Review of compliance

Southern CC Limited The Hall Nursing Home	
Region:	West Midlands
Location address:	100 Old Station Road Bromsgrove Worcestershire B60 2AS
Type of service:	Care home service with nursing
Date of Publication:	August 2012
Overview of the service:	The Hall Nursing Home provides accommodation and nursing care for up to 43 older people. The service also provides care for people who have physical disabilities or dementia related illnesses.

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

Our current overall judgement

The Hall Nursing Home was not meeting one or more essential standards. Action is 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 12 July 2012, 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

The service and the people who used the service had experienced a lot of change in recent months. A new manager, a new regional manager and a new deputy manager had all commenced work with the service within a few weeks of our inspection. The new manager had been in post two weeks when we inspected.

Two activities coordinators were working for the service so that people were provided with social and recreational activities seven days a week.

One person who used the service and could mobilise with support was in bed when we inspected. When we spoke to the deputy manager later in the day they told us that that this person was supported to get up every day and they were surprised to find that they were still in bed. When we had spoken with this person earlier in the day they told us that they never got asked whether or not they wanted to take part in activities.

We sat with someone who was eating their lunch in their room. They had been given their main meal and their hot pudding at the same time. This person did not eat very much of their lunch and they told us that the main meal had gone cold and that the pudding was too dry to eat.

One person we spoke with had only used the service for a few months. They told us that they were "settled in now" and that they were "well looked after".

What we found about the standards we reviewed and how well The Hall Nursing 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

The provider was not meeting this standard. The provider was not maintaining people's dignity, respecting their privacy or promoting their independence. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.

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

The provider was not meeting this standard. People were at risk of receiving inappropriate care, treatment and support. People's needs were not assessed accurately and appropriate support was not provided to manage any risks. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.

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

The provider was not meeting this standard. People were at risk of infection as practices were not in place to ensure the risks of infection were reduced. We judged that this had a minor impact on people who used the service and action was needed for this essential standard.

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

The provider was not meeting this standard. Suitable arrangements were not in place to ensure that staff were appropriately trained and supervised to enable them to meet the needs of people who used the service. We judged that this had a moderate impact on the service and action was needed for this essential standard.

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 was not meeting this standard. The service had not assessed, monitored or managed the risks to people who used the service. We judged this to have a moderate impact on people who used the service and action was needed for this essential standard.

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. We will check to make sure that this action has been taken.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
The service and the people who used the service had experienced a lot of change in recent months. A new manager, a regional manager and a new deputy manager had all commenced work with the service within a few weeks of our inspection. The new manager had been in post two weeks when we inspected.

One person who used the service and could mobilise with support was in bed when we inspected. When we spoke to the deputy manager later in the day they told us that that this person was supported to get up every day and they were surprised to find that they were still in bed. When we had spoken with this person earlier in the day they told us that they never got asked whether or not they wanted to take part in activities.

We sat with someone who was eating their lunch in their room. They had been given their main meal and their hot pudding at the same time. This person did not eat very much of their lunch and they told us that the main meal had gone cold and that the pudding was too dry to eat.

Other evidence
We pathway tracked three people who used the service. Pathway tracking is a way of

understanding people's experience of the care they receive. To gain this understanding, we talked with people who used the service, looked through people's care plans, observed care and spoke with staff.

There was no life history in one person's care plans. There was a life map document on the file as well as a document used to record things about a person's life history such as their school life and family life, but all of these records were blank. There was some information about one person's life history on a third file we looked at. We found a note made in November 2011 prompting the key worker to ascertain the person's preferences, but the relevant documents on file had not been completed. We spoke with this person whose care plans they were and they were able to communicate their likes and dislikes very easily. This meant that the service had not ensured that they knew more about this person in order to promote respect and maintain their dignity.

We saw that very little was recorded on what another person's preferences were when we looked at their care plans. We saw just one reference to their hobbies upon their admission almost five years ago.

There were assessment documents on all the files which assessed whether people were involved in their own care planning. These assessments had not been completed with several questions left unanswered. This meant that the service could not effectively demonstrate they had involved people in planning the delivery of their care.

As we observed care and walked around the service we found that people's doors were open and we could see people in their rooms and in their beds. There was nothing in people's care plans to assess whether they preferred to have their doors open or closed when they were in their rooms. One person we spoke with who used the service said they had never been asked if they wanted the door open or closed.

During our inspection we asked both the manager and another member of staff if someone could be sent to look at one person's television as it was not working. Both the manager and the other member of staff stated that the television would be looked at. As we prepared to finish our inspection three hours later we went to this person's room to say goodbye. The television wasn't on and we were told by this person that nobody had been to try to fix it.

During our inspection we asked kitchen staff if one person could have something else for pudding. This person had not eaten much of their meal and had told us they would like something else sweet to eat. When we went back to see this person just a short while later, we saw that they had been given a choc ice, which they told us they enjoyed.

We found that one person's medical administration chart was left on the landing outside their room and no one was there with them at the time. This meant that this person's privacy had not been considered.

When we spoke with care staff they showed an understanding for people's personal care needs that we had identified. The language they used when speaking with us suggested that they encouraged independence when supporting people with personal care.

Our judgement
The provider was not meeting this standard. The provider was not maintaining people's dignity, respecting their privacy or promoting their independence. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
The service and the people who used the service had experienced a lot of change in recent months. A new manager, a new regional manager and a new deputy manager had all commenced work with the service within a few weeks of our inspection. The new manager had been in post two weeks when we inspected.

Two activities coordinators were working for the service so that people were provided with social and recreational activities seven days a week.

One person we spoke with had only used the service for a few months. They told us that they were "settled in now" and that they were "well looked after".

Other evidence
We looked at people's care plans, spoke with staff, observed care and spoke with people who used the service to understand people's experience of care.

When we arrived at the service we met with the new manager. The manager told us that the local authorities care services quality team had recently visited and highlighted their concerns about the care and welfare of people who used the service. The manager had treated these concerns as a priority upon commencing their new role and had drafted an action plan to address the concerns highlighted. During our inspection we tracked the action plan against the concerns raised and we saw that the service had made improvements in all these areas.

When we inspected in March 2012 we found that there was not always accurate, recorded support in care plans where a risk had been identified to ensure that peoples' current needs were met. This meant that the service could not be sure it was appropriately managing these risks.

When we inspected this time we looked at risk assessments on people's care plans. Several examples we looked at were completed several months ago and had never been reviewed. These examples did not provide a coherent assessment of the risks to people. There were several risk assessments including daily life skills, mental health and multi-professional intervention assessments that fed in to a final assessment of people's needs. Scores were added up on this final assessment but there was no guidance as to how these scores were determined or what these scores demonstrated when they were added together. This meant that the service had not made any improvements to address the failures identified when we last inspected the service and that people were still at risk of receiving inappropriate care.

We saw on several people's care plans that they needed creams applied to their skin. The cream that was recorded in their care plans matched the cream that was recorded on their medical administration charts (MAR charts). When we looked at the MAR charts for two of these people the application of creams had not been recorded at all. This meant that the service could not be assured as to whether creams were being applied and whether people were receiving appropriate care and treatment.

We saw that the correct cream that had been prescribed for one person was in their bathroom. However, that person told us that the cream had not been applied regularly. As the service had not recorded when these creams had been applied they were unable to demonstrate whether creams had been administered to this person as directed.

We spoke with two care staff at the service. These staff showed a good understanding of people's care needs that we had identified. They knew people's mobility needs, their skin care needs which included what creams they needed applying and how often, and they knew people's personal care needs.

Our judgement
The provider was not meeting this standard. People were at risk of receiving inappropriate care, treatment and support. People's needs were not assessed accurately and appropriate support was not provided to manage any risks. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 08: Cleanliness and infection control. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We didn't talk to people who used the service about this standard.

Other evidence
The new manager had devised an action plan which addressed some of the issues that had been highlighted by other agencies in relation to infection control. We saw this action plan and we saw that actions had been followed through. This included the cleaning of dirty carpets and the replacement of carpets that were too old and dirty to clean adequately. A new rotary cleaner for the carpets had been purchased and the manager told us that there was a cleaning regime for carpets. This meant that the service had taken steps to address issues with infection control highlighted by another agency and to improve the service.

When we inspected in March 2012 we found that the service was not compliant with this standard and that improvements were needed. When we visited this time we found that the service had not carried out an infection control audit since before our last inspection in December 2011. The new manager told us that they had already identified the need for improvements without having to carry out an audit and that they wanted to make these changes before carrying out a full audit of infection control processes. This meant that at the time of our inspection people were at risk of infection as the service had not been monitoring or addressing the risks.

We went in to one person's bathroom and an open box of continence pads had been stored behind the toilet bowl. We also found that a box of aprons were stored in a communal toilet. This box was open and overflowing with many of the aprons on the toilet floor. This meant that that people were at risk of cross infection because systems

were not in place to ensure these things were stored appropriately.

The manager told us that the housekeeper managed a team of domestic staff and that they would carry out spot checks to ensure cleaning had been carried out effectively. We found that the toilets and bathrooms we looked at were clean, including underneath toilet seats. We also found that equipment that we looked at was clean including one stair lift which had recently been identified as a concern and had been cleaned. This meant that cleaning at the service appeared effective.

Our judgement
The provider was not meeting this standard. People were at risk of infection as practices were not in place to ensure the risks of infection were reduced. We judged that this had a minor impact on people who used the service and action was needed for this essential standard.

Outcome 14:
Supporting workers

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

The provider is non-compliant with Outcome 14: Supporting workers. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We didn't talk to people who used the service about this standard.

Other evidence
There was no information in the home to show what training staff should be having and how frequently they should have it. When we spoke with the manager they told us that they had recently identified this as a problem and that the regional manager was intending to introduce a document for recording all staff training on.

We looked at staff files and saw that new staff had received training in moving and handling upon starting. Some new staff had received some other training but that training wasn't consistently provided for all new staff. One staff member whose file we looked at had not received any training since 2010. This meant that there was a risk that staff working in the home may not be suitably trained and may place people who used the service at risk of harm.

On the day we inspected the manager had scheduled in a meeting with some staff in the afternoon. Prior to the inspection the last documented staff meeting was held in August 2011. Not having regular staff meetings meant that staff had not been given an opportunity to discuss any issues, including their own personal development and any concerns they may have about the care people receive.

The last documented supervision and appraisal meetings were held in May 2011. This meant that at the time of our inspection staff had not been supported through supervision for over a year.

The manager told us that they had a member of staff who had recently completed training which enabled them to train others in moving and handling. This would mean that all new staff could have moving and handling training as and when needed and that other staff could have refresher training and receive in-house support. The manager also told us that training was booked for people on infection control and safeguarding but the service did not have a list available at the time of which staff were due to attend. This meant that on the day we inspected we were unable to establish if these things had been implemented.

Our judgement
The provider was not meeting this standard. Suitable arrangements were not in place to ensure that staff were appropriately trained and supervised to enable them to meet the needs of people who used the service. We judged that this had a moderate impact on the service and action was needed for this essential standard.

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

The provider is non-compliant with Outcome 16: Assessing and monitoring the quality of service provision. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We didn't talk to people who used the service about this standard.

Other evidence
We looked at what audits the service carried out to monitor and assess the quality of the care it provided. The most recent medication, food hygiene, infection control and health and safety audits hadn't been carried out for four months with more than one type of audit not completed since 2011. No audits of care plans had been carried out by the service in recent months. This meant that the service had not recently assessed the quality of care people who used the service were experiencing.

The manager told us that surveys had been sent out to relatives by the regional manager and that they were waiting for these to be received back. These were sent out by the provider and not the manager so we could not see these surveys during our inspection or ascertain when they had been sent.

We asked the manager if meetings were held regularly for people who used the service. There were no records to suggest these had been happening regularly but the manager showed us a newsletter they had been drafting which invited relatives to attend a meeting with people who used the service in the near future. This meant that the manager had taken steps to look to gather the views of people who used the service and their relatives.

We looked at accident records for people who used the service. One accident report referred to a person we had pathway tracked who had been taken to hospital after a fall. The accident record stated that risk assessments and safety measures were in place as needed. When we looked at this person's care plan we saw that risk assessments and safety measures were not sufficient to manage the risk of future falls. This meant that the service was not effectively monitoring and acting to reduce the risk of falls and accidents.

Our judgement
The provider was not meeting this standard. The service had not assessed, monitored or managed the risks to people who used the service. We judged this to have a moderate impact on people who used the service and action was needed for this essential standard.

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: The provider was not meeting this standard. The provider was not maintaining people's dignity, respecting their privacy or promoting their independence. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.	
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: The provider was not meeting this standard. People were at risk of receiving inappropriate care, treatment and support. People's needs were not assessed accurately and appropriate support was not provided to manage any risks. We judged that this had a moderate impact on people who used the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met:	

	The provider was not meeting this standard. People were at risk of infection as practices were not in place to ensure the risks of infection were reduced. We judged that this had a minor impact on people who used the service and action was needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 14: Supporting workers
	How the regulation is not being met: The provider was not meeting this standard. Suitable arrangements were not in place to ensure that staff were appropriately trained and supervised to enable them to meet the needs of people who used the service. We judged that this had a moderate impact on the service and action was needed for this essential standard.	
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: The provider was not meeting this standard. The service had not assessed, monitored or managed the risks to people who used the service. We judged this to have a moderate impact on people who used the service and action was needed for this essential standard.	

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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
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