Review of compliance

Sharnbrook Care Home Limited Sharnbrook Care Home Limited	
Region:	East
Location address:	17a Park Road North Houghton Regis Dunstable Bedfordshire LU5 5LD
Type of service:	Care home service without nursing
Date of Publication:	July 2012
Overview of the service:	Sharnbrook Care Home Limited is a care home registered to provide accommodation for persons who require nursing or personal care. The home provides a service for up to 24 people who may have a range of care needs including dementia and physical disabilities.

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

Our current overall judgement

Sharnbrook Care Home Limited 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 to check whether Sharnbrook Care Home Limited had taken action in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services
Outcome 05 - Meeting nutritional needs
Outcome 07 - Safeguarding people who use services from abuse
Outcome 13 - Staffing
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 6 June 2012, checked the provider's records, 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

We used a number of different methods to help us understand the experiences of people using the service, because some of the people using the service had complex needs which meant they were not all able to tell us their experiences.

For example, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us to understand the experience of two people who could not talk with us.

During our visit on 06 June 2012, we spoke to another two people about their experiences and observed the care and support being provided to 17 people in total. We also spoke to three relatives and some members of staff, including the manager.

People told us that the food was good, and that they liked the staff.

However, they also told us that they would like to see people doing more activities.

What we found about the standards we reviewed and how well Sharnbrook Care Home Limited 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. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

People were not consistently treated with consideration and respect.

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

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

People using the service did not always experience appropriate care and support because the delivery of care did not promote people's welfare and well-being by taking into account their individual mental, social and emotional needs.

Outcome 05: Food and drink should meet people's individual dietary needs

The provider was meeting this standard. People were supported to be able to eat and drink sufficient amounts to meet their needs.

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

The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

However, the steps that have been introduced to achieve this require further strengthening to embed practices within the home, and ensure that all staff working in the home are confident about their responsibilities in identifying, reporting and responding to incidents of suspected and actual abuse.

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

The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Some of the staff working in the home did not have the right skills and experience to meet the complex needs of the people living there. This placed people at risk of not having their welfare needs met.

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 meeting this standard. Systems had been introduced to assess and monitor the quality of service that people receive.

However, the provider will need to strengthen these systems to be able to demonstrate that there is a continuous quality improvement system in place, that does not solely rely on feedback from external sources. People living in the home need to be clear about planned improvements, and benefit from these in a timely way.

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 minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We used a number of different methods to help us understand the experiences of people using the service, because some of the people using the service had complex needs which meant they were not all able to tell us their experiences.

A visitor told us that their relative had been able to bring personal items with them when they moved into the home; to help them to settle in, and that this had been appreciated.

Other evidence
Our inspection of 07 February 2012 found that people were not sufficiently involved in making decisions about the care and support they received.

When we revisited the home on 06 June 2012, we spent some time observing the support provided to people living in the home, and found that this had improved. We observed some positive engagement between staff and people using the service, and people were offered choices such as whether to have a biscuit with their drink or if they wanted to join in with activities that were being offered.

One person chose to sit on their own after lunch and this was respected. Other people

were asked if they would like to read a magazine or if they needed a cushion - to make them more comfortable.

We observed how staff explained to people what they were doing as they carried out their tasks, and that the majority of staff treated people with respect and dignity. People were encouraged to be as independent as possible in regard to their mobility and no one was rushed.

One person was visited by the GP and was supported to go to their room, to ensure their privacy and dignity was upheld.

The provider might find it useful to note however, that staff would benefit from increased awareness when hoisting people, particularly when they are wearing skirts and dresses. There were a few occasions when we observed people's dignity being placed at risk, although this was not intentional.

People looked well cared for in respect of their dress and appearance, and a few people had their hair styled during our visit by a hairdresser who carried out regular visits to the home.

A number of people living in the home had dementia related care needs and as such were not able to make some decisions about their care and support. There was evidence that relevant external professionals and family members had been involved in care planning decisions and reviewing people's needs.

In the afternoon, tea and coffees were brought out to people, but people were not asked what they would like to drink. Whilst it is recognised that people may no longer be able to make certain decisions about their care and support, the provider might find it useful to note that this arrangement did not demonstrate that people are enabled to make decisions, as far as they are able to do so.

After lunch, one person was seen repeatedly shouting out in a confused state. The majority of staff responded and tried to provide appropriate comfort, but sometimes they did not, meaning that the person was not treated with consideration and respect. At one point a member of staff told the person to stop shouting.

We passed our observations onto the provider after our visit who told us that the manager would give guidance on dignity and respect, and remind staff about the correct way of communicating with people, to ensure that appropriate support is consistently provided.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard.

People were not consistently treated with consideration and respect.

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 minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to three relatives during our visit who all told us that they thought their relatives would benefit from more activities, or activities that were tailored to their specific needs.

One person told us that the television was a "frustration", because it got in the way of conversations taking place.

Other evidence
Our inspection of 07 February 2012 found that care plans and related documents were not detailed enough and were not kept up to date, meaning that people's current needs were not always clear.

When we revisited the home on 06 June 2012, we looked at care records for two people living in the home and found some improvements had been made. For example, there was evidence of people's needs being assessed prior to moving into the home. Care records provided useful information, and we saw that care plans were being evaluated on a regular basis. Records showed that additional external professional support had been sought, to ensure people's welfare was protected and all their needs met.

People who were at risk of poor nutrition or developing pressure ulcers were being monitored, and we saw people who were at risk being encouraged to eat and drink during our visit. Staff were seen using specialist pressure relieving equipment - to

manage and reduce the risk of people developing pressure ulcers. The provider might like to note however, that the equipment we saw in the case of one person, did not exactly match the equipment described in the person's latest pressure area care plan. The manager confirmed that the equipment seen was the right equipment and that the person's care plan would be updated accordingly.

A tool that had been used to assess the risks to the person regarding nutritional intake had identified that they required a fortified diet. This was clear to see in the person's care records file, but a separate care plan regarding nutrition, had also not been updated to reflect this information. Despite this, there was evidence that the person's pressure ulcer had improved, and that they had gained weight.

People's needs were being reviewed on an annual basis or as required. Review meetings had involved the person, their family and/or a social worker. The most recent review notes for one person included comments such as: 'she looks well' and 'appeared comfortable and cared for' and 'care notes were clear and up to date. No concerns'. The person's relative had stated they were happy with level of care and stimulation provided.

However, we saw a number of people sitting around the home with no obvious stimulation, drifting in and out of sleep. We did see some activities being provided, and people who joined in with these were seen responding positively. However, we did not see anything that indicated that people with advanced dementia care needs were being provided with meaningful activities, suited to their specific needs and interests. One person's care plan stated that 'activities need to be tailored to her capability', but the care plan evaluation sheets made reference to the person spending most of their time in the lounge - observing activities, rather than participating in them. We noted that televisions were switched on in both lounges, and in one lounge, only one person out of nine was obviously watching it.

We noted too from reading some recent satisfaction survey responses received from people living in the home and their relatives, that a lack of regular activities and appropriate stimulation had also been raised by several people. One person living in the home had written that they liked activities "when we have them".

We passed our observations onto the provider after our visit. They told us that the manager was in the process of training members of staff to assist them in making sure that care records were always up to date. The provider had also recently undertaken to complete administrative tasks such as staff rotas, to free up more time for the manager to spend on care planning and overseeing the care provided to people living in the home.

We were also told that training regarding communication and the provision of activities for people with advanced dementia care needs, would be arranged for staff, to ensure that people using the service experience effective and appropriate care and support.

Our judgement
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

People using the service did not always experience appropriate care and support

because the delivery of care did not promote people's welfare and well-being by taking into account their individual mental, social and emotional needs.

Outcome 05:
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

The provider is compliant with Outcome 05: Meeting nutritional needs

Our findings

What people who use the service experienced and told us
During our visit on 06 June 2012, we spoke to one person living in the home who told us the food was good.

A visitor also told us they had no concerns about the food provided to their relative. They told us that their relative had gained some much needed weight since moving into the home.

Other evidence
Our inspection of 07 February 2012 found that people were not being given a sufficient choice of food and drinks to ensure their nutritional needs were met.

When we revisited the home on 06 June 2012, we found that a two weekly menu was in place, providing people with a choice of suitable and nutritious food three times a day.

The manager confirmed that there was no one living in the home at the time of our visit who required nutritional supplements, but some people did require a fortified diet, to provide them with adequate nutrition.

We spoke to the cook who told us she had a list of people who needed special diets, including soft and fortified meals. The provider might like to note that there was another list to remind kitchen staff when it was someone's birthday. We read that someone's birthday coincided with the day of our visit, but this had been overlooked and no arrangements had been made to mark the occasion.

Records showed that people who were at risk of poor nutrition had been gradually gaining weight, and that half of the staff team had received recent training regarding nutritional care planning.

Care records made reference to people's likes and dislikes in respect of food and drink, and we observed people being given food and drinks throughout our visit. People who were at risk of poor nutrition and dehydration were encouraged to eat and drink by staff.

Where people required assistance with eating, we noted that they were not rushed. Lunch was also served to suit the needs of the people living in the home. For example, one person had a visit from their GP, so their dinner was saved until after their appointment.

Our judgement
The provider was meeting this standard. People were supported to be able to eat and drink sufficient amounts to meet their needs.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We spoke to people using the service, but their feedback did not relate to this standard.

Other evidence
Our inspection of 07 February 2012 found that the provider did not have the appropriate policies, procedures and protocols in place to give staff sufficient guidance about protecting people using the service from abuse and harm.

When we revisited the home on 06 June 2012, we found the provider had taken steps to address the concerns we raised. A safeguarding poster, making reference to local and national procedures for responding to suspected abuse, was on display in the entrance of the home. The poster provided clear information to anyone who suspected that an incident of abuse had occurred, and included information on how to report any concerns.

Records confirmed that staff had received up to date training regarding the safeguarding of vulnerable adults, and that the service worked collaboratively with other services, teams and agencies in relation to safeguarding matters. For example, the home had appropriately reported incidents of suspected abuse, and corresponding records had been maintained, providing an audit trail of actions taken since the event.

Staff we spoke with confirmed they had received recent training on safeguarding vulnerable adults, and told us they would report any issues of concern to the manager or provider. However, they were not completely clear about their responsibilities if they

were required to report an incident, for example in the absence of the manager and provider.

We spoke to the manager about this at the time of visit. She told us that staff had been spoken to about safeguarding procedures at a staff meeting. The minutes from the meeting lacked detail, so did not support this statement. In addition, we could not see that the minutes had been shared with staff who had not been able to attend the meeting.

We fed this back to the provider after our visit, who took action to address our concerns. They told us that another meeting had taken place the week after our visit, where the manager had spoken in detail to staff about the reporting procedures to be followed in her absence. The provider showed us a list of signatures from the staff who had attended the meeting, and told us about their plans to ensure the same information was cascaded to people who had not attended the meeting.

Additional written checks had been introduced to test staff awareness and knowledge around safeguarding issues. We were told that this had been done to identify any gaps in knowledge on an individual basis amongst the staff team. The provider said that additional support would be provided to any member of staff where knowledge gaps were found.

Training in relation to safeguarding, and legal processes - to be followed when supporting someone who may lack capacity to make decisions about their own care and support, had been organised for new members of staff and the provider. This demonstrated the provider's commitment to ensuring everyone working at the home is appropriately trained, to protect people using the service from abuse and harm.

During our visit we found no indications that anyone using this service was subject to any form of inappropriate control or restraint.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

However, the steps that have been introduced to achieve this require further strengthening to embed practices within the home, and ensure that all staff working in the home are confident about their responsibilities in identifying, reporting and responding to incidents of suspected and actual abuse.

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 non-compliant with Outcome 13: Staffing. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
During our visit on 06 June 2012, one person's relative told us that they had a good relationship with the staff and felt comfortable to address any concerns they had with them.

Someone living in the home told us that the staff were "good".

Other evidence
Our inspection of 07 February 2012 found that the managerial arrangements were not adequate to ensure that people were receiving safe and effective care. Training records did not support training that had been attended by staff, and staff were not being properly supported to provide care and support to people using the service.

When we revisited the home on 06 June 2012, we found that the registered manager had recently returned to work following a period of absence. They had begun to take a look at the issues raised during our last visit and an action plan had been drawn up in conjunction with the provider, to move things forward and improve the service being provided to people living in the home.

Staff meetings were taking place and formal staff supervision had been introduced, to enable the manager to monitor staff practice and competence more closely, and to provide support to staff in carrying out their roles.

A training matrix was in place, enabling the manager to identify staff training needs. The

matrix had recently been updated and showed us that staff had received training in relevant subject areas, to support them in meeting the assessed needs of the people living in the home.

We noted that 12 of the 20 care staff working in the home had received training regarding dementia care. However, observations made during our visit showed that this training was not consistently being put into practice. Particularly in respect to a lack of meaningful activities for people with advanced dementia care needs, and poor levels of communication with people.

Our judgement
The provider was not meeting this standard. We judged that this had a minor impact on people using the service and action was needed for this essential standard.

Some of the staff working in the home did not have the right skills and experience to meet the complex needs of the people living there. This placed people at risk of not having their welfare needs met.

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 compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We spoke to people using the service, but their feedback did not relate to this standard.

Other evidence
Our inspection of 07 February 2012 found that systems in place to ensure that a quality service was being provided to the people living in the home were not robust.

When we revisited the home on 06 June 2012, we found that there had been some improvements. The registered manager had returned back to work following a significant period of absence, and had started to address the concerns raised at our last visit, in conjunction with the provider.

The provider had also arranged for satisfaction surveys to be completed by people living in the home, and their representatives; to gain some direct feedback about the service being provided by the home. A summary of the survey results was seen, which provided information about areas that the service was performing well in, as well as areas that required improvement.

We noted that a number of positive comments had been made such as "we have always been happy with the service and care provided" and "a big thanks to everything, staff are very welcoming warm and happy".

However, where less positive comments had been made, for example - at least four of the 22 people who had completed a survey had made comments about a lack of

suitable activities, the provider had not specified how the improvements were going to be made or by when. It was therefore not clear when people using the service would start to benefit from the improvements that were required.

We fed this back to the provider following our visit, who told us that they were in the process of arranging a relatives meeting to gain further feedback about the service provided and to discuss the improvements needed. The provider also told us that internal audits were planned, to assess the quality of service provision, in relation to the environment, care planning, health and safety and staff training. They said these would be completed by the end of June 2012.

Our judgement
The provider was meeting this standard. Systems had been introduced to assess and monitor the quality of service that people receive.

However, the provider will need to strengthen these systems to be able to demonstrate that there is a continuous quality improvement system in place, that does not solely rely on feedback from external sources. People living in the home need to be clear about planned improvements, and benefit from these in a timely way.

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: People were not consistently treated with consideration and respect.	
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: People using the service did not always experience appropriate care and support because the delivery of care did not promote people's welfare and well-being by taking into account their individual mental, social and emotional needs.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Some of the staff working in the home did not have the right skills and experience to meet the complex needs of the people living there. This placed people at risk of not having their welfare needs met.	

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

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