Inspection Report

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

Rush Court

Shillingford Road, Wallingford, OX10 8LL

Tel: 01491837223

Date of Inspection: 30 August 2013

Date of Publication: September 2013

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Elizabeth Finn Homes Limited
Registered Manager	Mrs. Ashley Michelle Sides
Overview of the service	Rush Court is a care home providing personal and nursing care to up to 50 people. People's needs arise from age and physical disability.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care 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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Respecting and involving people who use services	6
Care and welfare of people who use services	7
Safeguarding people who use services from abuse	8
Staffing	9
Assessing and monitoring the quality of service provision	10
About CQC Inspections	11
How we define our judgements	12
Glossary of terms we use in this report	14
Contact us	16

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 30 August 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

We saw evidence in individual care plans and notes of group meetings the provider was respecting and involving people. We observed people being treated with respect and their views being sought. We were told by a family member that "people are treated with dignity and respect at Rush Court".

We were told by one person that "we do lots of lovely things" and we saw the provider made a variety of activities available for people. We found the provider was providing personalised care, treatment and support and that peoples individual needs were assessed with appropriate plans being drawn up and implemented.

There was guidance in the home on safeguarding people from abuse. Staff members spoken to knew how to report any concerns regarding abuse. People we spoke told told us they would be able to speak up if they were unhappy with the way they were cared for. We found the provider was protecting people from the risk of abuse.

We found by looking at staff rotas and training records and speaking with the provider that there was sufficient qualified, skilled and experienced staff to provide care and support for people.

There was an improvement plan in place and we saw the provider was seeking the views of family representatives and making changes as a result. We found the provider was investigating comments and complaints and accidents and incidents and was learning from these in order to improve the care, treatment and support provided to people.

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

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

We looked at 12 care plans from the 35 people living at the home at the time of the inspection. We found evidence of a person centred approach being used. There were examples of individual activities being identified and planned for, showing that people were supported in promoting their independence and community involvement. There were examples of people's diversity, values and human rights being supported with cultural and spiritual needs being identified and planned for, including the provider arranging for a minister to visit the home.There were sections in the plans documenting that people had been given information in order to understand the care and support choices available to them.

People we spoke with confirmed that they had been given information and their views had been identified and acted upon with regards to the choices available to them regarding their care, treatment and support. We also looked at the minutes of the separate meetings held with people and family representatives. We saw in the minutes of a meeting with people supported in May 2013 that people had requested that an item of food regularly on the menu as a vegetarian choice be removed from the menu, we saw that this item was no longer part of the menu options. In the same meeting we saw that an issue had been raised regarding the call bell system used by people. We saw that this had been referred by the manager to be reviewed with a view to upgrading or replacing the system. We looked at the minutes of a meeting with family representatives held in June 2013 and saw that a further meeting had been planned to take place in October 2013.

Throughout the day we saw people being supported by staff in ways that ensured people's privacy, dignity and independence were respected. When talking to staff it was apparent that they value respecting and involving people and are consistently thinking about how this can best be achieved. We were told by a family member that "people are treated with dignity and respect at Rush Court".

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

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

We looked at the care plans for 12 people and found that these were up to date and most had been regularly reviewed. Each plan contained an assessment of need and a clear plan of how the person's needs were to be met. The plans were person centred and took into account the persons wishes and preferences as well as their individual needs and considerations on welfare and safety. The provider may wish to note there were some plans that had not been reviewed within the timescales stated in the plans.

We observed staff members supporting people around mealtime with getting to and from one of the dining rooms and in choosing and eating their lunch. Care was taken by staff to ensure that people were supported in accordance with their individual needs and as detailed in care plans confirming that their welfare and safety was considered and acted upon.

People told us they enjoyed a variety of different activities organised by the activities organiser. We saw a monthly planner identifying activities taking place in the home and were told by people that they enjoyed the activities. One person told us "we do lots of lovely things". The planned activities included film afternoons, sessions with pets, trips out, visits from local clergy and talks given by a variety of different speakers. The activities people were involved in were identified in their care plans and related to individual assessments and people's interests.

The provider had in place a contingency plan that identified arrangements for dealing with foreseeable emergencies and contact information and numbers were accessible to all staff. There was also detailed individual information in the care plans we looked at identifying how people would be supported in the event of emergencies.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Relevant and up to date government and local guidance regarding safeguarding people from abuse was accessible to all staff. When asked staff spoken to were able to give examples of types of abuse and what they would do if abuse was suspected, witnessed or alleged. All staff had received training in adult protection and we saw the provider had planned for refresher training to take place on a regular basis.

The provider had not raised any safeguarding alerts in the 12 months leading up to this inspection.

Three people supported were asked what they would do if they were unhappy with the way they were being cared for or supported. One person said "I'd tell them" a second said "I'd get it sorted out" with a third person saying "well, it doesn't happen here". When asked if people felt they would be listened to by the provider each responded that they would be. We asked a family member if they would know what to do if they were unhappy with the way their relative was being cared for. They told us "yes, I would talk to the manager and get it resolved".

People's mental capacity was considered in individual care plans, as were, issues relating to diversity, beliefs and values giving a framework for how these may affect any safeguarding issues that may arise. This showed the provider had taken into account how people's diversity, beliefs and values may influence the identification, prevention and response to safeguarding concerns. At the time of the inspection the home had authorisation in place for one person regarding deprivation of liberty safeguards. We inspected the records concerning these arrangements and found them to be appropriate.

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

On the day of the inspection was saw that there were two registered nurses and seven care staff caring for people in the morning and one registered nurse and seven care staff caring for people in the afternoon. The provider told us that the staffing levels we saw were consistent with those provided each day. They informed us that at night time there was a registered nurse and four care staff caring for people. We looked at the duty rota and found this to be the case. We asked the provider how they ensured that staffing levels were sufficient to meet peoples needs. They told us that a needs assessment and risk analysis was carried out to determine staffing levels.

A framework was in place to ensure that staff had the competencies, knowledge, qualifications, skills and experience to meet the needs of people. There was a training plan in place that identified dates for staff to receive training in relevant areas to meet this framework and evidence that training had taken place as planned. Staff spoken to stated they received sufficient training. The provider may wish to note that one staff member said that they would benefit from more specialist training, giving training in Diabetes and Dementia as examples.

One member of staff we spoke told us "there is a very good standard of nursing and personal care provided here". A family member told us "staff are kind and caring". One person supported said "the staff are lovely".

The provider was monitoring staff turnover and stated that there were enough staff who knew the needs of people to provide a consistency of care. Staff spoken to also said there was consistency of care and enough staff who knew people to provide this. Observation of staff interacting with people was seen to be friendly, caring and appropriate and demonstrated that there were sufficient staff who knew the needs of people to provide consistency of care.

We were told that responding to changing circumstances such as sickness and absence can be problematic but that staff members were flexible and provided such cover, with agency staff used if cover could not be provided from within the team. We looked at staffing rotas to examine how cover for changing circumstances had been provided and found this to be the case.

Assessing and monitoring the quality of service provision ✓ Met this standard

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 meeting this standard.

The provider had an effective system in place to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

We looked at a number of documents and discussed these with the provider. These included a number or internal audits carried out during the last year and a comprehensive quality audit carried out by a senior manager from the organisation in January 2013. This quality audit had included feedback from people and their family representatives, feedback from staff, auditing of records held at the home, direct observation of care and support practice and thorough reviews of care plans. We saw an action plan drawn up following the quality audit and noted a number of actions that had been completed and changes that had been made.

Concerns or complaints were clearly recorded along with action taken to investigate and address the issue. We looked at the complaints log and noted that a clear record was maintained of progress in dealing with the complaint including providing feedback to the complainant. We saw with one recent complaint from June 2013, that action had been taken to address the issue raised including providing individual coaching and additional training to a member of staff. This showed the provider took account of complaints and comments to improve the service.

The provider told us how an analysis of actual incidents and any near misses that had the potential to result in harm, was carried out and how any required action was implemented. We looked at examples of these and found they evidenced that learning from accidents, incidents and near misses took place and that appropriate changes were implemented. We saw minutes of health and safety meetings where a variety of information was reviewed. Records of investigations of accidents also demonstrated the provider made changes as a result, including involving external professionals to reduce the risks to people of falls. This provided evidence that learning from incidents took place and appropriate changes were made.

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.

Contact us

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