Review of compliance

Community Integrated Care (CIC) Linda Grove	
Region:	South East
Location address:	17a Linda Grove Cowplain Waterlooville Hampshire PO8 8UX
Type of service:	Care home service without nursing
Date of Publication:	November 2011
Overview of the service:	Linda Grove provides care and accommodation to two people who have a learning disability.

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

Our current overall judgement

Linda Grove 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 October 2011, carried out a visit on 20 October 2011, observed how people were being cared for and talked to staff.

What people told us

We did not, on this occasion, seek the views of people who use the service.

What we found about the standards we reviewed and how well Linda Grove 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

Staff spoke about people in a way that showed they cared about them. However, some of their actions did not always demonstrate they fully respected and involved people in day to day decisions about their care.

On the basis of the evidence provided we found minor concerns with this outcome.

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

Care plans are in place and are kept under regular review, however the information in them is not always accurate. Although staff try to accommodate people's preferences for activities outside of the home, they are not always able to meet their social and spiritual needs.

On the basis of the evidence provided we found minor concerns with this outcome.

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

There are insufficient staff to meet all of the social, leisure and spiritual needs of people who use the service.

On the basis of the evidence provided we found moderate concerns with this outcome.

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

There is not have an effective system in place to monitor the quality of care provided to people who use the service.

On the basis of the evidence provided we found moderate concerns with this outcome.

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 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

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We did not, on this occasion, seek the views of people who use the service.

Other evidence
There was evidence in care plans to show that people and their representatives were involved in the planning of their care. We also saw records showing good relations and communications between family members and staff. However, we did not see any evidence of the service proactively seeking comments from people who use the service and their relatives about the running of the home, for example through meetings or questionnaires.

When we spoke to staff it was clear they had a good understanding of the importance of promoting independence, privacy and dignity, however there were inconsistencies in how they delivered care. There were examples where we saw people being supported to make themselves a drink or their lunch however, we observed that staff would sometimes act without consulting people. For example, on two occasions we saw staff moving someone in their wheelchair without talking to them. We also saw staff putting coats on people, without speaking to them. On another occasion someone was waiting to go out to their morning activity. When we asked which staff member was supporting them we were told by staff that they would decide once another staff

member came on duty. They did not ask the person using the service who they would prefer to support them.

When we talked to staff about offering choices and promoting people's independence we were told that some people living in the home can vocalise their opinions and others would show by their actions. For example, we were told one person would kick off their shoes if they didn't want to wear them. Staff knew people very well and were knowledgeable about their individual preferences, this may mean that on occasions they automatically did things for people without asking them or involving them in the decision. There was no information about how the service monitors the arrangements for involving people in decisions about their every day lives or about the running of the service.

Our judgement
Staff spoke about people in a way that showed they cared about them. However, some of their actions did not always demonstrate they fully respected and involved people in day to day decisions about their care.

On the basis of the evidence provided we found minor concerns with this outcome.

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 minor 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 did not, on this occasion, seek the views of people who use the service.

Other evidence
Care plans we looked at were personalised and detailed. We saw that they had been reviewed in August and September 2011. People's health needs are detailed and issues are followed up, records of GP and other medical appointments are kept.
One person had a communication learning log which described ways in which this person expressed themselves. A section for agreed ways of staff responding was not completed.

People's preferences were recorded in their care plans and with regard to activities, these were put on a weekly activity plan. Each person had two activities each day including Saturdays and Sundays. When we looked at the home's daily records, which they called evaluation sheets, we saw that what was recorded on the activity plan was not always an accurate reflection of what happened. For example two people had expressed a wish to visit their place of worship and this was recorded on their individual weekly activity plan. When we looked at the evaluation sheets we saw that for September and October only one of the people had visited their preferred place of worship twice. The other had not visited theirs during this time period. On most of these occasions it had been recorded on the evaluation sheets there were not enough staff on duty for the activities to take place.

We also saw that another person had a visit to a golf driving range on their weekly

activity sheet, there was no record on the evaluation sheets that they had attended this in September or October. When I asked staff about this, one said they had never taken him to golf because they were not a car driver.

Other staff told us that there was often not enough staff on duty to ensure people's activities could take place. We were also told that there was not always staff on duty who could drive the home's vehicle which also limited people's access to some community activities.

Staff said they made every effort to go out with people, however this often meant everyone, rather than just those who wanted to, going out in the home's vehicle with two staff. Staff told us that one person living in the service did not like going out with the other people living there, but because of staff shortages this often happened.

In terms of care plans we noted there was some confusion with the information recorded in one person's care plan compared with what staff told us about their needs and what we observed. In the care plan it was recorded the person was at risk of choking when eating and drinking. When we discussed this with staff they clarified the issue was the risk of the person pushing themselves backwards on their wheelchair. This was not detailed in the care plan or risk assessment so it was unclear what the exact care and support was that was needed for this person. On two occasions we saw this person left alone in the dining room with food and drink. On the first occasion I asked a staff member who was supporting this person today and they replied "we all are". No individual staff member had been designated to support the person whilst eating and drinking even though their care plan had stated they needed a one to one staff ratio for eating and drinking.

Our judgement
Care plans are in place and are kept under regular review, however the information in them is not always accurate. Although staff try to accommodate people's preferences for activities outside of the home, they are not always able to meet their social and spiritual needs.

On the basis of the evidence provided we found minor concerns with this outcome.

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
We did not, on this occasion, seek the views of people using the service.

Other evidence
Staff told us they had received all of their mandatory training as part of their induction and were responsible for keeping this up to date by accessing the organisation's internet based refresher courses. They said they were allocated time to do this in their normal working hours. We were also told they could request specific training and the organisation was very responsive to their requests.

Staff told us that staffing levels were not always adequate to meet people's social and spiritual needs outside of the home. They said that inside the home people's care needs were met and they were always safe. However, there were occasions when people may have to wait for their care. An example of this is when only two staff are on duty as some people need two members of staff to provide some aspects of their personal care.

We looked at the rotas for an eight week period spanning September to November. On some weeks there were only two staff planned to be on duty for five of the seven days. We saw that rotas were not always arranged to accommodate people's preferences as expressed in their care plans. For example, for one person to attend church it would require three staff on duty and none of the Sundays in the eight week period we looked at had more than two staff on the rota.

There was no evidence to show that the service reviewed or addressed the staffing numbers to ensure they were able to meet the needs of people living there.

Our judgement
There are insufficient staff to meet all of the social, leisure and spiritual needs of people who use the service.

On the basis of the evidence provided we found moderate concerns with this outcome.

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 moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not, on this occasion, seek the views of people using the service.

Other evidence
An audit of the service had been undertaken in August 2011. The manager told us that the results of the audit were incomplete and although all outcome areas were assessed, the home had not received the full information and feed back. We were told that the service manager who had the information had now left the organisation.

This incomplete audit means that the home did not have all the information they needed to improve the quality of the service and could potentially mean people were not receiving the care they needed.

Staff said they attended regular staff meetings where they could influence the agenda and put across their ideas. However, there was no information about how, people who use service, relatives and other representatives were actively encouraged to comment on the service.

Our judgement
There is not have an effective system in place to monitor the quality of care provided to people who use the service.

On the basis of the evidence provided we found moderate concerns with this outcome.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: Staff spoke about people in a way that showed they cared about them. However, some of their actions did not always demonstrate they fully respected and involved people in day to day decisions about their care.	
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
	Why we have concerns: Care plans are in place and are kept under regular review, however the information in them is not always accurate. Although staff try to accommodate people's preferences for activities outside of the home, they are not always able to meet their social and spiritual needs.	

The provider must send CQC a report about how they are going to maintain 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.

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

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 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: There are insufficient staff to meet all of the social, leisure and spiritual needs of people who use the service.	
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: There is not have an effective system in place to monitor the quality of care provided to people who use the service.	

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

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