whilst eating, staff kindly and discreetly refocused their attention, providing additional support when needed. Staff showed skill at managing potentially disruptive situations and interruptions created by people, with ease and skill.

People eating in the dining room were observed throughout the meal time by staff. Where people were disinterested in their food, alternatives were offered and staff were very attentive and watchful to this. We could see that the effect of this was that people were being encouraged and supported to eat, and were having their nutritional needs met. People appeared to be enjoying their meal.

We saw from records that people had their weight recorded and that action was taken when people were noted to be losing weight. However, we also saw that one person had continued to lose weight over a two month period. This person's nutritional management plan had not been altered to show this increased risk.

We asked staff how they support people to choose what they want to eat. Staff told us that there were plans to have pictures of meals for people to choose from and that currently people chose from plated options. We saw that one person was not offered a choice for their savoury course but was shown the plated options for pudding.

We found that records relating to meeting people's hydration needs were not robust enough to ensure that people are having sufficient to drink. For example, we saw that one person was to be encouraged to drink 1500mls per day and that this person would need staff to support them to achieve this. We saw charts in the person's room relating to their fluid intake. We saw recorded on a chart for the day before our visit that the person had had one drink. Another chart relating to another day showed that the person had had 1000mls in the four hours up to lunchtime and then had had 100mls in the rest of the day. There was no indication on these records to show that the person had been offered drinks and refused them. We saw staff support this person with drinking on one occasion, but they did not complete the chart in the person's room to show how much this person had drunk. We asked a member of staff how often this person should be offered a drink. They told us this should be done at each meal, between those meals in the morning and afternoon, and by the night staff. This frequency was not reflected in the intake charts.

Staff showed us records for those people who were supported to drink and eat which were kept in the dining room. These records were clearer as they showed how much food and drink the person had been offered and how much they had actually taken.

Records that we saw did not include an evaluation as to whether the person had had sufficient to eat or drink in a day. A member of staff told us that fluid charts were totalled up so that it could be decided if the person had had enough to drink. However, we did not see these totals on the two fluid charts that we looked at, or in their daily record notes.

**Other evidence**
Staff told us that they would not give sandwiches to anyone who had been assessed as having swallowing difficulties. However, we saw that one person who had been assessed as being at medium risk of choking was eating sandwiches at tea time. We also met with one person who had been assessed as being at high risk of choking, and who had been assessed by the Speech and Language Therapist (SLT). The management plan, written by the SLT, included a list of foods that this person should not have. We looked at daily records and saw that staff were recording that this person was having foods that appeared to be of the type they should not eat. We checked with the SLT after this inspection, who confirmed that this person was receiving some foods that they should not have, thus increasing the risk that this person might choke.

**Our judgement**
People are receiving a nutritional diet in a pleasant and calm environment. However, the risks to people from receiving inappropriate foods are not being sufficiently well managed to adequately mitigate these risks.

- We have taken enforcement action against the provider for this essential standard to protect the safety and welfare of people who use this service.

# Outcome 07:
# Safeguarding people who use services from abuse

## What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

## What we found

**Our judgement**

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

**Our findings**

**What people who use the service experienced and told us**
We saw that people were comfortable and relaxed in the company of staff. Staff told us that if they suspected abuse that they would report this. They said they were confident that the nurse or manager would take action.

**Other evidence**
We received concerns that a member of staff had been dismissed from Lucerne House for safeguarding reasons. The manager explained that this person was dismissed for performance management issues. However, the dismissal letter, stated that the person would be referred to the Independent Safeguarding Authority (ISA) and another agency on the basis of allegations made against them. A referral to ISA usually indicates that the referrer considers that the person should not be allowed to work with vulnerable adults. The manager told us that these referrals had not been made. In addition, we were told that a referral had not been made to the local safeguarding team, as it should be if there are allegations of abuse or neglect. This means that there is confusion about the nature of the issues relating to this member of staff, and confusion about what safeguarding processes should be followed.

**Our judgement**
People may be at risk from being cared for by inappropriate staff if safeguarding procedures are not followed.

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

# 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 11 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 07: Safeguarding people who use services from abuse |
| | **How the regulation is not being met:**<br>People may be at risk from being cared for by inappropriate staff if locally agreed safeguarding procedures are not being followed. | |

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 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.

## 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<br>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 9 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 04: Care and welfare of people who use services | |
| | **How the regulation or section is not being met:** | **Registered manager:** | **To be met by:** |
| | Risks to people from choking are not managed adequately enough to ensure their safety. | Paul Courtney | 18 August 2011 |

| Enforcement action taken | | | |
|---|---|---|---|
| Warning notice<br>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 14 HSCA 2008 (Regulated Activities) Regulations 2010 | Outcome 05: Meeting nutritional needs | |
| | **How the regulation or section is not being met:** | **Registered manager:** | **To be met by:** |
| | The risks to people from receiving inappropriate foods are not being sufficiently well managed to adequately mitigate these risks. | Paul Courtney | 18 August 2011 |

# 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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