Croydon Council

For General Release

REPORT TO:	**Adult Social Services Review Panel** **24 April 2013**
AGENDA ITEM NO:	**9**
SUBJECT:	**CQC themed inspection of care homes for older people**
LEAD OFFICER:	**Hannah Miller, Executive Director Adult Services Health and Housing**
CABINET MEMBER:	**Councillor Margaret Mead, Cabinet Member for Adult Services and Health**
WARDS:	**All**

CORPORATE PRIORITY/POLICY CONTEXT:

The Care Quality Commission (CQC) has carried out a themed inspection of 500 care and nursing homes across the country. The inspection focused on the standards relating to dignity and nutrition. The outcomes of the CQC report are relevant both with regards to the care homes within Croydon that were inspected as part of this report but also the more general outcomes provide information about common failings and how these often arise from a culture of care that puts tasks before people.

FINANCIAL IMPACT

There is no specific financial impact related to this report.

1. RECOMMENDATIONS

1.1 That members note the content of the CQC report and its learning with respect to Croydon care homes.

2. EXECUTIVE SUMMARY

The CQC carried out a themed inspection of 500 residential care and nursing homes across England between April and October 2012. The standards considered related to dignity and nutrition under the headings of ‘respect and involving people’, ‘nutrition’, ‘safeguarding’, ‘staffing’ and ‘records’.

Of the 500 care homes inspected only 5 of the homes are within Croydon. However the lessons from the inspections have relevance for all homes in Croydon, for the service users and their families, for commissioners and providers. Alongside this series of themed inspections, the CQC is carrying out a regular inspection plan of

registered care providers and we check each week the outcomes of the inspections that relate to providers operating in Croydon.

3. DETAIL OF YOUR REPORT

3.1 The inspections carried out related to 'care homes with nursing' and 'care homes without nursing'. The selected homes were broadly representative of the total number of around 11000 homes across the country in terms of those providing for people with dementia, the size of the home and the size of the provider. The standards inspected covered five areas:

- **Respecting and involving people who use services**:
  Are people's privacy and dignity respected?
  Are people involved in making choices and decisions about their care?

- **Meeting nutritional needs**:
  Are people given a choice of suitable food and drink to meet their nutritional needs?
  Are people's religious or cultural backgrounds respected?
  Are people supported to eat and drink sufficient amounts to meet their needs?

- **Safeguarding people who use services from abuse**:
  Are steps taken to prevent abuse?
  Do people know how to raise concerns?
  Are the Deprivation of Liberty Safeguards used appropriately?

- **Staffing**:
  Are there sufficient numbers of staff?
  Do staff have the appropriate skills, knowledge and experience?

- **Records**:
  Are accurate records of appropriate information kept?
  Are records stored securely?

3.2. All the inspections were unannounced and for each inspection relevant stakeholders were contacted and their views taken into account. Each inspection was scheduled to coincide with a mealtime.

3.3. From the inspections some common themes emerged:

- Care homes that provide nursing care were more likely to fail to respect and involve people that those without nursing care.
- Care homes without nursing were more likely to fail the staffing standard.
- Homes that do not provide dementia care were more likely to have better outcomes than those that do on four out of the five standards. Homes providing dementia care did better on staffing.
- Corporate providers (owning more than 20 homes) did better on three out of the five standards (respect and involvement, nutrition and records) .

3.4. The CQC report revealed overall that almost two thirds of the homes inspected met all the standards. There were many examples of good care being provided. The homes that met the standards promoted a culture of care that put residents first and treated them as individuals.

3.5. In homes where all the standards were not being met, 80 homes did not always respect people's privacy or speak to people in a respectful way, in 87 homes, people were not always supported to eat and drink sufficient amounts or did not have sufficient choice of food or adapted cutlery.

3.6. The inspections found links between standards:

- Homes failing to respect and involve people were more likely to be failing to meet nutritional needs.
- Around half the homes not meeting nutritional needs were also not meeting the staffing standard.
- More than half the homes not meeting nutritional needs were also not meeting the standard on record keeping.

3.7. The report found some differences between homes that provide nursing care and those that do not, and between homes that care for people with dementia and those that do not. More homes that provide nursing care were failing to respect and involve people than homes that do not, whereas more homes that do not provide nursing care were failing to meet the staffing standard than those that do. Homes that do not care for people with dementia performed better than those that do on four out of the five standards.

3.8. The overall picture is contained in the table below:

Percentage of types of homes meeting the standards:

Standard	**Homes providing nursing care (217)**	**Homes not providing nursing care (283)**	**Homes caring for people with dementia (422)**	**Homes not caring for people with dementia (78)**
Respect and involvement	**80%**	**87%**	**83%**	**92%**
Nutrition	**83%**	**81%**	**82%**	**86%**
Safeguarding	**92%**	**94%**	**92%**	**96%**
Staffing	**88%**	**85%**	**85%**	**90%**
Records	**79%**	**75%**	**78%**	**76%**

The report gives examples of standards being well met and those that lead to failings.

3.9. **Respecting and involving people who use services:**

Homes that respected people's privacy and dignity made sure that:

- Staff had a good understanding of a person's preferences, including their preferred name and their likes and dislikes.
- All communication with a person was respectful, using appropriate words and

manners, and talking directly with them, explaining what they were doing.
- Residents had somewhere to keep their personal belongings safe and their privacy was respected, with staff knocking on doors before entering.
- People's preference for male or female care staff was respected and screens, curtains and covers were used when providing personal care or moving people.

When it did not work well there were examples of:

- Discussing people's care needs in the presence of other people living at the home.
- Moving people from one area to another without checking that they wanted to move and without telling the person why they were moving them or where.
- Using inappropriate language such as "feeders" to describe people who needed help to eat their meals.
- Having conversations between themselves while helping people to eat their meal.
- Failing to engage with people, particularly during mealtimes.

3.10. **With regard to nutrition homes that worked well:**

- Developed menus that provided a nutritionally balanced diet for people.
- Employed chefs who had a good knowledge of people's preferences and dietary needs.
- Provided menus to residents, usually displaying them on noticeboards or on tables in the dining room. To support people with dementia, some homes used pictures or presented plated meals to help them make a choice.
- Used their knowledge of people's preferences to provide the right meal for those unable to choose themselves.
- Could be adaptable, and provide an alternative meal for anyone who didn't like the main one.
- Offered drinks and snacks between meals.
- Met specific dietary requirements, including those for people who have difficulty swallowing or gluten allergies.

Homes that did not do well showed examples of:

- Not adequately assessing people's needs or monitoring what they ate and drank – even for people who we found to be losing weight.
- Not offering any encouragement, or an alternative, to those who had not eaten any of their meal.
- Not supporting people who were struggling to eat and drink by:
  Failing to cut up food.
  Putting food and drink out of people's reach.
  Placing meals on tables that were too low.
  Not providing adapted cutlery or plates with guards, which could support people to eat independently.
- Bringing people into the dining room too early. 'On one inspection, we saw 10 people who used wheelchairs seated at tables in the dining room at 11.15am'.
- Not planning mealtimes. 'During another inspection, everyone came to the dining room at the same time, but some people did receive their meal until others had finished theirs. No one was helped to leave the dining room until everyone had finished their meal.'

3.11. **The picture from these inspections relating to Croydon:**

Of the 500 themes inspections only 5 homes were located in Croydon. The homes inspected were as follows:

Barrington Lodge - care home with nursing , up to 44 beds

Clifton House – care home without nursing, up to 16 beds and can accommodate people with dementia.

Langley Oaks – care home with nursing that provides for up to 40 people with dementia

Oban House - care home with nursing providing for 61 people, some with dementia

Purley View – care home with nursing for up to 35 people, some with dementia

Of these five care homes three were found to be fully compliant in all areas; Barrington Lodge, Langley Oaks and Oban House. The other two homes were found to be non compliant in one area each. Purley View was non compliant in nutrition and this was considered to be a minor risk. Clifton House was found also to be non compliant in nutrition and this was found to be a moderate risk.

Purley View:

It was found that people were being supported to have sufficient food and drink to meet their nutritional needs. However, some people had not been given the opportunity to make choices about the food they would like to eat. This was found to have a minor impact on people.

Clifton House:

People were being supported to have sufficient food and drink to meet their nutritional needs. However, there was limited evidence to show that they had been offered the opportunity to make any choices about the food they would like to eat. This was considered to have a moderate impact on the people using the service.

3.12. Apart from the themed inspections reported on in the CQC publication, CQC inspectors continue to carry out regular inspections of all care providers. Each week the safeguarding coordinator checks on the new inspections that have been carried out and identifies any providers in Croydon who have not been fully compliant. It is important to note that providers can vary from inspection to inspection in terms of their level of compliance and that failure to meet a compliance standard in one area does not mean that overall the home is not compliant . Often the compliance issues can be easily rectified but close monitoring of these reports can help to identify homes that may be non compliant in several areas or where the non compliance is deemed to have a severe impact on the people using the services. This intelligence informs commissioning and together with information from any safeguarding alerts , creates a rounded picture of how homes are doing and when intervention is needed, for example by the care support team.

3.13. As of the 4th April 2013 the following facts and figures relate to the 147 operating care and nursing homes within Croydon.

Overall 24 of the 147 homes are non compliant – a figure that constitutes 16% of all homes.

The CQC website does contain a number of errors in relation to Croydon care homes. These errors have been explicitly shared with the CQC and include ratings for homes that are not within Croydon, ratings for homes that have ceased to operate and in four instances ratings for homes that are incorrect e.g. the actual report states full compliance whilst the website notes non compliance.

3.14. Of the 24 homes that are non compliant 9 presently fail to meet either respecting and involving people who use services and the standards around meeting nutritional needs. This can be further broken down into six homes failing to meet nutritional needs and three found to be lnon compliant in respecting and involving service users.

3.15. From the present CQC inspection reports the sole cause for the three homes failing to respect and involve service users was due to inadequate care plans. Three main reasons were identified with respect to concerns over nutritional needs – poor choice of food being available, poor staffing levels at mealtimes and poor crockery.

3.16. Of the nine homes presently non compliant in these key areas three are nursing homes, five are care homes for older people and one is a care home for people with mental health needs.

3.17. Overall of the 24 homes non compliant at present 10 are for older people, 5 are for people with a learning disability, 4 are for people with a mental health need and 1 is for younger people with nursing needs.

3.18. The safeguarding coordinator continues to monitor inspection reports and to follow up with commissioners whenever concerns are discovered that may have a significant impact on service users. If substantial concerns were identified, we should involve the care support team. In this way we take a proactive approach to identifying and managing potential risks.

4. CONSULTATION

The lessons from this report will be used to inform commissioning and quality assurance processes.

5. FINANCIAL AND RISK ASSESSMENT CONSIDERATIONS -

There are no specific financial considerations attached to this report.

6. COMMENTS OF THE COUNCIL SOLICITOR AND MONITORING OFFICER

6.1 The Solicitor to the Council comments that there are no legal issues arising from the report

(Approved by: J Harris Baker, head of social care and education law and deputy monitoring officer on behalf of the Council Solicitor & Director of Democratic & Legal Services)

7. HUMAN RESOURCES IMPACT

7.1 There are no immediate HR considerations that arise from this report for LBC staff.

Approved by: Michael Pichamuthu Strategic HR Business Partner on behalf of the Director of WCR

8. EQUALITIES IMPACT This report is concerned with people who are protected under the equalities act due to a number of protected characteristics including age and /or infirmity and who are vulnerable adults. The learning from the report and continuing work by commissioning and quality assurance will help to strengthen service delivery for these individuals.

9. ENVIRONMENTAL IMPACT – None

10. CRIME AND DISORDER REDUCTION IMPACT – None

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BACKGROUND DOCUMENTS: