Review of compliance

Southern CC Limited **The Hall Nursing Home**	
Region:	West Midlands
Location address:	100 Old Station Road, Bromsgrove, Worcestershire, B61 2AS
Type of service:	Care Home with Nursing
Publication date:	May 2011
Overview of the service:	The Hall Nursing Home is a 43 Bedded home set over two floors. It provides nursing care, including dementia related care needs.

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

What we found overall

We found that The Hall Nursing Home was not meeting one or more essential standards. Improvements were needed.

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
- Meeting nutritional needs
- Cleanliness and infection control
- Staffing

How we carried out this review

We reviewed all the information we hold about this provider, surveyed people who use services, carried out a visit on 15 March 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

People we spoke to told us that they were happy with the care and activities provided and that the food was good, with large portions being served. One person told us that they did not like the attitude of the night care workers. Two relatives told us that the accommodation provided for their relative was good. They said that they felt that the care provided had improved over the last few weeks

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

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

Risk assessments are completed but these can be delayed following admission to the home. People's individual needs may not always be met and daily monitoring plans are not always completed effectively.

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

Outcome 5: Food and drink should meet people's individual dietary needs

People who use the service are at risk of not having encouragement and support to receive adequate nutrition and hydration.

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

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

Not all areas and equipment in the home are managed and maintained effectively to prevent and control infections.

- Overall, we found that improvements were 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

People who use the service are at risk of not having their needs met by insufficient care workers being on duty.

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

Action 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.

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 get up earlier than they would like. They like to sit in same place each day so they are able to watch the birds in the garden.

One person told us that they were happy in the home, but did not like the attitude of the night staff.

One person told us that the attitude of staff was poor and that they felt dictated to. Staff wanted them to get up but they had chosen to stay in bed.

We spoke to two relatives who were visiting. They told us that the care had got better over the last two weeks, although sometimes they felt their relative was not always dressed appropriately when involved in external activities.

In the afternoon the home had provided entertainment. There was live music and singing and people were clapping along to the music. Staff and some people who use the service were dancing.

Other evidence

We saw that people were able to make a choice to stay in their rooms or go to the

lounges. People in their rooms had access to a call bell system to gain assistance from staff. Care workers were not always present in the shared areas. In these areas there were no systems in place for people to communicate their needs when care workers were not present.

The home provides an activities co-ordinator and has daily group activities that people can join in. Details of a monthly day trip was also displayed on a notice board.

The care plans we looked at showed people's preferences for bed times and wake up times, and other personal preferences for people who use the service. The daily care sheets we looked at were not always completed with the correct information. Peoples weights were monitored, but when we looked at a nutritional daily record these did not always record the amount of food eaten. A care chart we saw in one room did not detail how often the person should be moved and it was not clear how staff were monitoring how the person was positioned. There was a delay in completing some assessments for a person who had recently moved to the home.

In one lounge on the first floor we saw three people. No staff were present in the room .The television reception was poor and the picture was poor. One person became upset and began shouting that they wanted to go home. When care workers did enter this room any interaction was focussed on the tasks to be completed.

We saw that a residents meeting had happened and the minutes from the meeting were available on a notice board. We did not see any other ways for people to communicate with the home about their choices or how the home is run.

Our judgement

Risk assessments are completed but these can be delayed following admission to the home. People's individual needs may not always be met and daily monitoring plans are not always completed effectively.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:

- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

There are moderate concerns

with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

People told us that the food was nice and that the portions were generous. We saw some people having lunch in the dining room, a lounge and in their rooms. There was a choice of two meals at the point of serving. We saw two people being assisted with their meals. We saw care workers serving the meals without telling people what they had.

We saw that the care workers were not spending time with people and we saw one person sucking on knife, one person drinking out of plastic beaker lid the wrong way and one resident using a spoon to drink out of a beaker.

One person poured their juice over their dinner, when this was seen by a care worker the meal was replaced. We saw a care worker ask a person if they had finished their meal, they said ‘it was too hot’ but the care worker removed the meal and brought their dessert.

We saw people who required a soft diet left waiting for their meal while other people around them ate their meals. We were told by staff that the blender had broken and that someone had gone to purchase a replacement. People had not been told about the delay and they remained in the dining room or lounge while everyone else ate.

One person that was eating in the lounge appeared to have difficulties in cutting their meal and no care workers were present to offer assistance.

A relative told us that sometimes their relative is served vegetables they do not like even though they have told the home about the preferred vegetables.

Other evidence

We saw a menu on the notice board in the dining room. The manager told us that the choices for today had been changed and that it had been communicated to the people in the home. The manager told us that sandwiches are available for the evening menu, including two other choices.

We looked at some care plans. The care plans did not easily identify who required their nutritional intake monitored. When we looked at a nutritional daily record for those people who did require monitoring we saw that they did not always record the amount of food eaten. Records showed that people's weights were monitored.

Our judgement

People who use the service are at risk of not having encouragement and support to receive adequate nutrition and hydration.

Outcome 8:
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 8: Cleanliness and infection control

Our findings

Other evidence

We looked at some rooms in the home. There were several rooms that had dirty commodes and towels that were worn and we saw a number of personal wash bowls which had been placed on the toilet seat lid. Most of the rooms we looked at had damaged flooring under the sink making cleaning difficult. The manager told us that the sinks had been changed and they were waiting for the repairs to the floors.

On the first floor we saw that the shower room had a rusty and dirty raised toilet frame and shower seat. One toilet we looked at had an unpleasant odour and some wall tiles behind the door were broken.

The manager told us that one room was prepared and ready for a new person to move in to that afternoon. In the room we saw a chest of drawers which looked worn and the top was chipped. The washing bowl in this room was also cracked and the hand towel was frayed and worn. There was a pressure cushion with a dirty mark on the cover in the wardrobe. The commode was dirty underneath the pan and the underside of the frame. On the pin board in the room there was information displayed which related to the previous occupant.

Our judgement

Not all areas and equipment in the home are managed and maintained effectively to prevent and control infections.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:

- Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns

with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

We saw that care workers appeared busy and spent time focussed on completion of tasks rather than spending time talking with the people who use the service. In the dining room care workers were not able to spend time supporting people with meals as time was being taken up serving meals.

Other evidence

The manager told us that the number of care workers had been reduced recently and that the provider set the staffing levels based on the number of people living in the home. They provided us with information which identified how many people needed the support of two care workers but were not able to demonstrate that they had carried out a needs analysis and risk assessment to decide sufficient staffing levels.

Our judgement

People who use the service are at risk of not having their needs met by insufficient care workers being on duty.

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 Treatment of disease, disorder or injury Diagnostic or screening procedures	9	4: Care and welfare of people who use services
	How the regulation is not being met: Risk assessments are completed but these can be delayed following admission to the home. People's individual needs may not always be met and daily monitoring plans are not always completed effectively.	
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury Diagnostic or screening procedures	14	5: Meeting nutritional needs
	How the regulation is not being met: People who use the service are at risk of not having encouragement and support to receive adequate nutrition and hydration.	
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury Diagnostic or screening procedures	12	8: Cleanliness and infection control
	How the regulation is not being met: Not all areas and equipment in the home are managed and maintained effectively to prevent and control infections.	

Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury Diagnostic or screening procedures	22	13: Staffing
	How the regulation is not being met: People who use the service are at risk of not having their needs met by insufficient care workers being on duty.	

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

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA