Inspection Report

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

Kingsthorpe View Care Home

Kildare Road, off the Wells Road, St Ann's,
Nottingham, NG3 3AF

Tel: 01159507896

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01 October 2013

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We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✗ Action needed
Care and welfare of people who use services	✗ Action needed
Safeguarding people who use services from abuse	✗ Enforcement action taken
Cleanliness and infection control	✗ Action needed
Safety and suitability of premises	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✗ Action needed
Notification of other incidents	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	HC-One Limited
Registered Manager	Ms. Lynne Belinda Brewell
Overview of the service	Kingsthorpe View Care Home provides accommodation for up to a maximum of 50 persons who require nursing or personal care in the Nottinghamshire area.
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

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 1 October 2013 and 2 October 2013, 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 people who use the service, talked with carers and / or family members and talked with staff.

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

What people told us and what we found

We found the previous registered manager had left employment. A new manager was now in post and working towards making the required improvements.

We found there had been improvements in respect of staff respecting people's privacy and dignity. People using the service told us that staff were respectful at all times and their privacy and dignity were maintained.

We saw that people were able to make their own choices and decisions wherever able throughout our visit. One person said, "I am happy here, I can do what I want to do when I want to do it." However further improvements were needed in respect of implementing the Mental Capacity Act 2005.

During our observations we saw there had been an improvement in respect of staff interactions with people and the way in which they responded to people's needs. We saw that staff were available to give assistance to people where needed. Staff were responsive to individual needs.

We spoke with four people about the care they received from staff. They all told us they were happy with the care and support they received. One person said, "It's wonderful care." Another person said, "The staff are very nice, they look after me well. I am happy here."
We found due to a lack of care planning and risk assessments that people were not fully protected from the risk of abuse.

We found there had been improvements in respect of the cleanliness and maintenance of the home.

We spoke with four people using the service and they told us they felt there were enough staff available to support them. We also spoke with a relative of a person using the service and they told us they felt there were enough staff to meet the needs of people.

Four people we spoke with told us they liked the staff and felt they supported them as they should. One person said, "They are nice and they know what they are doing." Another person said, "The staff are very kind, they know how to look after me."

We found there had been some improvement in respect of the quality assurance and record keeping.

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 14 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Kingsthorpe View Care Home to protect the health, safety and welfare of people using this service.

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.

People's privacy, dignity and independence were respected.
People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

When we inspected the service in June 2013 we had concerns that people's privacy, dignity and independence were not consistently respected. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

We spoke with two people about how well staff respected their privacy and dignity and they told us they did not have any concerns about this and felt staff respected them. We spoke with one relative who said, "The home is respectful and give [the person] their dignity."

Staff were able to tell us how they would respect people's privacy and dignity whilst giving care and support. Two members of staff told us they knocked on people's doors before entering their room and they asked people for their permission before doing anything.

We found there had been an improvement in respect of staff interactions with people and we saw staff treated people with respect, offered them explanations when needed and they were mindful of people's dignity when supporting them. We saw staff knocked on people's bedroom doors before entering, to ensure they respected their privacy.

We saw the doors to people's rooms had been personalised with photographs and memory boxes. We saw signs above communal areas to help people understand what each room was for.

We saw that some bathroom doors did not have a lock on and this posed a risk of people's privacy and dignity being compromised. The manager addressed this on the day of our visit.
We spoke with a visitor and they told us their relative had been wearing another person's clothing when they had visited previously. We found there was clothing belonging to two

other people when we looked in the person's wardrobe, despite them being clearly marked with another person's name. The provider may find it useful to note that this was not dignified for the person as there was a risk they would wear another person's clothing.

People told us they were able to do what they liked with their day and staff supported this. We observed people during our visit and we saw they were able to move around the home freely. One person we spoke with told us they could choose what time they got up and went to bed. We saw this happening in practice with one person choosing to stay in bed until late morning.

We saw an improvement in respect of the meal time and these were organised and people were being supported and given the assistance they required. We saw there was a choice of meal and this was displayed in the dining areas in a large picture format which would be easy for people to see. However, we saw that some main choices did not have pictures available and these were handwritten, which may mean some people would struggle to make an informed choice if offered those meals. We saw staff offered choices at lunchtime and two people we spoke with told us there was always a choice of food.

We saw in two people's care plans that they liked to be dressed a certain way. We saw staff had observed this instruction on the day of our visit and the person was dressed in line with their preference. This meant staff had respected their choices in relation to their care and support.

We saw in the care plan for one person living with dementia that they had started to revert to their first language. We read that the person could become agitated when they were not understood, and for staff to use simple, clear language and picture aids to support communication. We spoke with one member of staff who told us they tended to speak slowly with hand gestures, did not use picture aids and had not asked the person's relatives for prompts in the person's first language. We observed the person respond positively to staff interactions. The provider may find it useful to note that simple language prompts in this person's first language may support staff in communication with this person.

One person told us they had requested a key to their bedroom so they could lock the door and this had been arranged quickly. This meant the person was involved in decisions about their care.

We saw there were meetings held for people using the service and relatives to attend. The minutes of the last meeting for people using the service were on display and we saw people had been involved in decisions about what they ate and what activities they took part in.

We spoke with one person and one relative about the admission process and they told us they had looked around the home before deciding if it was the right place for them. The relative said, "I was told I could come to view the home at any time." They told us they had received enough information about the service prior to making the decision.

Consent to care and treatment ✖ Action needed

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements.

We have judged that this has a minor 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

When we inspected the service in June 2013 we had concerns that people were not asked for their consent before they received care or treatment and the provider did not consistently act in accordance with their wishes. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

We found mixed evidence for this outcome.

We saw staff interacted well with people and they provided explanations where necessary before supporting them with their care. Staff were also seen to ask people for their consent before assisting them.

We saw that people were able to make their own choices and decisions wherever able throughout our visit. One person said, "I am happy here, I can do what I want to do when I want to do it."

We found there had been an improvement in respect of staff training and understanding of the Mental Capacity Act 2005 (MCA). We spoke with four staff members about their understanding of the MCA. The MCA provides a legal framework to empower and protect people who may lack capacity to make some decisions for themselves. The MCA provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests.

One staff member told us, "We make sure residents have the right to make their own choices." The other staff member told us, "It's about resident's capacity to consent. If not, then we put a care plan together and do it in their best interests." This meant that these staff members had an understanding of the importance of involving people and seeking their consent to care.

We found the manager had begun to implement the MCA within people's plans of care

working towards ensuring people's rights and choices were maintained.

We saw from the records relating to one person that a decision had been made in their best interest in relation to their care. The appropriate assessment had been completed which detailed why the decision was being made, who was involved and what action was needed for staff.

However, we saw care plans for two people who lacked the capacity to make some decisions. We spoke with senior staff who told us that these people could make some decisions but not others. We found no consideration of the MCA for those care needs in which the people lacked capacity to make associated decisions.

We saw a care plan for a person living with dementia. The care plan stated that they had no insight to their health needs and were, "Totally dependent on staff for all aspects of daily living." We found no assessments of capacity or best interest decisions within the care plan. This meant that the staff had not legally assessed this person's capacity to make their own decisions and there was a risk their rights to consent or refuse treatment may not be upheld.

We saw a care plan for another person who may have lacked capacity to make some decisions. We saw that a generic best interest assessment had been made for, "Daily living – bathing, dressing, toileting, eating and drinking, administration of medications, use of bedrails." We did not find 2-stage tests for capacity to consent for each of these areas. We found a generic best interest decision for these areas of daily living and a consent form for the use of bedrails signed by a relative. This meant that there was a risk this person may receive care they had not consented to or was not in their best interests.

We saw where someone had been refusing some treatment and support that staff had documented that the person had the capacity to do this. However there was no evidence of a MCA two stage test to test the level of the person's capacity and understanding of the impact this may have on their welfare and safety. This meant that there was a risk of the person refusing treatment when they may not understand the consequences.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a minor 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

When we inspected the service in June 2013 we had concerns that people did not experience care, treatment and support that met their needs and protected their rights. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

Due to the complex needs of some people living at Kingsthorpe View they were unable to talk with us. We therefore used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We carried out this observation in two areas of the home. In one area we carried out the SOFI for a period of 40 minutes over the lunch period. In another area, we carried out the SOFI for a period of 25 minutes.

During our observations we saw there had been an improvement in respect of staff interactions with people and the way in which they responded to people's needs. We saw that staff were available to give assistance to people where needed. Staff were responsive to individual needs. For example they supported a person to independently eat their meal and when the person stopped trying to eat their meal staff responded to this and sat and supported them. We saw people were offered a choice of meals and those who ate all or most of their meal were offered second helpings. Staff supported people's hydration throughout the meal by continually filling up juice glasses when people had finished. We had identified one person required a special diet and we saw this was provided as detailed in their care plan. We saw that when one person started to get anxious, staff intervened quickly to calm the situation.

We saw many examples of staff responding to the needs of people in a caring and kind way throughout the inspection. One person looked in discomfort and this was quickly noticed by staff and they made the person more comfortable. Another person told staff they wanted to have a rest on their bed and staff supported them to do this.

We spoke with four people about the care they received from staff. They all told us they

were happy with the care and support they received. One person said, "It's wonderful care." ". Another person said, "The staff are very nice, they look after me well. I am happy here."

We spoke with one relative who said, "The care is wonderful, I couldn't ask for anything better." However another relative told us they were not happy with all aspects of the care their relative had received. We fed this information back to the manager who told us they would look into this issue.

We spoke with two members of staff and asked them about the care needs of people who used the service. They were able to give us a good description of individual care needs and how they supported people.

We saw a timetable of group based activities on display around the home. We saw staff engaging groups of people in activities at specific times during the day, although this did not always follow the timetable. However we observed some people walking around the home without purpose or sitting passively for long periods. We spoke with staff who told us that more could be done for some people if additional resources were available for providing activities.

We looked at the care plans and associated risk assessments for 13 people using the service. A care plan is a document which should identify a person's needs and how staff can meet those needs, including assessments or identified risks for each person.

We found the manager had been working on reviewing plans of care and implementing a new format so these offered clearer and more accurate information about people's needs. We looked at number of plans that were in the new format and found these were detailing people's needs better. We found that although there had been improvements care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare.

We saw one person had diabetes and staff had put a care plan in place detailing the signs which would indicate this was not under control. There was information telling staff what the person's usual blood sugar levels were and what signs to look for indicating the person's blood sugar levels were not safe. This meant staff would be aware of how to respond to this person's medical need.

However, we saw another person had diabetes and staff had put a care plan in place detailing the signs which would indicate this was not under control. We spoke with staff and the relative of the person, and found the information in the care plan telling staff what the person's usual blood sugar levels were was incorrect. We spoke with a healthcare professional who confirmed the care plan was incorrect. This meant that there was an increased risk to the health and wellbeing of this person due to this inaccurate information in the care plan.

We saw that where people had been assessed as being at risk of developing a pressure ulcer there was not always a care plan in place telling staff how to manage the risk of these occurring. We spoke with three staff about the needs of these people and the staff we spoke with knew they were at risk of developing a pressure ulcer and what they needed to do to minimise the risk of this happening. Although staff had a good knowledge of people's needs in relation to pressure care, the lack of care planning posed a risk of a pressure ulcer developing as there were no clear instructions on the re-positioning of

people and the need for a nutritious diet.

Although there had been improvements in respect of the completion of people's Malnutrition Universal Screening Tool (MUST) records we saw that these were not always consistently being updated on a monthly basis to ensure staff had an up to date record of the nutritional risks of people.

Safeguarding people who use services from abuse ✖ Enforcement action taken

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

Our judgement

The provider was not meeting this standard.

People who use the service were not fully protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We inspected this regulation due to concerning information we had received about the service.

We spoke with two staff working in the home and they told us they had received recent training in how to safeguard vulnerable adults from abuse. Training records confirmed this training had been delivered. We spoke with one relative who said, "I have no fears [The person] is safe here. Someone grabbed [the person], but staff intervened straight away. "

Staff we spoke with were all able to tell us how they would respond to allegations or incidents of abuse and they knew the lines of reporting in the organisation. They both said they would report any poor practice they witnessed in the home immediately.

During our visit we had concerns about whether 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. We found that people were not fully protected from abuse or the risk of harm.

We some people using the service had behaviour which staff may find difficult to manage. We saw that two people had a care plan in place describing what might trigger this behaviour and how staff should respond to it. However we saw from the care plans of four other people that although they had been assessed as displaying aggression to other people there was no care plan detailing what might trigger this or how staff should respond to it. We saw there had been incidents when people had been hurt due to their own or other people's behaviour. Had there been a care plan in place telling staff how to manage this behaviour, these incidents may have been avoided.

On arrival at the home on the second day of the inspection, we found one person standing

in the corridor punching the air and making threats of violence. We asked staff to attend to this person and at the person voiced they were angry as they didn't have any cigarettes or money.

We spoke with staff and they told us the person had been admitted to the home the previous night. We looked at the person's assessment records and saw they had been assessed as having behaviour which staff may find challenging. Despite this, staff had not put in place a risk assessment or care plan detailing what might trigger the behaviour or how to respond to it. This meant other people were at potential risk from this person.

We saw that where people had been identified as having behaviours which staff may find difficult to manage, referrals had been made to the appropriate healthcare professionals.

We saw that staff were completing 'ABC' charts, which were used by the home to record any incidents of challenging behaviour. However these were not always being fully completed with information which would assist staff in minimising the risk of a further incident. For example, following one incident staff had recorded their action as, 'cleaned the carpet' under the action taken column when a person had thrown a drink. This meant staff were not learning from incidents and taking action to prevent further incidents.

We looked at the care plan for one person living with dementia who was given medicine as and when required to support them with behaviours which challenged the service. We saw that the care plans did not indicate the triggers nor the distraction techniques used prior to administering the behaviour modification medication. We also saw the care plan did not indicate if this action was in the person's best interest. We spoke with staff who told us the triggers and the distraction techniques used for this person. This meant that there was a risk that staff were using the medication to control this person's behaviour without their permission or in their best interests and without engaging the person beforehand.

Cleanliness and infection control ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not always cared for in a clean, hygienic environment.

We have judged that this has a minor 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

When we inspected the service in June 2013 we had concerns that people were not protected from the risk of infection because appropriate guidance had not been followed and people were not cared for in a clean, hygienic environment. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

We spoke with two people about the cleanliness of the home. Both of them told us they thought the home was kept clean and tidy. One person said, "The staff always make sure everywhere is clean." Another person said, "They come to clean my room, it is usually once a week because that is what I want them to do."

When we visited we saw that an infection control policy was in place and an internal audit had taken place. We saw that the provider had set out an action plan to address the issues of concern about cleanliness which had previously been raised. We found staff were working toward completing the action plan.

We found there were improvements in respect of alcohol hand gel and signage about hand hygiene being available at the reception of the home. This meant good standards of hand hygiene were being promoted to visitors and people who entered the home. However we found a small number of other hand wash stations and hand gel dispensers were either not working or they did not have alcohol hand gel in them which would compromise effective hand hygiene should these areas be used.

We saw the staff member responsible for maintenance within the home was in the process of replacing the stained ceiling tiles which had been highlighted as a concern at the previous inspection.

We found that there were instructions for housekeeping staff in respect of the areas they were responsible for cleaning on a daily basis. There also were cleaning rotas in place which staff had to sign when they had completed the necessary cleaning tasks. Although we found that general standards of cleanliness within the home had improved we did see

that some areas of the home were in need of further cleaning. When we checked the cleaning rotas we saw there were gaps for these areas of the home for the day prior to our visit. We discussed this with the manager as there were also other gaps within the cleaning rotas which would suggest that staff were not always either following or completing these. The manager discussed this with housekeeping staff whilst we were at the home and made plans to look into these issues.

We found there had been some improvement in respect of pressure cushions and wheelchairs being kept clean. However we did see that a number of chairs in a communal area had food debris down the side of the chair cushions and they were in need of cleaning. We alerted this to the manager who stated they would address this issue. We also saw that bed rail bumpers in two people's rooms and crash mats in another two people's rooms were in need of cleaning. We spoke with a member of the housekeeping team and they told us this was their responsibility. However when we looked on the cleaning rota this was not listed. This meant that this equipment may be missed when housekeeping staff were cleaning people's rooms.

When we checked mattresses on people's beds we saw there had been an improvement in these and all were clean and serviceable.

We found that a toilet seat within one toilet was in need of replacing as it presented an infection control risk. This had not been picked during cleaning tasks and reported to the maintenance person. We requested that this was changed. The manager ensured this took place after the first day of our visit.

We found work was being undertaken on the sluice room and staff had stopped using this as a storage area. This meant that clean mops were no longer stored next to the sluice sink. However when we entered the laundry area we saw that clean mop heads had been stored in the area where dirty linen was stored. This meant there was an infection control risk.

We found there had been an improvement in respect of the cleanliness of the kitchen since our previous visit and cleaning rotas for this area were now available to ensure the kitchen was cleaned on a regular basis.

We saw work was being undertaken in the laundry room and an additional hand washing sink had been plumbed in so staff had a hand wash station.

We saw there had also been an improvement in respect of the storage of clean linen.

We found there had been an improvement in respect of the cleanliness of the outside courtyard area. We did see throughout the day that at times this area was littered with discarded cigarette ends. We spoke with the manager about this and they told us they were working with those people who smoked to try and encourage them to use the litter bins and clean up their discarded cigarette ends. We did see that the area was cleaned at regular intervals during our visit.

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.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

When we inspected the service in June 2013 we had concerns that people who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

We spoke with one person about the maintenance of the home. They told us they were happy with the upkeep of the service.

We spoke with two members of staff and asked them if they felt there had been improvements in the home since our last inspection. They told us there had been improvements which had made the environment better. They said there had been new furniture purchased, new flooring laid which suited the needs of the people using the service and areas had been redecorated.

We saw the budget for the financial year and that resources had been allocated to the continued maintenance of the home.

We found that an audit of the environment had taken place and following this an action place had been put into place. When we visited we saw that the staff member responsible for maintenance was working towards completing the action plan.

We conducted a tour of the home which included looking at communal areas, toilets, bathrooms and individual rooms. We found that some areas had been redecorated and new flooring and carpets had been laid. However the home was still in need of redecoration in a number of areas.

We found that harmful substances were no longer stored in areas where people had access to. This meant people were protected from coming into contact with these.
We saw there were still a number of radiator covers which were twisted. This meant it was easy to catch or injure oneself when passing in the corridor.

We found that all hand rails had been replaced ensuring that if people had the need to use these for support when walking they had something stable to hold onto.

We observed fire escapes were clear and fire extinguishers had been checked. We saw that a fire assembly point sign had been assigned outside the home since our previous visit to ensure that staff and people knew where to assembly should there be a fire or a fire drill.

We found that shelves in the linen store had been replaced and an additional linen store cupboard was now available.

We found that some new comfortable chairs had been purchased as long with new curtains for people's rooms and communal areas. With the new carpets in place this provided a welcoming and comfortable environment.

We saw there had been an improvement in respect of the outside grounds of the home. These were now maintained and people could access more garden space if they wanted to.

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.

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

Reasons for our judgement

When we inspected the service in June 2013 we had concerns that there were not enough qualified, skilled and experienced staff to meet people's needs. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

We spoke with three members of staff about the staffing levels in the home. They told us they felt there were generally enough staff on duty. The provider may find it useful to note that both staff said that if people displayed behaviour which staff may find difficult to manage, this could sometimes lead to other people becoming agitated and they felt more staff were needed at these times.

We spoke with four people using the service and they told us they felt there were enough staff available to support them. We also spoke with a relative of a person using the service and they told us they felt there were enough staff to meet the needs of people.

Throughout our two day visit we did not have any concerns about the number of staff available to support and care for people. People's needs were responded to in a timely manner and staff were available when people needed support.

When we looked at the staff duty rota we saw that different levels of experienced staff were available. We also saw that when staffing numbers had been low due to sickness or holidays that alternative arrangements had been made wherever possible. To ensure that the correct skill mix of staff was available to support people in each area of the home we saw that staff were allocated according to their skills and experience and the needs of people using the service throughout the day.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We inspected this outcome due to concerns that had been raised in respect of the knowledge and skills of staff.

Four people we spoke with told us they liked the staff and felt they supported them as they should. One person said, "They are nice and they know what they are doing." Another person said, "The staff are very kind, they know how to look after me."

Concerns had been raised in respect of staff knowledge and skills in respect of medicine management and responding to medical emergencies. We looked at the staff training chart and saw that staff had undertaken training in these areas. We also saw that additional training and competency assessments were being undertaken in medicine management. When we looked at the medicine audits we saw that some areas of concern had been raised about staff competency and the manager had highlighted that additional supervision sessions were to take place with staff to discuss and address these issues. The manager told us that one member of staff had undertaken a supervision in respect of this however the provider may find it useful to note that the manager was unable to locate the documentation at the time of our inspection to evidence this.

When we looked at the training chart we saw that staff were able to obtained further relevant qualifications to ensure they had the necessary knowledge and skills to perform their job role. We saw that a variety of training was available for staff such as infection control, first aid, manual handling and health and safety to ensure staff had the necessary knowledge and skills to support people using the service. We saw that all staff training was monitored and when training was due the manager was informed so this could be arranged. The provider may find it useful to note that limited training in respect of mental health awareness had been made available for staff and people with mental health care needs were living at the home. Providing additional training in this area would enhance staffs knowledge and skills in supporting someone with mental health care needs.

We spoke with one staff member who told us they accessed a range of training, but would like more training on mental health conditions.

We found there had been an improvement in respect of staff undertaking supervision to enable them to receive appropriate professional development. We saw that the manager had undertaken supervision sessions with staff and they were able to discuss their development, training and any issues of concern.

One member of staff told us they had supervision every few months and felt supported by their manager.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have a fully effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a minor 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

When we inspected the service in June 2013 we had concerns about the quality monitoring of the service. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when. They also informed us that peripatetic manager was in post to facilitate the necessary improvements. Since this time a new manager had also been recruited and they were working with the peripatetic manager to make the necessary improvements.

We spoke with two members of staff about staff meetings and they both told us staff meetings were taking place and that they felt they were being listened to if they raised issues.

We received positive comments from staff and one person using the service in relation to the management team. Staff told us they felt if they raised issues they would be listened to and acted on. The person we spoke with in relation to the management team told us, "[The manager] is lovely, I would be able to speak with them about any concerns I had."

We found that people who use the service, their representatives and staff were asked for their views about their care and treatment however these were not always acted upon. We found that questionnaires had been sent out to people using the service, however those that had been returned had not been dated and we therefore could not establish whether the feedback from these was current. We saw the information also had not been analysed and therefore no action had been taken to address any issues if raised. The manager acknowledged this and said because of this the questionnaires were to be re-sent to people so the process could be undertaken again to ensure that people could provide feedback which would be used to improve service provision.

We found there had also been meeting held for people using the service. These meetings showed that people had been given the opportunity to talk about the activities on offer for them. We also saw that if people had not been able to attend these meetings then a

member of staff had spoken with people on an individual basis so they could have their say. This meant that people were given the opportunity to provide feedback about their care and the facilities on offer to them.

We saw that staff meetings continued to take place. We found there had been an improvement in these in respect of staff being facilitated to air their views and any concerns. The meeting minutes clearly reflected that these were considered by the manager. We also saw the manager was working with staff to resolve issues and make improvements to demonstrate that their views about the service quality were listened to. This meant the system to discuss, monitor the quality of service for people living in the home and make changes in response to any problems was more effective.

We saw that fire equipment and other equipment was checked and maintained regularly.

We found the provider had quality monitoring systems in place and there had been an improvement in respect of these. We found numerous audits took place in areas such as infection control, the environment, medicines, care plans and accidents and incidents. However we did see that on occasion that sometimes an action plan had not been put into place to address issues raised, or that an action plan had been put into place but not followed up to ensure all issues were rectified. This meant that although there were quality monitoring systems in place they were not always fully effective.

We also found that accidents/incidents were being audited. This enabled the manager to see if there was a pattern or trend in respect of accidents so the necessary action could be taken to reduce these.

A complaints policy and a whistleblowing policy were in place. The complaints policy was also displayed in the main entrance of the home. We found where complaints had been received that these had been investigated and the necessary action taken to resolve the issues of concern.

Notification of other incidents ✓ Met this standard

The service must tell us about important events that affect people's wellbeing, health and safety

Our judgement

The provider was meeting this standard.

The provider informed us about important events that affect people's wellbeing, health and safety.

Reasons for our judgement

When we inspected the service in June 2013 we had concerns the provider not telling us about important events that affect people's wellbeing, health and safety. We told the provider they needed to make improvements in relation to this outcome. The provider sent us a report telling us what action they would take and by when.

We didn't speak with people in respect of this aspect of this regulation.

We found there had been an improvement in respect of the provider notifying us of any other incidents.

The provider had notified the Care Quality Commission (CQC) of all incidents which had occurred within the home as required by the CQC (Registration) Regulations 2009.

We found that the care home had been appropriately notifying the local safeguarding authority about safeguarding referrals and they had also notified the Care Quality Commission (CQC). Informing CQC of safeguarding incidents is a regulatory requirement.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not fully protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained.

We have judged that this has a minor 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 four members of staff about the records in the home and they both told us they knew how to complete the records in the home and that the process was clear to them.

We looked at the records of three people, who staff were monitoring fluid intake for. We saw care plans which indicated people who required support to maintain an adequate fluid intakes. The records we saw did not indicate the amount or frequency of fluid intake required to maintain their health and wellbeing. We saw the fluid intake charts were being completed but that staff were not totalling the amount the person had consumed each day nor what their expected intake should be. This meant staff were not checking people's fluid intake was sufficient.

We looked at the records kept by the night staff and we saw staff were recording care given at the appropriate times. However, we found the daily records did not include all incidents which occurred during the night. We saw the incident records of one person who had been physically aggressive towards another person. Their night entry in the daily records indicated this person had a, "Settled night, no concerns." This meant that there was a risk that incidents were not being recorded and followed up to ensure the ongoing safety of people.

We looked at the food charts kept for two people using the service. There were no gaps in the records and staff were recording how much both people had eaten.

We looked at blood sugar level monitoring charts for one person who had diabetes. Whilst their care plan indicated the frequency and time when blood sugar levels should be monitored and recorded, we found gaps in these records. This meant that the health of this person was at risk due to inconsistent monitoring of their blood sugar levels.

We found some care records which were not being reviewed regularly. For example, the bed rails risk assessment for one person had never been reviewed since its introduction in

May 2013. A moving and handling risk assessment for another person had not been reviewed since February 2013. This meant there was a risk of people receiving inappropriate care due to changes in their needs not being reflected in their care records.

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 Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: Where people did not have the capacity to consent, the provider did not always act in accordance with legal requirements. Regulation 18.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare. Regulation 9 (1) (a) (b).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**

This section is primarily information for the provider

care Diagnostic and screening procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** People were not always cared for in a clean, hygienic environment. Regulation 12 (1) (a, b, c) (2) (c) (i, ii).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision** **How the regulation was not being met:** The provider did not have a fully effective system to regularly assess and monitor the quality of service that people received. Regulation 10 (1) (a, b).
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records** **How the regulation was not being met:** People were not fully protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not always maintained. Regulation 20 (1) (a).

This report is requested under regulation 10(3) of the Health and Social Care Act 2008

This section is primarily information for the provider

(Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 14 November 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 30 October 2013 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who use the service were not fully protected from the risk of abuse, because the provider had not taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Regulation 11 (1) (a) (b).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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.

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