Review of compliance

Southern Cross Care Homes Limited Pitchill House Nursing Home	
Region:	West Midlands
Location address:	Pitchill Salford Priors Evesham Worcestershire WR11 8SN
Type of service:	Care home service with nursing
Date of Publication:	October 2011
Overview of the service:	Pitchill House is a care home registered to provide Accommodation for up to 52 people who require nursing or personal care.

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

Our current overall judgement

Pitchill House Nursing 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 because concerns were identified in relation to:

Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 20 - Notification of other incidents

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 August 2011, checked the provider's records, talked to staff and talked to people who use services.

What people told us

Before we visited the service a relative wrote to us and told us they were concerned about the lack of management. They told us, 'The staff seem to be doing their best but with nobody in charge or taking responsibility I feel that the residents are at risk. Already standards are dropping and I believe that it is only a matter of time before something serious happens.'

There were 43 people living at Pitchill on the day of our visit. We spoke with six people who were using the service and one relative.

People were complimentary about the staff. They told us they were friendly and helpful. One person said they were 'thankful for the companionship' given by staff.

The people we spoke with told us they did not have any concerns, they were satisfied with the service.

We talked with the administrator, two registered nurses and a relief manager.
We had a telephone discussion with the provider's service quality advisor, who was providing cover for the annual leave of the area manager. Before we completed our visit arrangements had been confirmed for a manager to be in the home Monday to Friday with 'on call' provision at weekends.

What we found about the standards we reviewed and how well Pitchill House Nursing Home was meeting them

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

The absence of a manager or deputy manager in the home means staff do not always have access to suitable guidance and support to carry out their duties.

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 has not developed action plans to adress the shortfalls identified during their quality assessment process.

Outcome 20: The service must tell us about important events that affect people's wellbeing, health and safety

The provider is not consistent in telling us about important events that might affect the health, safety and welfare of people using the service at Pitchill to make sure action is taken when needed.

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. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

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

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

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

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

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

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

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

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

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

Outcome 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
In July 2011 a relative of a person living at Pitchill Nursing Home contacted us to share concerns about the absence of the manager and the inconsistent arrangements for relief managers. They said, 'The staff seem to be doing their best but with nobody in charge or taking responsibility I feel that the residents are at risk. Already standards are dropping and I believe that it is only a matter of time before something serious happens.'

We observed that nursing staff spent time in discussion with visiting health professionals such as doctors and social workers as well as delivering nursing care, maintaining records and administering medicines.

We spent time talking to six people who used the service and one of their relatives. People were complimentary about the staff. They told us they were friendly and helpful. One person said they were 'thankful for the companionship' given by staff. The people we spoke with during our visit told us they did not have any concerns, they were satisfied with the service.

Other evidence
The local authority (Warwickshire County Council) told us they were concerned about the absence of an effective management structure. People were complaining that there was no one in charge they could bring their concerns to.

In July 2011 we contacted the area manager to check the management arrangements

in the home. She told us the manager was absent pending an investigation onto concerns about the way the home was managed. We were told managers from other Southern Cross care homes in the area were providing a system of 'relief' cover in the absence of the manager.

However, the actual arrangements for relief managers only provided cover for two days a week.

We made an unannounced visit to Pitchill House on 15 August 2011 and we found there was no manager on duty.

Staff told us the relief managers were only in the home two days every week. For the rest of the week, management support consisted of telephone advice.

This meant that registered nurses had to undertake some management duties. Nursing staff were not allocated supernumerary time 'off the floor' to undertake these duties. Nursing staff told us they were always 'rushed and busy'. One nurse commented, 'It is very stressful dealing with the other things that go on while trying to look after my patients, although the relief managers are available by phone and respond quickly.'

When an adverse event occurred in the home, there was not often a manager present to deal with it. For example, a 'whistleblower' contacted us to tell us the home was without gas so hot water was limited. This was due to a faulty meter which should have alerted the (LPG) gas supplier to renew the tanks. This was resolved within 24 hours without any adverse impact on people using the service.

On another occasion the cooker broke down which affected the provision of cooked meals to people using the service.

At the time of our visit the cooker was operational and there was sufficient gas.

The local authority made us aware of several safeguarding referrals concerning medicine errors. On two occasions, these errors were made by a bank or agency nurse, not a regular, permanent staff member. The absence of a manger meant that clinical supervision was not taking place and agency staff were not routinely assessed for competence or given a brief induction.

Nursing staff told us the usual staff complement for the home was:-

- two nurses and eight care assistants on duty between 8am and 8pm

- two nurses and three care assistants OR one nurse and four care assistants on duty between 8pm and 8am

The nurses we spoke to told us the staff complement has been consistently maintained at these levels for the past few weeks. One nurse said, 'It has improved since the relief managers have been supporting the home. We often worked short of staff previously. ' We looked at staff duty rotas which showed the service was relying on the use of agency staff to make sure there are enough suitably qualified staff on duty. This means people using the service are not always cared for by staff who are familiar with their needs.

During this visit, we had a telephone discussion with Southern Cross's service quality advisor who was providing cover for the annual leave of the area manager. She made a commitment to immediately arrange and sustain effective management cover Monday to Friday with on call provision at weekends. These arrangements were put in place before we completed our visit and confirmed in writing by email later the same day.

Our judgement
The absence of a manager or deputy manager in the home means staff do not always have access to suitable guidance and support to carry out their duties.

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
People did not feel they had a say in the way the home was run, but they told us they had some control over their care and how they spent their day. One person told us, 'I get up when I like and go to bed when I like. The staff give me the care I want.'

A relative told us it had been difficult to 'pinpoint' who was in charge if they wanted to raise a concern so they were not confident their concerns would be acted upon.

Other evidence
Southern Cross undertakes internal service quality inspections.
We looked at the outcome of the April 2011 internal key outcome inspection. It was a very comprehensive audit of all aspects of the service. It evidenced a general deterioration across all quality themes and found poor outcomes in care and support, environment, staffing and management and leadership.
There was no evidence that action plans were developed to implement improvements.
We looked for evidence of clinical supervision. We saw records to demonstrate that all nurses had supervision sessions in body mapping, medicine administration record (MAR) documentation and medication counting and handover. This was in response to several recent medication errors.
There was limited evidence that staff received regular supervision or appraisal.

Our judgement
The provider has not developed action plans to adress the shortfalls identified during their quality assessment process.

Outcome 20:
Notification of other incidents

What the outcome says

This is what people who use services should expect.

People who use services:
* Can be confident that important events that affect their welfare, health and safety are reported to the Care Quality Commission so that, where needed, action can be taken.

What we found

Our judgement

There are moderate concerns with Outcome 20: Notification of other incidents

Our findings

What people who use the service experienced and told us
No views were sought for the review of this outcome from people who use this service and their families.

Other evidence
The Provider did not notify us of absence and the alternative management arrangements. We reminded the area manager of the provider's duty to notify us of events that threaten to prevent the provider from carrying on regulated activities safely and properly. They sent us this statutory notification when we asked for it.

In August 2011 we received information from a 'whistleblower' concerned that there was no gas supply in the home. The provider did not tell us about this event.

Our judgement
The provider is not consistent in telling us about important events that might affect the health, safety and welfare of people using the service at Pitchill to make sure action is taken when needed.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People are not supported by a clear management structure due to the lack of a manager or deputy manager in the home so staff do not have suitable guidance and support to carry out their duties.	
Diagnostic and screening procedures	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People are not supported by a clear management structure due to the lack of a manager or deputy manager in the home so staff do not have suitable guidance and support to carry out their duties.	
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: People are not supported by a clear management structure due to the lack of a manager or deputy manager in the home so staff do not have suitable guidance and	

	support to carry out their duties.	
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: .	
Diagnostic and screening procedures	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: .	
Treatment of disease, disorder or injury	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: .	
Diagnostic and screening procedures	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	How the regulation is not being met: The provider is not consistent in telling us about important events that might affect the health, safety and welfare of people using the service at Pitchill to make sure action is taken when needed.	
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	How the regulation is not being met: The provider is not consistent in telling us about important events that might affect the health, safety and welfare of people using the service at Pitchill to make sure action is taken when needed.	

Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009	Outcome 20: Notification of other incidents
	How the regulation is not being met: The provider is not consistent in telling us about important events that might affect the health, safety and welfare of people using the service at Pitchill to make sure action is taken when needed.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of this report being received.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

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

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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