Review of compliance

Barchester Healthcare Homes Limited Lucerne House	
Region:	South West
Location address:	Chudleigh Road Alphington Exeter Devon EX2 8TU
Type of service:	Care home service with nursing
Date of Publication:	October 2011
Overview of the service:	Lucerne House Care Centre is a purpose-built home providing nursing care 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 having en suite facilities. Areas for those people

	who live in Shillingford, where people with 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. 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 to check whether Lucerne House had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 23 September 2011, observed how people were being cared for, looked at records of people who use services and talked to staff.

What people told us

We carried out this unannounced inspection visit to check on the service's compliance with two warning notices that we had issued in August 2011. The notices were issued following a visit we made, on 25 July 2011, at the request of the coroner under Rule 43 of the Coroner's Rules. The coroner had asked us to look at how the risks to people who were assessed to be at risk of choking were being managed. When we did this, we found that they were not being managed sufficiently to ensure people's safety, and so we issued notices requiring the service to take prompt action to address these risks.

On this visit, we looked at the support given to five people who staff had assessed as being at high risk of choking because of swallowing difficulties they had. These difficulties were due to a range of causes. The people lived on 'Shillingford' or 'Ide', the two units for older adults. We met them and, in some cases, their visiting relatives. We observed the support they received over a mealtime, looked at their care records, and spoke with staff who supported them.

Some people living at the home had various communication needs and were thus not able to give us their views directly. We observed staff interacting with people in a kindly, patient, calm and respectful way. When we asked one person what they thought of the food provided, they said they liked it and the quantity was right for them. We saw people were served good sized portions. Most people appeared to enjoy their food, and were offered 'seconds' as well as more to drink.

We saw that the mealtime was managed in a skilful way, ensuring that all people were attended to and that people were not rushed by staff supporting them to eat or drink.

Two visitors we met said they knew about the risk to their relative of choking. One told us they had no concerns and considered the care to be "very good indeed".

We found that staff knew who was at high risk of choking. They could describe the individualised support required by the people we followed up, to reduce their risk of choking when eating or drinking. We saw they provided the required support, to promote people's safety. Daily records reflected that people were given appropriate foods as indicated by advice from a Speech and Language Therapist, to avoid causing choking.

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

Identified risks to people from choking are comprehensively managed by the service, promoting individuals' safety.
On the basis of the evidence provided, we found the service to be compliant with the warning notice.
· Overall, we found that Lucerne House was meeting this essential standard.

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

People receive a nutritious diet, in a pleasant environment, with action taken to ensure food provided is appropriate for their individual needs.
On the basis of the evidence provided we found the service to be compliant with the warning notice.
· Overall, we found that Lucerne House was meeting this essential standard.

Other information

In a previous review, we found that improvements were needed for the following essential standards:

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

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

The provider is compliant 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 on our visit on 25 July 2011 that some plans for managing individuals' risk of choking were not being completely followed, which meant that this risk was not being fully managed. On this visit we found improvements had been made such that choking risks to individuals were being managed in various ways, promoting their safety and wellbeing.

Staff we spoke with knew who was at high risk of choking, or had printed information that we saw they referred to when serving food and drink. The information included the level of any risk for each person living on the unit. Staff told us that day to day care was discussed at each shift hand-over and individual diet needs were discussed, with any recent changes to it. They told us the printed information was re-issued every shift if necessary because someone's level of risk had changed – as we found had happened recently on Shillingford. We noted the information sheets had a printed date on so that staff could easily identify the most recent version. We saw this information had also been provided to the home's kitchen staff, who told us how they used it when preparing meals for individuals.

We found people had individualised care plans for managing the risks to them of choking, and staff could describe the support individuals needed whilst eating and after meals if necessary. We saw they provided this support. In one person's case, it was advised that they remain upright for a period of time after their meals, rather than lying down just after they had eaten. The person had dementia, and staff had found the person was unable to understand the advice. Staff we asked knew about this, and how

long the person should remain upright. We saw they encouraged the person in an activity to distract them from going to lie down straight after their meal.

In one person's records, it stated they were to have a drinking beaker without a spout, as part of the plan to minimise a risk of choking and aspiration. We observed there was a spout on the beaker in their room. Senior staff told us staff had perhaps put the lid on to keep the drink warm, but said they would follow this up immediately. In another person's records, the advised use of a drinking beaker was being followed by staff as per the plan.

Some people required a quiet environment when eating, helping them to concentrate on eating by reducing distractions. We saw staff ensured this – such as by turning off a television in one dining area, and senior staff ensuring that care workers did not call across the dining room to each other.

We spoke with the relatives of two people who were at high risk of choking, and found that they knew about this risk. One, who visits very frequently, also said they had never witnessed the person choke whilst at the home, and confirmed that the person's drinks were always thickened, as indicated in their care plan. This relative told us they had no concerns and considered the care provided to be "very good indeed".

We spoke with a visiting GP and a member of the Speech & Language Therapy (SLT) Team. One told us they had noted the home had tightened up on protocols and care plans since our last visit - such as improving the 'choking risk' form used during meal times, with relevant information made more obvious. They added that there was a consistent staff group, which would promote consistent care for individuals.

The other thought the staff were "very good indeed" and that they "carry out information to the letter". They thought communication had been improved since our last visit. This was also reflected by two nurses we spoke with, who identified it as a previous issue. They said SLT recommendations and other communications were now passed on promptly from the home's main office and so on. We saw a letter from the SLT about one person. It included that their medicines should be changed and now given in syrup form. We saw from records that had been followed up quickly by the home.

There was evidence that any inconsistencies in information for staff were now being looked for, such as regarding information provided by the SLT Team and dieticians. Staff also told us that the manager had started audits, which included visiting the units, to check staff had relevant information available and that they were using it.

Other evidence
One person we met was having fluid provided through an infusion, to ensure they received enough fluids to maintain their health and wellbeing. Good records were in place, showing how much fluid people had when they were at risk of dehydration.

Relevant training and updates for all staff were being rolled out across the home, which included training by the local SLT Team. Training records we read included training for ancillary staff. We were told that all staff had had first aid training which included what to do if someone choked, and staff records we sampled reflected this. The home had a training dummy which can be used for this training specifically.

Staff we spoke with were able to describe signs of choking and aspiration, as well as what they would do to help someone in such a situation. The home's trainer told us that no staff assisted with feeding until they had had training on how to feed people safely, and how to react if somebody chokes.

The induction programme for new staff included aspiration and choking. We spoke with a new staff member who confirmed this. They also had detailed knowledge of people they could be supporting, including any choking risks. We saw they were accompanied at all times by other staff whenever they provided support to individuals, including at the mealtime.

We were told that each staff member had a development plan. This plan might, for example, identify that a staff member lacked confidence in providing certain care or support and how this was to be addressed. When we asked senior staff about formal or recorded one to one supervision of staff, they said this was the responsibility of unit managers, although it had not been audited to confirm it was being provided. A care worker we asked about such supervision told us they had not received this for over six months. Thus it was not clear that any staff performance issues would be followed up in a timely and evidenced manner. The manager told us about group supervision sessions held earlier in the year, but confirmed some supervision had lapsed. He said he would address this.

Our judgement
Identified risks to people from choking are comprehensively managed by the service, promoting individuals' safety.
On the basis of the evidence provided, we found the service to be compliant with the warning notice.
· Overall, we found that Lucerne House was meeting this essential standard.

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

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
We found on our last visit that some people were being given some foods or food and drink combinations which were associated with an increased risk of choking.

On this visit, we found assessments by Speech & Language Therapists (SLT) in all but one person's care records. Each had a clear, related care plan and a list of foods. The list described foods that should be avoided to reduce the risk of choking, and guidance about when drinks should or should not be given during the meal. The information for one particular person was available in the dining room on one of the units. We saw staff took it with them when they went to support the person, checking it before assisting the person with their meal.

In one case, staff had sought clarification from the Dietician service that was also supporting the person, to ensure recommendations from both services were appropriate in this particular person's case. Records for one person stated they were to have thickened fluids and 'comfort feeding only'. We discussed with the registered manager that we found a lack of consistency, among staff we spoke with, as to what 'comfort foods' were in practice, for this person.

One plan we read gave the reasons behind the support staff were to provide, clarifying the importance of such action for this particular person. Staff explained this to us, and we saw they provided this support at the mealtime. We also saw they provided other people with appropriate food, as indicated in their care plans. This included withholding drinks during the meal where this was part of the person's care plan to avoid mixing fluid and food, where this was an identified choking risk for an individual.

Meals, including pureed meals, were served attractively and in good sized portions. People were able to take their time, and were not prevented from leaving the table if they chose to during their meal. Senior care workers in the dining room coordinated mealtime activities, which included meals taken on trays to people's rooms. Other staff had the role of monitoring that each person had their full meal, and we saw this was achieved even though this meant the mealtime lasted two hours.

We heard staff checking with people if their meal was satisfactory when they were first offered it and again as they ate it. We saw them look at people's body language also, to determine their views if the person did not express a clear view. When someone did not continue with their meal, staff noticed this and offered them an alternative, which they accepted.

We saw that most people had choices about what to eat, including both hot and cold food choices, and drink. However, we also noted that some people who required a pureed diet were going to be given pureed minced meat for both lunch and tea. Kitchen staff told us this was because it was difficult to puree fish - the other lunchtime meal option - for various reasons. The manager has since told us that he has sought advice on how fish can be made part of a pureed diet, so that people can benefit from more variety.

People's care records included risk assessments for malnutrition. Staff had reviewed these regularly, with changes made to their care plans according to the level of risk identified. We saw evidence that staff generally followed the detailed care plans for people who were losing weight - providing the support indicated, monitoring their weight regularly and so on. However, we noted that one person was not always given two supplement drinks daily as advised by their GP, without a record to explain this.

We saw from their food intake records and during our visit that they sometimes refused to eat a meal. On their admission to the home, it had been recorded that they had lots of foods they disliked, but their dietary likes/dislikes had not subsequently been obtained. After we asked staff about this, they consulted the person's visiting relative to get such information, which could help in encouraging the person to eat and improve their weight.

The person's care records also showed that staff had made a referral in recent weeks to the SLT, because they had noted the person was still losing weight and was beginning to cough when eating – which can be a sign of swallowing difficulties.

Other evidence
Information about different types of diets - such as pureed, soft, and high risk foods - was clearly displayed. A document called 'Plan of care for assessed needs', was also available, which was 'to minimise risk of choking and aspiration'. We were told that this was updated daily, highlighting the level of any choking risk for each person. We saw this in the dining rooms during lunch and it was referred to by different care workers. We noted the SLT advice about one person's support needs was also displayed in their bedroom.

Training had taken place since our last visit about a malnutrition risk assessment tool used in the home, and the use of nutritional supplements.

Our judgement
People receive a nutritious diet, in a pleasant environment, with action taken to ensure food provided is appropriate for their individual needs.
On the basis of the evidence provided we found the service to be compliant with the warning notice.
· Overall, we found that Lucerne House was meeting this essential standard.

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
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