Review of compliance

Avery Homes Northampton Limited Seagrave House	
Region:	East Midlands
Location address:	Occupation Road Corby Northamptonshire NN17 1EH
Type of service:	Care home service without nursing
Date of Publication:	October 2012
Overview of the service:	Seagrave House is registered to provide Accommodation for people who require nursing and personal care, Diagnostics and screening procedures and Treatment of disease, disorder or injury for up to 75 people. Before 15 October 2012, the home was organised into three units. A residential unit for elderly people, a nursing unit for people who required nursing care and a unit for people who had dementia. From 15

	October 2012, the home ceased to have a nursing unit and no longer provided nursing care.

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

Our current overall judgement

Seagrave House was meeting all the essential standards of quality and safety inspected.

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 13 - Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 26 September 2012 and talked to people who use services.

What people told us

We spoke with five people who used the service. All of those people told us that liked they living at the home they could spend their time how they wanted and because there was lots for them to do. When we asked people about the care they had experienced one person told us, "We are well looked after." Another person said, "It's pretty good. We are getting the care we need." People we spoke to told us that they felt that enough staff were on duty. One person told us, "Staff do what they are supposed to do."

We were able to corroborate what people told us about their experience of living at the home.

What we found about the standards we reviewed and how well Seagrave House was meeting them

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

People experienced care, treatment and support that met their needs and protected their rights.

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

There were enough qualified, skilled and experienced staff to meet people's needs.

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 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 compliant 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 five people who used the service and asked them about what they thought about the quality of care they had experienced. Four people told us that their care had been "very good" and a fifth person described their care as "so, so". Every person we spoke with told us that they liked living at the home because there was lots of things to do and because they were able to spend their time how they wanted.

We saw people relaxing alone or with other people in several of the communal areas in the home. Other people spent time in their rooms reading or watching television. Some people ate their lunch in their bedrooms, but most people ate their lunch in a dining room where the ambience was very much like that of a restaurant.

Other evidence
When we visited the home on 25 May and 6 June 2012, we found that the quality of documentation and recording of how people had been supported with personal care and nursing needs was variable. That pointed to the possibility that people had not received or experienced a satisfactory level of care, treatment and support especially in the nursing and dementia units of the home.

Senior management had been involved in actions to improve the quality of care, treatment and support provided at the home. A new manager had been brought into the home to implement an action plan to achieve higher standards. An important development had been that the provider had decided that the home would not, from 15 October 2012, provide nursing care.

On 26 September 2012 we looked at 15 care plans of people from each of the three units in the home. We found that all of the care plans had been reviewed during July and August 2012 and people's health and mobility needs had been reviewed and reassessed. The local authority had carried out an audit of the home's arrangements for the moving and handling of people with restricted mobility which found those arrangements to be satisfactory.

The quality of care worker's recording of information about care routines had significantly improved since our visit in June. Records of how and when people had been supported with personal care, health needs and nutrition had been appropriately maintained. The home had introduced a `resident of the day' process for reviewing and assessing whether a person's needs were being met to their and their relative's satisfaction and in keeping with their care plan.

Staff had recently received training that helped them support the diverse needs of people who used the service. Training had included awareness of dementia, the Mental Capacity Act and the Deprivation of Liberty safeguards. There had been regular staff meetings at which staff were reminded about the importance of maintaining records of how people had been supported. All team leaders had been issued with a copy of the Care Quality Commission's Essential standards of quality and safety so that they understood what standards of care were required. A programmed of staff supervision had been introduced to support staff and to monitor that staff had put learning into practice.

The home had a recreation and leisure officer who had arranged a comprehensive programme of activities for people who used the service.

We found that people's needs had been assessed and that care and treatment had been planned and delivered in line with their individual care; and that care and treatment had been planned and delivered in a way that ensured people's safety and welfare.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spoke to five people who used the service. None told us anything that suggested that they felt that not enough staff had been on duty. Our observations throughout the day of our inspection were that people's needs had been attended to promptly and courteously.

Other evidence
When we inspected the home on 25 May and 6 June 2012, staff and relatives raised concerns that there had been occasions when not enough staff had been on duty and that as a consequence some people's care needs had not been met, especially at the home's nursing unit.

After we reported our concerns arising out of our visits in May and June, the provider a had implemented an action plan to improve the management of the home, including more effective ways of deploying staff to ensure that enough staff with the right knowledge, skills and experience were on duty to meet the needs of all of the people who loved at the home. A significant change was that the provider had decided that the home would not provide nursing care from 15 October 2012.

The provider had set a requirement that minimum staffing levels required a ratio of one member of staff to six people who used the service. More staff would be on duty depending on the assessed needs of people who used the service. In practice that meant that five care workers and a team leader staff supported 31 people who lived in the residential care unit (a ratio of one staff to five people); and six care workers

supported 23 people who lived in the dementia unit (a ratio of one staff to four people).

Three people who were in the nursing unit were cared for by a nurse and, when required, a care worker from the dementia unit or from the residential unit. That was not an ideal situation, but if the nurse required immediate help there were means of contacting the manager or a team leader without the nurse leaving the nursing unit. However, that would not be an issue from 15 October 2012.

Taking the service as a whole, 13 staff supported 53 people (a ratio of one staff to four people) during the day. At night, five staff were on duty.

During our inspection on 26 September 2012 we saw staff responding promptly to requests from people. Records we looked at confirmed that people had been supported with aspects of personal and nursing care at scheduled intervals. All of the people we saw in the residential and dementia units were smartly dressed. Staff had supported a group of people to get ready for an excursion, other staff engaged in meaningful activities with people . That showed that enough staff were on duty.

Our judgement
There were enough qualified, skilled and experienced staff to meet people's needs.

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
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