Review of compliance

Southern Cross OPCO Limited Cheviot Court	
Region:	North East
Location address:	Horsley Hill Square South Shields Tyne and Wear NE34 6RF
Type of service:	Care home service without nursing
Date of Publication:	September 2011
Overview of the service:	Cheviot Court is a 73 bed care home. The service is registered with the Care Quality Commission for the regulated activity of accommodation for persons who require nursing or personal care. The service provides personal care only to older people with mental health and general care needs.

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

Our current overall judgement

Cheviot Court 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 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

People using the service gave mixed feedback about the workers who provided their care. Their comments included, "Many of the staff are very good and go out of their way but some are not kind or approachable", "some staff become defensive", "most staff are very good but not all", "staff attitudes towards me have improved recently", "The staff are kind and helpful", "You can't get on with all the staff but on the whole they are good".

They told us that generally their care and support needs were met. One person said "We are well looked after here, I can't fault the care". Another person said that they felt that the staff worked hard but they could do with more staff as they were always 'run off their feet'.

People had mixed views about their safety although the majority appeared relaxed and content. However others were anxious not to be seen talking to us and asked not to be identified.

What we found about the standards we reviewed and how well Cheviot Court 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 the majority of people were respected and involved in most decisions about their care and support. However some people were not consistently treated with respect and their views were not always sought or acted upon to enable them to exercise choice and influence the delivery of their care.

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

Care planning, risk management and the delivery of care were inconsistent and did not demonstrate that people using the service received continuity of care, safe intervention or planned support.

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

We found that people using the service were not consistently protected from abuse or the risk of abuse.

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

We found that people using the service were not fully protected against the risks of unsafe management of medicines.

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

We found that the arrangements for staff training were not robust and some training provision had proved ineffective in preventing poor practice.

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. 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 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
We visited on two separate occasions and spent time on all three floors of the home.

We first met with people using the service and a relative during an afternoon visit when, in addition to positive feedback, concerns were raised over some staff attitudes. Comments included "many of the staff are very good and go out of their way but some are not kind or approachable", "one carer is sharp and intolerant", "some staff become defensive", "most staff are very good but not all", "staff attitudes towards me have improved recently", "well the staff are very busy and I am one of many".

We commenced our second visit at 07.15am. We toured the home and saw that 37 of the 70 residents were up and that most were washed and dressed with either their beds stripped or made. Several people told us that they chose to get up early but others said they would have preferred to stay in bed and that they got up when staff asked them to.

We met four people on the second floor who had just got up and taken a late breakfast. One told us that they liked to lie-in and that the staff allowed them to do this.

We observed that staff were attentive and responsive to people's needs on the

dementia care unit. Staff spoke respectfully and tailored their communication to help people understand information and make choices. There was a relaxed atmosphere on this unit and staff provided support at a pace to suit individuals. Music was played gently and later in the morning some people were engaged in a bread-making activity session. There was good interaction between people using the service and staff.

Staff respected people's rights to refuse intervention. We saw that one lady had put on extra layers of clothing including a bed jacket. A care worker explained that she often did this and staff attempted to intervene to protect her dignity, but withdrew if she started to become upset or agitated.

Staff told us they were designated to work on a particular unit of the home to provide continuity of care to people using the service. They said there were flexible routines and that the number of people out of bed in the mornings varied daily. They believed people were given choice about times of getting up. Two staff we spoke with said they had previously worked on night duty and described how they used to check people who wished to stay in bed to ensure their comfort and attend to their continence needs.

A relative we spoke with told us staff were good at keeping relatives involved and informed about care and welfare issues through telephone contact and individual care reviews.

We saw that a review of an individual's care was taking place and the person's social worker and their relative were in attendance.

Jugs of water and fruit squash were provided in communal areas. At meal times and the mid-morning drinks round people were offered choices of food and drinks. We saw that some people used aids to promote independent eating and drinking. Some people wore protective aprons to prevent food being spilled onto their clothing during meals.

We observed that some staff on the ground floor spoke sharply and were dismissive of someone in the dining room who constantly asked for their walking stick. We heard a care worker say "you will get it back when breakfast is finished".

We met with people and their relatives on the ground and second floors where personal care was provided. On the second floor people described how they and their relatives had been involved in making the decision to live at Cheviot Court. One person said "since coming here I have been consulted about my care and my views are listened to during reviews". Another person told us "I'm glad I chose this place I don't regret it".

Other evidence
We had received information of concern about the service relating to early rising and staff regularly getting people up, washed and dressed. The manager was on duty when we arrived at 07.15am and found that over half of the people using the service were up. She was of the view that people were all up out of choice but acknowledged this included fourteen people who had dementia.

Most of the care records we examined did not specify individual's preferred times of rising and retiring and 'night time routine' care plans were incomplete for two people who we met with. We discussed this with the manager who said staff were in the process of making sure these preferences were documented in night care plans.

We saw evidence that people and their relatives had been involved during the preadmission assessment process.

Most of the care plans we looked at stated people's preferred gender of carer to provide support with personal care. They also contained details of preferred daily routines and how to promote independence.

There was evidence that care plans had been introduced that focused on informed choices and the involvement of relatives in making decisions for people with dementia. However most of these plans were identically worded and were not personalised to the individual.

Our judgement
We found that the majority of people were respected and involved in most decisions about their care and support. However some people were not consistently treated with respect and their views were not always sought or acted upon to enable them to exercise choice and influence the delivery of their care.

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 eight people on the general units about the care and support they received from the staff. One said that she felt that the staff worked hard but they could do with more staff as they were always 'run off their feet'. Another person told us that on the whole they were happy with the care but sometimes they had to wait for a long time for the staff to answer the buzzer as they were always busy.

Other comments included:
"We are well looked after here, I can't fault the care".
"The staff are kind and helpful".
"You can't get on with all the staff but on the whole they are good".
"I have problems with a couple of carers but it is not a big problem. The management are aware of my views on this".

A relative visiting the dementia care unit said they had two family members who lived at the home. They were very happy with the care which they described as 'good quality'.

We spoke with a District Nurse who told us that in the main staff worked well with the nursing team, had good attitudes and were friendly and helpful.

We observed during meal times that staff provided appropriate support to people who required assistance with eating and drinking. They gently encouraged and prompted people with their meals and, where space permitted, staff sat with and helped people who were unable to eat independently.

One relative felt that there was lack of stimulation and recreation for people using the dementia care service on the second floor. She told us that although there were organised activities, these tended to be concentrated on the ground floor and the first floor.

The activities coordinator told us that he tried to make sure that everyone benefited from the provision of activities. We saw a number of notices and posters throughout the home which described forthcoming social events such as a trip to Beamish Museum.

Other evidence
We had received information of concern about the service relating to the handling of someone using the service and cramped conditions in some dining rooms. Also someone else had described reluctance by some staff to use mechanical hoists to assist with moving people.

We did not observe any unsafe moving and handling procedures during our visits. We did see one person who was being transported in a wheelchair without the foot rests in place. When they saw us the care worker stopped and put the person's feet up correctly.

We did see that some of the dining rooms were small and that access to people who needed support with eating was difficult in these areas.

We had also received a notification from the manager which raised some concern over immediate first aid care for someone following a fall. We looked at this person's care records and accident forms and confirmed that the staff involved had not managed this incident appropriately which the manager acknowledged.

We found several significant shortfalls within this person's care records which included out of date care plans and inadequate daily entries. For example no entry had been made when the person had returned from hospital after their fall.

During our second visit we looked at a selection of care records for people on each floor and found a variance in the quality and standard of record keeping.

We found that some individual documentation failed to provide staff with clear information and advice about people's personal and health care needs and preferences.

For example, we found that a risk assessment and mobility care plan for someone on the second floor was well detailed and provided staff with information on how best to support and handle this person.

We found that care records for three people who had been admitted to the home in May and June 2011 were not yet fully detailed. For example, someone on the second floor where the person's physical care needs had been addressed but there was no detail in relation to their psychological and social care needs.

Another person on the ground floor was doubly incontinent but had no elimination care plan. A continence assessment was in place but this provided no information on the

type of continence aids which were being used. This person, who required full assistance, had no personal hygiene assessment or care plan in place.

We knew that another person was anxious and quite obsessive about access to their walking stick. They also took tablets for a skin condition which staff treated topically. However none of this information, treatment or staff involvement were detailed in any of this person's care plans.

The care records for another person, whose condition had deteriorated, were not up to date. For example, the mobility care plan had not been reviewed since 13 May 2011 when the person had been independent and ambulant. Also their nutritional risk assessment had not been repeated since early May despite a four kg weight loss identified on 27 June 2011.

Our judgement
Care planning, risk management and the delivery of care were inconsistent and did not demonstrate that people using the service received continuity of care, safe intervention or planned support.

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 major concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People had mixed views about their safety although the majority appeared relaxed and content. However others were anxious not to be seen talking to us and asked not to be identified. One said "I have problems with a couple of carers" and another commented "they become defensive if I challenge what they want me to do".

Other evidence
We had received some anonymous information of concern about the service relating to the management of used needles and inappropriate behaviour by one of the care workers. We had shared this with the Local Authority safeguarding team who had commenced investigations and visits to the service.

This had highlighted additional concerns such as early rising and some staff had raised concern over bullying and unpleasant behaviour by a small number of care workers. In addition three people who used the service and a relative had raised concern with us over the attitudes and intolerance of some staff.

We found evidence of some poor and ill informed staff practice and inadequate care delivery which had compromised people's safety and wellbeing. For example medicines management, first aid after accidents, some staff behaviours and the standard of record keeping.

We saw that the manager had recently requested urgent training in protecting vulnerable people. The in house training statistics stated that only 41% of staff were up

to date in this area. We were told that training sessions were planned for.

We found that everyone spoke highly of the registered manager but that some lacked confidence in her ability to identify and stamp out any bad practices amongst the staff.

Our judgement
We found that people using the service were not consistently protected from abuse or the risk of abuse.

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
During our first visit a visitor expressed concern and described some delays in obtaining medicines for their relative and gave examples where this person's medicines supply had run out of stock.

During our second visit we observed that medicine administration times were flexible to accommodate people who had chosen to get up later in the morning or close to lunch time. A senior care worker told us the medicines for these people would be staggered throughout the day.

Other evidence
We had received information of concern about the service relating to medication arrangements in particular staff leaving insecure medicines trolleys unattended. We did not see any evidence of staff leaving trolleys unattended during our visits.

We had also received a notification from the manager about someone using the service who had missed their medicines for a five-day period. This had involved three senior care workers who had failed to alert management when this person's medicines had run out of stock. This matter was under investigation by senior management and we were unable to access the relevant records which had been removed from the service.

We examined a random sample of medicine records. The files contained checklists that staff signed to confirm whether medication administration records were appropriately

completed. This resulted in senior care workers monitoring their own practice and we saw that the day's checklists on the dementia care unit had been signed in advance of medicine rounds.

Each person's medicine record had a front sheet with their name, photograph for identification purposes, date of birth, GP contact and details of any allergies. Daily balance records were kept for boxed and bottled medicines that were held separate to monitored dosage blister packs.

The majority of administration records had clear directions and were suitably signed to verify that medicines had been given, including prescribed nutritional supplements. One handwritten entry for an eye cream had unclear directions and a senior care worker amended this straight away.

We noted there was a gap in the previous week's record for a medicine directed to be given once weekly. A senior care worker told us that night staff took responsibility for giving this medicine as it was to be given at least 30 minutes before eating breakfast. The supply of this medicine could not be located at the time of our visit and we brought this to the attention of the manager.

Our judgement
We found that people using the service were not fully protected against the risks of unsafe management of medicines.

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
We did not receive any comments from people using the service about staff training.

Other evidence
We found that shortfalls in systematic arrangements for monitoring attendance at training had created a backlog of staff who were not fully trained.

The manager told us at our first visit that staff training was overdue in certain areas including health and safety, first aid, infection control, nutrition and safeguarding vulnerable people. This was confirmed by the training statistics for the home and we saw that the manager had just raised these shortfalls with the provider.

We observed that details of forthcoming training courses were displayed on a notice board on the dementia care unit and in a ground floor office. Topics included health and safety, nutrition, safeguarding, fire and food safety.

The staff we spoke with said they had received training appropriate to meeting the needs of the people they cared for. This included nationally recognised qualifications in care, dementia awareness and challenging behaviour.

We found that where recent incidents had occurred such as a medicine's error and poor management of an accident that the staff involved had recently received appropriate training. This had included competency assessments which had been carried out by the manager and other senior staff at the service.

Our judgement
We found that the arrangements for staff training were not robust and some training provision had proved ineffective in preventing poor practice.

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 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 the majority of people were respected and involved in most decisions about their care and support. However some people were not consistently treated with respect and their views were not always sought or acted upon to enable them to exercise choice and influence the delivery of 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
	How the regulation is not being met: Care planning, risk management and the delivery of care were inconsistent and did not demonstrate that people using the service received continuity of care, safe intervention or planned support.	
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: We found that people using the service were not consistently protected from abuse or the	

	risk of abuse.	
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 people using the service were not fully protected against the risks of unsafe management of medicines.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting staff
	How the regulation is not being met: We found that the arrangements for staff training were not robust and some training provision had proved ineffective in preventing poor practice.	

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 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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