Review of compliance

MacIntyre Care Hubbard Close	
Region:	East
Location address:	15 Hubbard Close Flitwick Bedfordshire MK45 1XL
Type of service:	Care home service without nursing
Date of Publication:	January 2012
Overview of the service:	15 Hubbard Close provides a service for up to five adults with a learning disability. It is registered for the regulated activity of: Accommodation for persons who require nursing or personal care. It currently does not provide nursing care.

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

Our current overall judgement

Hubbard Close 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 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 19 December 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

One of the people who spoke with us said that they liked the staff as they helped him to do things for himself. They said, "I love living here, the staff help me with all sorts of things". Another said that they liked living there and that the staff were kind. One person told us that they looked after their own medicines with a bit of staff support.

We observed staff supporting people in a kind and sensitive way. There was good communication between staff and people living in the home.
During our visit we heard people living in the home telling one of the people to, "Shut up" and to, "Be quiet".

What we found about the standards we reviewed and how well Hubbard Close 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 is compliant with this outcome. People are encouraged to maintain their independence and to be involved in planning their care. People are treated with dignity and respect.

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

The provider is not compliant with this outcome. Improvements are needed. Staff require

additional support and guidance to safely meet the needs of one person living at the home and whose needs have recently changed. This has impacted on their ability to care in a safe and appropriate manner for all people at the home.

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

The provider is not compliant with this outcome. Improvements are needed.
People are not sufficiently safeguarded from the risk of abuse or harm.

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

The provider is not compliant with this outcome. Improvements are needed. People are at risk from the lack of clear records relating to the administration of medicines.

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

The provider is not compliant with this outcome. Improvements are needed. The staffing levels are not adequate to meet the needs of the people living in the home.

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 is not compliant with this outcome. Improvements are needed. The provider has not effectively identified the current concerns, nor taken action to address them.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

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

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
One of the people who spoke with us said that they liked the staff as they helped him to do things for himself.

We observed staff supporting people in a kind and respectful way.

Other evidence
During our discussions with staff they were clear about the importance of encouraging people living in the home to be as independent as possible. They described the ways in which people were able to maintain their independence and skills.

The care records showed evidence of people having been involved in the reviews of their care plans and of their individual choices and preferences having been taken into account.

Regular house meetings took place and people were encouraged to take part and to share their views about issues affecting them and the running of the house.

Our judgement
The provider is compliant with this outcome. People are encouraged to maintain their

independence and to be involved in planning their care. People are treated with dignity and respect.

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
One of the people living in the home told us, "I love living here, the staff help me with all sorts of things". Another said that they liked living there and that the staff were kind.

We observed staff supporting people in a kind and respectful way. Staff were providing 1:1 support to one of the people living in the home and they did this in a very patient way, explaining what they were doing many times.

Other evidence
People told us about a range of activities that they took part in, including attending a day service, going out for bike rides, making videos, shopping and other leisure activities.

Some people went out independently and there were arrangements in place to manage any risks associated with this. There was a car available for the use of people living in the home but staff said that there were only approximately half the staff team who were able to drive.

In recent months the needs of one of the people living in the home had rapidly increased due to increasing frailty and other health problems. This had led to the development of behaviours which the other people living in the home were finding difficult to cope with.

One person told us that they did not like the noise and did not want to be in the same

room. We saw from the care records that another person was spending a lot of time in their bedroom as they did not want to be in the lounge. Another person had said in a house meeting that they did not want to be in the house with the other person.

During our visit we observed the impact that the person was having on other people in the house. The staff worked hard to support everyone and to minimise the effects on the other people but this was difficult to do.

We spoke to staff about the situation and they described the ways in which they were providing support to the individual and to the other people living in the home. They said that there were two members of staff on duty during the day and so they offered other people the opportunity to go out.

Staff said that they had received some training with regard to supporting people living with dementia but that they felt that they needed more support to ensure that they were supporting the person appropriately.

We looked at two of the care records. These were written in a very person centred way and provided a lot of information about how to meet people's needs. There was evidence to show that people were involved in the reviews of their care plans and that they had been consulted with regard to their personal preferences and choices.

One of the care records that we looked at was for the person whose needs had increased recently. There was evidence that referrals had been made to appropriate health professionals and that advice had been provided with regard to their changing needs. However, the care plans had not been reviewed or updated since March 2011 and did not reflect the current needs of the person. Therefore, there were no written guidelines available for staff to follow.

The format used for the daily notes did not provide sufficient space for staff to record what had taken place over night and so the records were being kept on two different formats. This meant that the records were not consecutive and made it more difficult to review what care had been provided to the person.

The manager was not present during our visit to the home on 19 December 2011 but we spoke to her in the days following the visit. She said that she was qualified to provide moving and handling training and that she would be providing this to all staff due to one person's increasing needs with regard to mobility.

There were no waking night staff at the home, instead, staff provided sleep in cover overnight. This was usually preceded by them doing a late shift and then an early shift the next morning. We spoke to staff and they all said that, due to the needs of one person, staff were not able to sleep at night. The person concerned had a sensor mat by their bed to alert staff when they got up during the night. However, the daily notes showed that there had been several nights recently when they had been up for most of the night.

Staff said that they were able to go home in the morning if they had been up during the night if the manager could find alternative staff cover, although on the day of our visit the member of staff did not finish work until 3pm despite having been up for most of the night.

We were so concerned about this situation that we contacted the area manager for the organisation as soon as we left the house to tell her of our concerns.

Our judgement
The provider is not compliant with this outcome. Improvements are needed. Staff require additional support and guidance to safely meet the needs of one person living at the home and whose needs have recently changed. This has impacted on their ability to care in a safe and appropriate manner for all people at the home.

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
Two people told us that they like living at the home and that they like the staff. During our visit we heard people living in the home telling one of the people to, "Shut up" and to, "Be quiet".

Other evidence
Staff who spoke with us were clear about the procedure to follow if they had any concerns about a safeguarding issue. They said that they had confidence in the manager and area manager to take appropriate action if they raised concerns with them. Staff said that they had received safeguarding training.

During our visit we saw an incident record that stated that one of the people living in the home had hit another of the people. This had not been referred to the local authority safeguarding team. We spoke to the manager about this following our visit and she said that she had spoken to staff and that this had not actually taken place.

During our visit we heard people living in the home complain about the behaviour of one of the people, as well as telling them to be quiet. We also saw evidence within the records that showed that people were unhappy about the current situation within the home.

The mobility needs of one of the people living in the home had greatly increased recently and they required staff support to move around. They were at risk of falls as they tried to move around without staff support. The care plans and risk assessments

for this person had not been reviewed or updated. The provision of only a sleep in member of staff at night meant that staff were reliant on the sensor mat in the bedroom to alert them that the person was up.

We were so concerned about this situation that we contacted the area manager for the organisation as soon as we left the house to tell her of our concerns.

Our judgement
The provider is not compliant with this outcome. Improvements are needed.
People are not sufficiently safeguarded from the risk of abuse or harm.

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

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
One person told us that they looked after their own medicines with a bit of staff support.

Other evidence
During our visit we looked at the arrangements in place for the management of medicines. Staff told us that there was PRN (as required) medicine available for the person whose needs had increased. On the day of our visit the doctor had prescribed additional medicine to be taken twice a day. The medication administration record (MAR chart) did not include the times of day when the medicine should be taken and the staff did not know what these were. We found that the records were not clear and the staff did not know whether they were now able to administer the PRN medicine, if needed, in addition to the recently prescribed medicine.

We were so concerned about this situation that we contacted the area manager for the organisation as soon as we left the house to tell her of our concerns.

Our judgement
The provider is not compliant with this outcome. Improvements are needed. People are at risk from the lack of clear records relating to the administration of medicines.

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 moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us that they liked the staff. We observed good communication between staff and people living in the home. Staff supported people in a kind and sensitive manner.

Other evidence
Staff told us that, prior to one person's needs increasing recently, the people living in the home were quite independent in a lot of areas of their lives. They said that there were now two staff on duty during the day so that all of the people living in the home were able to be supported.

At night there was only a sleep in member of staff and staff said that this was not currently sufficient as one person was needing support throughout the night. We looked at the care records for this person and this confirmed this situation. Whilst the person was not requiring additional support every night it was not possible for staff to predict when this may happen. Therefore, there had been occasions when staff had worked a late shift, a sleep in and then a morning shift which meant that they were awake and providing support to people for 24 hours.

The staff we spoke with were very concerned about the person whose needs had increased and were very keen to ensure that their needs were met. They were aware of the impact that this was having on the other people and were concerned about this.

We were so concerned about this situation that we contacted the area manager for the

organisation as soon as we left the house to tell her of our concerns.

Our judgement
The provider is not compliant with this outcome. Improvements are needed. The staffing levels are not adequate to meet the needs of the people living in the home.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

There are major concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
During our visit on 19 December 2011 we did not speak with people about quality assurance measures.

Other evidence
We saw the records of the house meetings that took place. People were encouraged to raise issues and to discuss what they wanted to do over the coming weeks.

We looked at the records of the staff meetings and could see that issues relating to the care of individual people were disused as well as specific staffing issues. The increasing needs of one of the people had been discussed over the last few months.

The provider had a range of audits in place with which to monitor the service. However, these had not identified some areas of serious concern, such as the lack of clear assessment and care planning for one person, the lack of clear guidance to staff about how to meet this person's changing needs and the staffing situation at night.

We spoke to the manager and to the area manager after our visit as we were concerned about the situation within the home. We were assured by both people that action would be taken to immediately address the situation.

Our judgement
The provider is not compliant with this outcome. Improvements are needed. The provider has not effectively identified the current concerns, nor taken action to address

them.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The provider is not compliant with this outcome. Improvements are needed. Staff require additional support and guidance to safely meet the needs of one person living at the home and whose needs have recently changed. This has impacted on their ability to care in a safe and appropriate manner for all people at the home.	
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: The provider is not compliant with this outcome. Improvements are needed. People are not sufficiently safeguarded from the risk of abuse or harm.	
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 is not being met: The provider is not compliant with this outcome. Improvements are needed. People are at risk from the lack of clear records	

	relating to the administration of medicines.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: The provider is not compliant with this outcome. Improvements are needed. The staffing levels are not adequate to meet the needs of the people livening in the home.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The provider is not compliant with this outcome. Improvements are needed. The provider has not effectively identified the current concerns, nor taken action to address them.	

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 7 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	Copyright © (2010) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.

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