Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Leacroft

120 Colchester Road, Leicester, LE5 2DG

Tel: 01162461425

Date of Inspection: 19 December 2012

Date of Publication: January 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Meeting nutritional needs	✓ Met this standard
Safeguarding people who use services from abuse	✗ Action needed
Safety and suitability of premises	✓ Met this standard
Staffing	✓ Met this standard

Details about this location

Registered Provider	HC-One Limited
Registered Manager	Miss Clare Armstrong
Overview of the service	This service provides personal care for up to nineteen people with learning disabilities. A number of people also have physical disabilities.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 19 December 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with carers and / or family members and talked with staff.

What people told us and what we found

Because of people's communication difficulties, we were not able to speak with them.

We spoke with five relatives/friends. They all told us that the care supplied was good, although one person said that this had not always been the case. One friend said; "It's marvellous there. The care is excellent ". A relative said; "Staff are friendly and helpful. The new manager is trying to make things better as well".

One friend said that staff sometimes would sometimes speak with each other, rather than the people living in the home. Another person said that staff sometimes watched the TV rather than engaging with people.

The main issues that needed attention was to ensure that there were enough staff on duty to care for people at mealtimes. Management also need to ensure that we are kept informed of any safeguarding incidents so that we can monitor whether we need to take action before the next scheduled inspection.

This was a generally positive inspection. The issues we identified from the last inspection were followed up. Relatives and friends were generally very satisfied with the care that staff provide.

Management quickly responded to us as to the issues identified in this inspection.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 29 January 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

The provider has met this regulation. People were generally respected in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

Due to people's communication difficulties, we were not able to speak with them.

Three relatives/ friends said that they had been involved in reviewing care plans. One friend said she was invited to reviews sometimes, but not all the time. Another person said that she was not involved in reviews. Management may wish to note that including relatives/people's representatives is needed to ensure that care is fully relevant to people. The manager later told us that this would be done.

One person said that people's clothes sometimes went missing and sometimes were mistakenly given to other people. The manager later told us that he had already looked into this issue, and was monitoring it.

We spent time observing the relationship between people and staff. We found staff were friendly and helpful to people. For example, we saw a staff member getting a person some bangles to play with. At lunchtime, a person was given the option of a choice of utensil to eat with, either a spoon or a fork. We saw staff helping a person who seemed confused, to sit down, in a calm and friendly way.

We saw evidence from the manager that relatives meetings were to be set up, so that people could give their views about the running of the home.

We saw that the service employed an activities organiser five days a week. Her job was to provide activities throughout the day. We saw that people had the opportunity to dance. Other activities included singing, baking, colouring and going out to community activities such as to the park, cafes and pubs.

We saw that one person was taken out to the local park and to a cafe to have a drink. We looked at this person's care plan. This confirmed that he liked to go out regularly.

This showed us that people's needs were taken into account in providing activities.

We did see the TV on in lounges, when there was no one looking at it. Comment was also made by one person that staff watched the TV, and watched their own programmes on TV, rather than engaging with people. The manager said that this would be followed up and monitored.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider has met this regulation. People had experienced care and treatment that generally met their needs.

Reasons for our judgement

We spoke with five relatives/friends.

Relatives expressed their satisfaction with the care. Three friends and relatives said they had been involved in reviews of care. One relative said; "I am always invited to reviews ". Another relative said; "staff listen to what I say about my son's care and this is put in the care plan". One friend said she was involved sometimes. Another person said she had not been involved in care planning. This suggests that people's representatives are not always involved in care planning. Management may wish to note this is needed to ensure proper individual care is supplied to people. The manager later stated that he would ensure that this issue was in place.

The manager informed us he was in the process of reviewing care plans to ensure they fully reflected people's needs. This statement was supported by information we found in the quality assurance manager's report of November 2012.

We also saw evidence in recent staff meetings at the manager was to introduce a more person centred care planning system. This would ensure that people's care met their specific individual needs.

Each person who used the service had a file containing their care plans and other information that staff needed to care for and support them. We looked at three care plans. We saw they contained information about people's individual needs. We saw that care plans were reviewed regularly. Staff told us that they were asked to read care plans to ensure the care they provided was relevant.

One plan gave us information about how the service was meeting the needs of a person with sight loss. There was a report on file from a specialist service which detailed what was needed to meet this person's needs. We found this information had generally been incorporated in the care plan. However, one recommendation about the need for staff training on how to effectively communicate had not been taken up. The manager said that this would be followed up and acted upon. We were quickly sent information by the manager on how this was to be achieved.

We looked at another care plan for a person who was on a low-calorie diet due to a high

cholesterol level. The care plan stated that person needed to have a diet low in saturated fat, have limited processed food and sweet foods. However, there was no specific advice about this in the plan. This made it difficult for staff to know whether the diet provided followed relevant guidelines. The manager said he recognised this and said it would be followed up. Again, we were quickly sent information on how this was to be achieved.

Another care plan contained a person's likes and dislikes of food. However, there was no information as to the person's religious or cultural needs. The manager said that he had identified the same issue. He said he was in the process of ensuring this information was available in the plan, so it could be acted upon by staff.

Management may wish to note that care plans should always be clear as to people's specific care and cultural needs, so they can be met.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

The provider has met this regulation. People were protected from the risks of inadequate nutrition.

Reasons for our judgement

We were concerned about this issue in last inspection, so we followed this up.

We also spoke with five friends and relatives about this issue. Three people told us that they thought that the food had improved in the past year.

We observed people having a meal.

We saw that there day's menu was available in pictures on notice boards throughout the home.

We looked at the issue from the last inspection of dining rooms not been prepared in advance. We found on this inspection dining tables had tablecloths on them, and there were flowers on the table. This made dining rooms look more homely.

We saw that people were given a choice of food. This was either a meat dish or a vegetarian alternative. A choice of vegetables were available.

We witnessed staff assisting people to eat their meals if they could not do this themselves. Staff helped people at a relaxed pace and waited for the person to finish eating before offering more food. Staff were seen trying to encourage people to eat.

The meal looked nutritionally balanced and appetising. On the last inspection we noted that people on soft diets had their meals pureed altogether, which looked messy. On this inspection we saw that this was not the case. Meals therefore looked more attractively presented, which encouraged people to eat them.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider has not met this regulation. People who used the service were not sufficiently protected from the risk of abuse because the provider had not taken all necessary precautions to ensure a proper system to protect people was in place.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with five friends and relatives. They all told us they considered that their relatives were safe living in the service.

We spoke with two staff members. Both staff were aware of how to report abuse to the management of the home. They were also aware of how to use whistleblowing procedure and which appropriate outside agencies to report to, if management had not properly acted to protect people.

We looked at incident reports. In these reports it stated that there had been a number of physical altercations between people live in the home. However, we only saw evidence of one incident that had been reported to us. There was evidence that management had not reported all relevant incidents to the lead agency for investigating such incidents, or to us. This meant that people were potentially at risk because there had been no thorough investigation, or monitoring, of all the incidents that had taken place.

Management quickly sent us information outlining how this would properly be acted upon in the future.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

The provider has met this regulation. The provider has taken steps to provide care in an environment that is generally suitably designed and adequately maintained.

Reasons for our judgement

Relatives and friends all told us that the premises had been improved in the past year. They thought that bedrooms were personalised and homely. One relative said; "There have been a lot of improvements, which is welcome". We received one comment that the home was not always clean and that staff did not always wash up, so that some kitchenettes in the bungalows looked messy. The manager said that he had checked this issue. He had not found this to be the case since he started working in the home two months previously.

We were concerned at premises were not meeting people's needs on the last inspection, so we followed up this issue.

We toured the home and found that it was warm, clean and tidy. We saw that a decorator was in the process of painting corridor walls.

We looked at lighting levels in bedrooms. Bedrooms did not have bright lights, as the lighting in place produced shadows. This meant that people could have been confused if they could not see everything in the bedroom. The manager said that this would be assessed and followed up.

The varnish of some bedroom windowsills was coming off. The manager said that there was a plan to rectify this.

We saw that a person had a specialist chair that was wide. We saw that staff had difficulty going through doorways. There was one comment that if the person had his arms outside the line of the arm rests, then his arms could catch on doorframes. This could have caused an injury. The manager sent us information that doorframes are to be widened, to help the person to go through doorframes without the risk of injury.

Management may wish to note that the issues noted above need to be followed up to ensure people's needs are fully met.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider has met this regulation. There were generally enough staff to meet people's needs.

Reasons for our judgement

We were not able to gain their views of people about staffing levels, due to their communication difficulties.

Relatives and friends told us that generally there appeared to be enough staff on duty.

We had concerns about staffing on last inspection, so we followed up this issue.

We received comments that in one bungalow there were five people who needed assistance or supervision to have their meals. However, on some occasions, when staff had gone out with people to community activities, there was then only one staff member to help people to eat. It was stated that at times the nurse on duty was able to assist. However, if the nurse was busy, this was not possible. This meant that it was difficult to ensure that everyone was able to have their full meal. The manager immediately investigated this issue. He said that this had happened in the past, but it was currently not an issue. He said that this would be monitored to ensure there were enough staff to assist people.

We also received comments that it was difficult to have the time to complete a large number of e-learning courses, at the same time as trying to provide care that people needed.

We looked at the staff rota. This indicated that there was generally a sufficient number of care staff in the three separate bungalows on weekdays, except when staff were out in the community with people.

However, at weekends, no domestic or laundry workers were employed. This meant that care staff had to undertake these duties. This took them away from providing essential care duties to ensure that people's needs were met. The manager recognised this situation and said he would talk to his line manager about this. We were then quickly sent information as to how the staffing shortfalls would be followed up.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: There was evidence that management had not reported all relevant incidents to the lead agency for investigating such incidents, or to us. This meant that people were potentially at risk because there had been no thorough investigation, or monitoring, of all the incidents that had taken place.

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 by 29 January 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – 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.

Moderate impact – 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.

Major impact – 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk