Review of compliance

Mimosa Healthcare (No 9) Limited Longlands Care Home	
Region:	North East
Location address:	35 Longlands Road Middlesbrough Cleveland TS4 2JS
Type of service:	Care home service without nursing
Date of Publication:	December 2011
Overview of the service:	The Longlands Care Home is a home for people requiring residential care. The home is registered to provide the regulated activity of accommodation for persons who require nursing or personal care for 43 people. The home is situated on the outskirts of central Middlesbrough and is close to shops, pubs and other amenities. The home is a modern, two storey, purpose

	built facility.

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

Our current overall judgement

Longlands Care Home 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 2 November 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

During our visit to Longlands Care Home, we spoke with five people who use the service and two relatives.

One person told us that "I like living here. I could live with my daughters, but I prefer to live here. The staff are all lovely, and that's half the battle."

Another person told us that "One of the problems here is that staff don't spend much time talking to you when they come to answer the buzzer. As soon as they have finished they are off doing something else. I like to chat and they don't seem to have the time". They also told us "The lift being broken has been a problem. I have missed medical appointments, as I can't get downstairs".

Over lunch, people told us "There are things such as bingo going on, if you like that type of thing".

We spoke with a family member who told us "It's smashing here, my mother seems happy here. I can visit whenever I want. There are lots of activities going on. There is a Halloween party happening this Friday".

What we found about the standards we reviewed and how well Longlands Care Home 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

We found that people were not always enabled to make or participate in making decisions relating to their care or treatment. We also saw evidence that practices within the home did not ensure that people using the service were treated with consideration and respect.

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

We found that while there was evidence that the care and welfare needs of people were being met most of the time, this was not consistent. Some of the records we saw did not comprehensively reflect the care needs of the individual.

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

People who use services are largely safeguarded from abuse by the actions taken by the service and the leadership given, to minimise the risks of abuse.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

Overall we found there are appropriate standards of cleanliness and hygiene. We found adequate systems in place to prevent; detect and control the spread of health care associated infection. However to remain compliant in this outcome the flooring in the medication room should be replaced and the room redecorated.

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

We found that the home does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of the appropriate arrangements for the recording, storing, safekeeping and safe administration of medicines.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

We found that whilst the lift is out of order people using the service are not protected against the risks associated with unsafe or unsuitable premises and there have been two instances of this occurring in recent weeks.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

We found that the majority of staff had received mandatory and essential training for their roles, but have not attended Deprivation of Liberties and Mental Capacity Act training. The service supports staff through team meetings. However we found that the frequency of supervisions needed to be increased to meet the recommended frequency of bi-monthly.

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

We found that there are effective systems in place to monitor the quality of the service provided. However, the service needs to develop effective methods for gathering the views of people using the service, their representatives or relatives.

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 moderate concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
A person we spoke with said, "One of the problems here is that staff don't spend much time talking to you when they come to answer the buzzer. As soon as they have finished they are off doing something else. I like to chat and they don't seem to have the time."

One of the relatives we spoke with said "I've had no problem with getting information from the manager and staff here, they tell me about what's happening with my mother" and "I have no concerns. If anything goes wrong, the home will get in touch."

Other evidence
For part of the inspection we observed the care offered to people sitting in the lounge. During this time there were limited interactions with staff, and where staff did speak to people using the service it tended to focus on tasks, such as providing drinks and snacks or attending to people's toileting needs. Staff asked people using the service to wait for assistance, if they were engaged in another task, such as providing tea and coffee. Although one staff member did engage a person in pleasant conversations whilst escorting them into the room.

Over lunch, we observed staff treating people with dignity and respect, and engaging

people in conversation and taking account of people's preferences and wishes.

The home has a nominated dignity champion and has a board displaying information about dignity and respect. The staff we spoke to said that they respected people's dignity and respect by talking to people and asking about their preferences.

We reviewed three people's care records and found that some people had been involved in their reviews of care, which had involved their social workers. However, the records did not show that people had been routinely involved in deciding what should be included in the plans for care or asked to discuss their views on the regular evaluation of the care they were provided.

However, the manager told us that the home is in the process of revising the records of care for each person, to improve them and bring them in line with their corporate standards.

Our judgement
We found that people were not always enabled to make or participate in making decisions relating to their care or treatment. We also saw evidence that practices within the home did not ensure that people using the service were treated with consideration 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 moderate 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 spoke with people over lunch and they told us "There are things such as bingo going on, if you like that type of thing." We spoke to one person during a break in bingo and they told us, "I like it here, I could live with my daughters, but I prefer to live here."

One family member said "It's smashing here, my mother seems happy here. I can visit whenever I want. There are a lot of activities going on. There is a Halloween party happening on Friday."

One person we spoke with said, "The lift being broken has been a problem. I have missed medical appointments, as I can't get downstairs." They also said, "Apart from the problems with the lift I am quite happy here."

Other evidence
During our visit, we observed staff invite some people sitting in the lounge to play bingo, but not everyone got an offer to join in. In particular, the home did not appear to offer those who were less able to communicate verbally the opportunity to participate in activities. The activity schedule included bingo, sweet shop, manicure sessions, hairdressers, church services, exercises, dominos, cake baking and cards.

We observed some people playing bingo and two people getting their nails done. There are two activity coordinators in post. Staff told us that the activity coordinators take some people over to the working men's club or for other outings if the weather is okay. Staff told us that activities are set up and ran by the activity coordinators. Although

other staff will sometime get involved in helping out with activities, they would not normally start or run activities themselves.

The manager told us that people using the service going out on trips had been limited recently due to the problems with the lift not working. These problems had reoccurred despite the lift being regularly serviced and having a contract in place for fixing it.

The manager told us that the home is in the middle of revising the records of care for each person, to improve them and bring them in line with their corporate standards. The new format is more person centred. We looked at three records for people, one of which was in the new format.

Each care record contained physical and social assessments, risk assessments and care plans based on the identified needs of the person. In addition, staff regularly reviewed them. However there were instances in each of the old style records where changes had been identified through evaluation, but had not been reflected in amendments to care plans. There were no records of a life history or important information about a person past. One file did have a space to record this, but staff had recorded in this section that the service was waiting for family input to this. There was no evidence to suggest they had not asked the person or recorded the information they had learnt about the person's life.

Staff told us that the manager and deputy manager initially put together the care records when people start using the service. The senior staff review these seven days later to check for any changes. From then on, the key worker reviews them every month or when care needs change. The key worker makes changes from their own knowledge of working with the person using the service.

The records we looked at did not include plans to maintain or improve people's mental, social or emotional welfare, by inclusion in appropriate daytime activities that were tailored to a persons needs.

The records we looked at showed that there was appropriate involvement of other health professionals to maintain people's health and well-being.

Our judgement
We found that while there was evidence that the care and welfare needs of people were being met most of the time, this was not consistent. Some of the records we saw did not comprehensively reflect the care needs of the individual.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us they felt safe in the service.

Other evidence
The staff we spoke with could describe what they would do if they suspected someone was at risk of abuse. The majority of staff had received training in the safeguarding of vulnerable adults.

The records of care for people using the service we looked all contained a form to give people's consent to use of the their photo and an assessment of people's capacity to make decisions. The purpose of this form is to help staff identify any instances where a person may be deprived of their liberties or may be unable to make their own decisions.

However the fact that these were not completed or had been completed by staff on behalf of people using the service, demonstrated that there is not a good understanding of what the Mental Capacity Act or Deprivation of Liberties meant for people using the service.

Our judgement
People who use services are largely safeguarded from abuse by the actions taken by the service and the leadership given, to minimise the risks of abuse.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
One of the people we spoke with told us "I've no problem with the cleanliness of the home."

Other evidence
During our visit, we walked around each of the floors at Longlands Care Home and observed communal areas. We found that these communal areas were clean and well presented. The home has an infection control champion in place.

However, the flooring of the medication room was worn out and sticky and walls of the room were stained and scuffed. Staff told us that the room was planned for redecoration.

Our judgement
Overall we found there are appropriate standards of cleanliness and hygiene. We found adequate systems in place to prevent; detect and control the spread of health care associated infection. However to remain compliant in this outcome the flooring in the medication room should be replaced and the room redecorated.

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
The people we spoke with did not mention to us how they felt about the way the service handle and manage their medication.

Other evidence
We looked at this outcome following a series of incidents notified to us by the provider. These included administering one person with the wrong dose of medication and an audit of medication showing a discrepancy in the amounts recorded for a person's medication. The Local Authority has also visited the service as part of its commissioning process, and identified additional errors in the administration and management of medication.

Following these incidents the home had put an action plan in place to address the problems. This included a daily audit for four weeks following the incident, which then moved to weekly audits. The manager also checked the competency of staff that administer medication, and had put a sign on the medication cupboard and ordered tabards to remind people that when staff are administering medication they were not be disturbed.

However, on the day of our visit we identified an instance where medication had not been administered as prescribed and records had not been updated to show that a person had taken their medication. We pointed this out, and staff took action to address this.

The home were due to move to a different provider for medication and had planned to ensure staff were trained to use the new system. The manager told us that she had identified problems with the management and administration of boxed medication, and hoped the new provider having more of the medication in blister packs would address this.

Our judgement
We found that the home does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of the appropriate arrangements for the recording, storing, safekeeping and safe administration of medicines.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
One person using the service told us "The lift being broken has been a problem. I have missed medical appointments, as I can't get downstairs."

People told us that a staff member has to help them downstairs, when the lift was out of order. They worried that they would fall down the stairs, but didn't have any option but to do as there were no other means of getting between floors.

One of relatives we spoke with said she was scared to take her mother in the lift in case it broke down again.

Other evidence
Prior to our visit, the provider had notified us that the lift had broken down on 28 October 2011. The service had put arrangements in place to have a temporary kitchen to provide hot drinks for people and set up a temporary smoking room for those people on the first floor.

When we arrived for our visit the manager told us that the lift was repaired on 1 November 2011. However, during our visit the lift broke down again. We observed the impact of this on outcomes for people using the service. The bingo session which was supposed to include both floors, had to be restricted to those living on the ground floor only due to the lift problems.

Our judgement
We found that whilst the lift is out of order people using the service are not protected

against the risks associated with unsafe or unsuitable premises and there have been two instances of this occurring in recent weeks.

Outcome 14:
Supporting staff

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 competent staff.

What we found

Our judgement

There are moderate concerns with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
One of the people we spoke with told us "One of the problems here is that staff don't spend much time talking to you when they come to answer the buzzer. As soon as they have finished they are off doing something else. I like to chat and they don't seem to have the time." They also told us "The staff are ok here; there are enough of them to help me when I need it."

Another person told us "The staff are all lovely, and that's half the battle. "

Other evidence
Records showing that the majority of staff had received mandatory training. Staff also reported that they had access to the training required and were able to identify and ask for additional training, which is appropriate to people using the service.

However, staff had received no specific training in the Mental Capacity Act and Deprivation of Liberties. Staff confirmed that they had no specific training on this, although it may have been covered briefly in other courses, such as dementia care.

One staff member told us that they were supposed to have a minimum of six supervision sessions a year. However, they could not remember the last supervision session they had. Two other staff members said they thought they had supervision every six months and appraisal annually.

The manager told us that due to the identification of errors in the management of medication she had focused supervision sessions on the senior care workers. The

supervision records showed that staff had received regular supervision, but the rates of these had declined significantly since July 2011.

Staff told us that staff meetings are held every couple of months, and notes are printed out and displayed in the staff room. We saw recent notes for meetings of senior care workers, care workers, kitchen staff and domestic staff.

Our judgement
We found that the majority of staff had received mandatory and essential training for their roles, but have not attended Deprivation of Liberties and Mental Capacity Act training. The service supports staff through team meetings. However we found that the frequency of supervisions needed to be increased to meet the recommended frequency of bi-monthly.

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 minor 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 specifically ask people about how well the manager and staff quality assure their practices.

Other evidence
The home has a number of systems in place for monitoring quality. These include audits, for example health and safety, maintenance, personnel, nutrition, infection control and medication.

We saw evidence of reviews on people living at the home, health and safety checks and checks made to the home by both the management and owners. Action plans are in place to address all issues raised by regulators or commissioners.

We asked for a copy of the most recent survey results. The manager told us that they had recently sent out surveys to representatives, family and friends of people using the service, but no one had responded. The previous questionnaire had been completed December 2010, and issues had been fed back to staff via their regular meetings. They are looking at ways to increase feedback from people using the service, and from family and friends. Resident meetings are normally held monthly, although recently some had been cancelled due to problems with the lift being out of order.

Our judgement
We found that there are effective systems in place to monitor the quality of the service provided. However, the service needs to develop effective methods for gathering the

views of people using the service, their representatives or relatives.

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 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	Why we have concerns: Overall we found there are appropriate standards of cleanliness and hygiene. We found adequate systems in place to prevent; detect and control the spread of health care associated infection. However to remain compliant in this outcome the flooring in the medication room should be replaced and the room redecorated.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	Why we have concerns: We found that the majority of staff had received mandatory and essential training for their roles, but have not attended Deprivation of Liberties and Mental Capacity Act training. The service supports staff through team meetings. However we found that the frequency of supervisions needed to be increased to meet the recommended frequency of bi-monthly.	
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
	Why we have concerns: We found that there are effective systems in place to monitor the quality of the service provided. However, to maintain this the service needs to develop effective methods for gathering the views of people using the	

	service, their representatives or relatives.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: We found that people were not always enabled to make or participate in making decisions relating to their care or treatment. We also saw evidence that practices within the home did not ensure that people using the service were treated with consideration and respect.	
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: We found that while there was evidence that the care and welfare needs of people were being met most of the time, this was not consistent. Some of the records we saw did not comprehensively reflect the care needs of the individual.	
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: We found that the home does not fully protect people against the risks associated with the unsafe use and management of medication by means of the making of the appropriate arrangements for the recording, storing, safekeeping and safe administration of	

	medicines.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: We found that whilst the lift is out of order people using the service are not protected against the risks associated with unsafe or unsuitable premises and there have been two instances of this occurring in recent weeks.	

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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