Review of compliance

Southern Cross Care Homes No 2 Limited Chaseview Nursing Home	
Region:	West Midlands
Location address:	Water Street Chase Terrace Burntwood Cannock WS7 8AW
Type of service:	Care Home with nursing
Date the review was completed:	28. 1. 2011
Overview of the service:	Chaseview is a care home providing nursing and personal care for up to 60 people. The home is situated in a town centre location with easy access to the shops, bus stops and local amenities. Accommodation is on two floors with two shaft lifts for access to the upper floor. All rooms are single occupancy and all have en suite facilities. The home is generally established in two groups, with the ground

	floor being used for those people requiring residential care and the top floor for nursing care. Each floor has its own lounge and dining area. All people who use the service if they wish to use this lounge can access a designated smoking lounge on the first floor. There is a very pleasant quadrant garden and parking for several cars.

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

What we found overall

We found that Chaseview Nursing Home was meeting outcomes 4 and 13 of the essential standards of quality and safety. We reviewed those standards, but to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out the 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:

- Care and welfare of people who use services
- Staffing

How we carried out this review

We reviewed all the information we hold about this provider. We asked them to send us information about the care and welfare of the people using the service, and their staffing. We visited Chaseview Nursing Home on 29th December 2010. We observed how people were being cared for and talked to people who use services, to staff and relatives. We looked at records of people who use services.

What people told us

We spent time sitting and talking with people in the main lounges upstairs on the nursing floor and downstairs on the residential floor. We spoke to three people who were having their hair dressed, and spoke to four staff about their role and responsibilities and the care given in the home.

We saw that people were involved in daily activities, listening to music, watching television, having their hair dressed and nails manicured. They were treated kindly by

staff and there were good interactions between care staff and the people in the home. People said that they were happy with their care or indicated by a thumbs up sign that they were. We found that there were delays in updating records.

We were told that care plans and personal risk assessments were kept up to date, and that there was a system of auditing and monitoring of these in place.

However, one of the three care plans we looked at had not been updated in relation to a person whose needs had changed following discharge from a hospital stay. Care staff spoken to were able to tell us how to care for the person despite the delay in recording. People were seen to have their needs anticipated and met.

We were told that the home is well staffed for the numbers and dependency levels of the people using the service, and that cover is always provided when care staff need to escort individuals using the service to clinic appointments.

During our visit we saw that there were not enough care staff available. One agency care staff had not turned up for the morning shift on the nursing floor, and the nurse in charge of that floor had not reported this to the care manager at the time. There was also a shortfall of one care staff on the residential downstairs floor. This was due to a staff member escorting a person for a planned clinic appointment that morning.

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

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights.

Care staff spoken to were able to describe how care should be given to individual people. Observations showed that this was the way care staff usually worked.

People in the service receive better care than the care plan records indicate. Delays in updating records could mean that new careworkers are not given sufficient or timely information. Improvements are needed to ensure that there are consistent and up to date levels of information available for careworkers.

- Overall, we found that improvements are needed for this essential standard.

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

Lack of communication between management and senior staff has affected the quality of the service.

The provider must ensure that there are sufficient, skilled and experienced care staff in the home.

- Overall, we found that improvements are needed for this essential standard.

Action we have asked the service to take

We have asked the provider to send us a report within 28 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.

Other information

Please see previous review reports for more information.

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 4:
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 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

One person told us that they “had a lovely Christmas”, had been out for meals with their family, had received lots of visitors and that they could visit anytime. Said she was “quite happy thank you very much” with the home and the staff.

Another person said his wheelchair was being mended, and that he was well looked after and “had a nice Christmas”, his family had visited over the holiday period, said “the food was good too, and I’ve got no complaints at all”.

Three people were in the process of having their hair dressed and nails manicured, and told us that they really enjoyed this. One person told us “the staff are great, and very kind”, I’ve got no complaints at all, and I often stay in my room watching my own television then I can watch what I want”.

Other evidence

We looked at three care plans. These showed that a risk based full assessment of needs had been undertaken for those individuals on admission. The care plan had then been generated based upon those levels of risk. Care plans were usually reviewed on a monthly basis and monitored daily.

The assessments gave information about the persons needs across all activities of

daily living, including their cognitive awareness and mental health, risk assessment including nutrition, falls, bathing, moving and handling and fire safety. However, one of the three records showed that the individual concerned had been recently discharged from hospital and that their care plan and risk assessment had not been updated to reflect the changes in their level of need.

We observed that generally people's needs were being met. Care staff were observed addressing people appropriately, providing assistance with toileting, drinks, access to newspapers and magazines.

Care staff spoken with, were able to describe how care would usually be given to individuals, our observations showed that this was the way that care staff usually worked. People in the home received better care than care plan records indicated.

We spoke with care staff about moving and handling, and how they helped people to safely mobilise and transfer using appropriate equipment.
We saw people being moved safely by care staff.

Our judgement

Lack of up to date records could mean that new care staff are not given sufficient and or timely written information. Improvements are needed to ensure that there is consistent and up to date written information available for care staff.

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 minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
Groups of people spoken with in the main lounges confirmed that they had really enjoyed their Christmas at the home, they had enjoyed a good Christmas lunch, and had lots of visitors. Many told us the staff were “lovely and kind”, and that they had no complaints. People also confirmed they “needed to wait sometimes for staff to answer the call bell when they called”, but they also acknowledged that “there were others in the home to be considered, apart from us”.

Other evidence

We spoke with four staff members about training, their role and responsibilities, and the care given in the home. Each staff member told us that they had received the necessary training in order for them to provide appropriate and individualised care for the people using the service. Staff knew people well, and were able to tell us about their individual care.

Staff supervision records confirmed that sessions for all staff had been undertaken in November 2010. The next round of supervision sessions were due in January as they are held two monthly.

We were told that regular staff meetings had been established, we saw staff meeting minutes that evidenced this. Dates included 11/8/10, 8/10/2010 and

28/10/2010.

We looked at the staff rota for the 29/12/10 early shift – this confirmed that although it was planned that there should have been five care staff and one qualified staff upstairs on the nursing floor, and four care staff downstairs on the residential floor. We observed there was a shortage of one agency care staff upstairs, and one care staff downstairs for the whole morning.

We discussed the shortage of one staff member on both floors with the acting care manager, during our visit. We were told that one agency staff did not turn up for duty on the nursing floor, for the morning shift, and one staff member on the residential floor went out on escort duty to a planned hospital clinic appointment with a person using the service, this took her away from her duties all morning. We were told that this usually does not occur, as planned hospital appointments that are booked in the diary are usually covered by an extra staff member. We observed that the qualified nurse on duty that morning did not report the shortfall of the agency staff member upstairs, to the acting care manager. This showed that although appropriate staffing levels had been planned for, the rota had not allowed for the extra cover needed.

The staff rota for mid November to mid December, and weeks ending 21/11/10, 26/12/10 and 2/1/11 were examined. We confirmed that the planned numbers of staff were meeting the needs of people using the service, and we highlighted the need to ensure that the information contained within the rota is clear and up to date.

We were told by the acting care manager that the dependency levels of all individuals using the service are reviewed and audited on a weekly basis, using the organisation's "dependency assessment" tool. The outcome of the audit then determines the appropriate staffing levels.

Our judgement

The provider must ensure that there are sufficient numbers of care staff in order to meet the needs of the people using the service.

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.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 9</td><td>Outcome 4 Care and Welfare of people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:
Individual care plans and risk assessments should be kept up to date, to provide timely and consistent written information for care staff.</td></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 22</td><td>Outcome 13 Staffing</td></tr>
<tr><td colspan="2">Why we have concerns:
The provider must ensure that there are sufficient numbers of care staff in order to meet the needs of the people using the service.</td></tr>
</table>

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 within 28 days of this report being received.

CQC should be informed in writing when these improvement 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 Adult Social Care Act 2008 and relevant regulations.

These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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Audience	The general public
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