Review of compliance

The Foundation of Lady Katherine Leveson The Foundation of Lady Katherine Leveson	
Region:	West Midlands
Location address:	Masters House Kenilworth Road, Knowle Solihull West Midlands B93 0AL
Type of service:	Care home service without nursing Domiciliary care service
Date of Publication:	September 2012
Overview of the service:	This location is registered to provide accommodation for a maximum of 30 people who require personal care. It is also registered to provide personal care to people living in the supporting housing scheme on the same site

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

Our current overall judgement

The Foundation of Lady Katherine Leveson 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 The Foundation of Lady Katherine Leveson had taken action in relation to:

Outcome 09 - Management of medicines
Outcome 13 - Staffing
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 31 July 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We carried out this visit to review improvements in relation to medication, record keeping and staffing following our last inspection of the home. We found that although some action had been taken to address specific concerns, further improvements were needed.

People told us that they were receiving their medicines but we could not be sure from viewing records and medicines available that medicines were always being managed as they should. Medicine records did not always clearly show that medicines prescribed had been given or were available.

People were complimentary of the care staff supporting them although they acknowledged sometimes staff were busy. People told us: "They are all nice, I have got no complaints at all, they are all very kind." "Yesterday my breakfast came at 9.00am, I usually prefer it earlier." Staff told us they could not always deliver care to people to a standard they were happy with.

We did not speak with people about their care records but we found that some care records were not up-to-date or accurate. This meant there was a risk that people may not always receive appropriate care.

What we found about the standards we reviewed and how well The Foundation of Lady Katherine Leveson was meeting them

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

The provider was not meeting this standard. We have judged that this has a moderate impact on people who use the service. Some people were not receiving their medicines as prescribed and some medicine records were not sufficiently clear to demonstrate how medicines had been managed for people.

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

The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs although the deployment of staff will require ongoing monitoring to ensure people's needs continue to be met.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The provider was not meeting this standard. We have judged that this has a moderate impact on people who use the service. Care records for some people were not accurate, up-to-date or sufficiently clear to protect people from the risks of inappropriate care and treatment.

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 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is non-compliant with Outcome 09: Management of medicines. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
When we arrived at the home we saw that the senior carer was giving medicines to people. People told us that they were receiving medicines prescribed for them. We were told: "I have tablets for all things. I don't take tablets on my own, I don't think anyone does." "I was on an antibiotic I have just come off it." We spoke with one person who was managing their own medicines, they told us: "They are locked in a draw, they are put in a plastic 'thing' and you press it out, you know where you are with them then. They come and check the medication is being taken."

Other evidence
During our last visit we saw that medicines had been audited by the Solihull NHS Care Trust and areas for action had been identified. We received an action plan from the home following our last visit stating that many of the actions listed on this audit had been addressed. We confirmed during this visit that this was the case. This included the medicine fridge being in full working order and temperatures being recorded so that it was clear medicines were being stored safely.

During this visit we carried out our own audit of medicines and found different areas of concern needing improvement. We looked at medicine records for four people. We saw that there were gaps on the Medicine Administration Records (MARs). Staff were required to sign the MAR each time a medicine was being given or record a code to define a reason why a medicine had not been given. This was not happening consistently so we could not tell if people had received their medicine or not. We saw

that some medicines on the MAR could not be located in the medicine trolley. The senior carer could not find them when asked. This meant it was not clear if people always received the medicines prescribed for them.

We saw that sometimes the code '0' was being used on the MAR but the code had not been defined. This meant we could not tell if people had been given their medicine or not. Sometimes people had been asleep when the medicine round had been completed and had not taken medicines prescribed for them. We discussed this with the person in charge. There did not appear to be a system in place to revisit these people to ensure this was given. We saw that one person had been prescribed 'Lithium'. This came with specific instructions for staff to show a 'Lithium alert card' to any health care professionals involved with this person so they were aware they were using it. This had not been removed from the information wallet and there were no instructions to staff within the care records to make sure this happened.

We saw that where creams had been prescribed, the MAR was mostly blank. This meant we could not be sure that creams were being applied as often as they should. We saw handwritten changes had been made to the MAR that were inappropriate. Errors identified on MAR's should be followed up with the pharmacist or GP as required so that amended MAR's can be provided.

We discussed our concerns regarding medicine management with the provider who agreed to take the necessary actions to ensure improvements were made.

Our judgement
The provider was not meeting this standard. We have judged that this has a moderate impact on people who use the service. Some people were not receiving their medicines as prescribed and some medicine records were not sufficiently clear to demonstrate how medicines had been managed for people.

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spoke with three people living at the home and observed others to find out what their experience of using the service was like. We saw that staff were friendly and supportive in their approach to people. People told us: "I am happy here, it's a very happy home. I have been helped this morning, the night staff come round every hour." "They are all nice, I have got no complaints at all, they are all very kind."

We saw people in the lounge area during the morning were being supported by one member of staff to have a drink. This was done in a caring and unrushed way.

We asked one person if their call bell was always responded to within a reasonable time. We were told: "Mostly yes, if there are problems no, they are all a bit slow today."

One person told us: "They are a bit short of staff sometimes in the morning, but on the whole they cope, we never go without. Yesterday my breakfast came at 9.00am I usually prefer it earlier. I say to them sometimes why are you late and they say they're short of staff."

Other evidence
During our last visit we identified concerns around night staffing arrangements. This was because some people needed two staff to support them and the layout of the home meant that large parts of the building may be unattended while staff delivered care in another part.

Following our last visit we were provided with an action plan stating that a 'needs analysis' had been done to determine which people needed two staff to support them at night. We were also told that there was a computerised system in place to record any call bells used by people at night so that the manager could determine the staff support required at night. Following completion of this 'needs analysis', the night staff numbers were increased to three at night.

During this visit we saw that duty rotas showed there had been three staff on duty for a short period of time in July 2012. Staff told us that this was to provide extra support to two people who needed one-to-one care. This demonstrated that there had been some consideration given to people's needs when they increased. We were told that staff carried pagers so that if people rang call bells at night, staff were alerted to this wherever they were within the premises.

On the day of our visit there was one senior carer on duty with four other care staff. The manager was on holiday and the senior carer told us she was the person in charge. The senior carer was not working in a supernumerary capacity. We observed during our visit that the senior carer was very rushed dealing with staff queries, telephone calls, attending to people's needs and attempting to deal with management issues. The provider may wish to note that duty rotas showed there was no specific person allocated to cover the manager's role in her absence. Duty rotas also did not give an accurate reflection of staff on duty to demonstrate sufficient staff were available to support people's needs.

Duty rotas showed that on some days care staff numbers had been increased but on others the home appeared to be working below the agreed staff numbers. For example on 27 July 2012 there was only one member of night staff indicated on the rota. On 26 July 2012 there was no senior indicated to be working on the morning shift. Some of the staff had been selected to complete training as part of their shift. We could not establish if the staff had completed this training. This meant that we could not be sure the numbers of staff on duty were actually available to provide care.

Duty rotas showed that at least three care staff were completing regular shifts of 14.5 hours per day. We also saw that a senior member of staff had worked a day shift from 7am – 2.30pm and had then returned to then work a night shift. We discussed these long shift patterns with the provider with a view to checking this was not impacting on people's care.

The provider may wish to note staff told us they didn't always have time to have a break because they needed to support people. In particular during the morning and early evening. Staff told us "We don't have much time to spend sitting down with people, we have 10-15 minuets but most residents want more time". "There is never enough at the moment but it falls on us to give extra. They put an extra one on for a short period….I have only just had a cup of tea."

Despite staffing arrangements not always being clear, it was evident that staff were putting people's needs first so that they experienced positive outcomes. The provider told us that arrangements would be made to ensure there was always a member of staff working in a supernumerary capacity in the absence of the manager. This would then ensure that any concerns relating to staffing could be effectively managed in her absence.

Our judgement
The provider was meeting this standard. There were enough qualified, skilled and experienced staff to meet people's needs although the deployment of staff will require ongoing monitoring to ensure people's needs continue to be met.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

The provider is non-compliant with Outcome 21: Records. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
During this visit we did not speak to people about their care records as we were following up improvements made from our last visit.

During our last visit we found that some care records gave conflicting information and it was therefore not clear what people's needs were. We also found that one person did not have any plans of care on their file. This meant we could not see how their care needs were being met.

We checked to see that care plans had been developed for the person who did not have any during our last visit. We found that these had been developed.

Other evidence
When we looked at the new care records for the person who did not have any during our last visit, we found that some of the information was not clear or accurate.

For example the mobility care plan and risk assessment indicated that the person's mobility had last been assessed in February 2012. We were told about a fall this person had in May 2012 which had changed this person's mobility. This was not reflected in this person's mobility care plan records. Care records stated that the person was using a walking stick but daily records indicated they were using a tripod.

A communication care plan stated that the person spoke English but this may "hinder some communication with carers" and they may need an interpreter. This information was not accurate. A professional visit sheet showed advice given from the physiotherapist. This was not dated and it was not clear if this was current or still appropriate.

For another person we saw that they had a mental health condition that staff told us had resulted in an increase in staff to meet their needs. We found that the care records did not give an accurate or up-to-date account of this person's care. A risk assessment had been completed in 2011 relating to their depression. It was not evident that this had been reviewed or updated since this date. Staff told us information about this person's behaviours linked to their mental health condition that were not reflected in this person's care plan or risk assessment.

We saw a dependency assessment on file which was last reviewed on 15 March 2011. It was not evident this had been updated since this date and we therefore could not tell if this information was accurate.

If care records are not dated and do not accurately reflect people needs and how they need to be supported, this could lead to people receiving inappropriate or unsafe care.

In addition to the above issues we also found discrepancies and omissions of information in regards to medication records.

The provider advised that the home had been trialling a new records system which had involved reviewing all care plans. She agreed that this system would need to be revisited to ensure records were accurate. Staff told us there were still some care plan records that needed to be updated and one of the care files we had viewed was one of them.

Our judgement
The provider was not meeting this standard. We have judged that this has a moderate impact on people who use the service. Care records for some people were not accurate, up-to-date or sufficiently clear to protect people from the risks of inappropriate care and treatment.

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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Some people were not receiving their medicines as prescribed and some medicine records were not sufficiently clear to demonstrate how medicines had been managed for people.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: Care records for some people were not accurate, up-to-date or sufficiently clear to protect people from the risks of inappropriate care and treatment.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of

compliance.

CQC should be informed in writing when these compliance actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

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

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA