Review of compliance

Praxis Care Rose Orchard	
Region:	West Midlands
Location address:	7 Baxter Avenue Kidderminster Worcestershire DY10 2EU
Type of service:	Care home service with nursing
Date of Publication:	September 2012
Overview of the service:	Rose Orchard is a nursing home for five people who have learning disabilites.

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

Our current overall judgement

Rose Orchard 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 18 June 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

Rose Orchard is a nursing home for five people with severe learning disabilities. We spoke with two people who lived at Rose Orchard. The two people we spoke with had limited verbal communication. Both people said they were happy at Rose Orchard and said that they felt safe.

While we were at Rose Orchard we conducted a Short Observational Framework for Inspection (SOFI). SOFI is designed to be used when we visit a service were people cannot reliably give their verbal opinions on the services they received. SOFI is used to observe peoples experience of care first hand by observing staff interaction, staff engagement and their mood. The SOFI highlighted to us that care staff were kind and caring, engaging positively with all of the people that we were observing during the period of time.

What we found about the standards we reviewed and how well Rose Orchard was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

The provider was not meeting this standard. People's privacy, dignity and independence were not always respected.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The provider was not meeting this standard. People did not always experience care, treatment and support that met their needs and protected their rights.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The provider was meeting this standard. People who used this 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.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

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.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider was meeting this standard. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Actions we have asked the service to take

We have asked the provider to send us a report within 28 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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is non-compliant with Outcome 01: Respecting and involving people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with two people who lived at the home about the quality of care they received. While verbal communication was limited the response that we received was positive. They told us they were happy and felt safe.

Other evidence
On arrival to the service, we observed staff around the dining table with the people who used the service making arts and crafts. The mood was positive, people were smiling and interacting together. This showed the care staff were involving people who used the service. We also observed care staff closing doors while assisting people with their personal care needs. This showed that carers were respecting people's dignity.

We conducted a Short Observation Framework for Inspection (SOFI) on two people who used the service during lunch time. This tool enabled us to observe care staffs interaction with the two people and their mood state during the interaction. One person that we observed was able to feed themselves with supervision. Care staff respected this and only assisted when they needed to. The care staff interaction with this person was positive, and showed that they were treated with dignity and respect during the period of time that we observed. The second person that we observed needed to be fed

by the care staff. The main observations we made were that the care staff did not sit down besides the person while assisting to feed them and stood up for the entire meal. The pace in which the meal was eaten appeared rushed and the main meal was finished in just over a minute. The person was then brought a cup of tea. The cup of tea was given within a five minute period, during this time the person was calling out. This was a negative experience for the person. Another care staff member asked the person if they would like quiet time, to which the person responded with a yes. This interaction was positive, it had a positive affect on the persons mood and they stopped calling out. We spoke with the registered manager about our observations made during lunch time, the registered manager took note that lunch time appeared rushed and that the care staff member did not sit down while feeding the person. This evidence demonstrated that it was not a dignified experience for the person who needed help to eat their meal.

We looked at two care files for the people who used the service. We saw evidence that the care plans had been signed and agreed by the person's next of kin. This showed that the service were involving peoples next of kin along with the person who used the service in the way their care and treatment was to be delivered.

We saw evidence on the notice board in the reception area details of the services complaints procedure. The notice board also displayed Care Quality Commissions contact information. There was also a compliment and comments book for people to write in should they wish. This showed that people were provided with the opportunity to be involved in the way the service was run.

Our judgement
The provider was not meeting this standard. People's privacy, dignity and independence were not always respected.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a minor impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke with two of the five people who lived at Rose Orchard. The two people we spoke with had limited verbal communication but were able to respond with a yes or no. Both people said they were happy at Rose Orchard and said that they felt safe, they said they enjoyed the activities and the food.

Other evidence
We looked at two care records for the people who used the service. The care plans for both records were personalised. The care plans were easy to follow with a detailed step by step guide for the care staff to follow. This ensured that care staff were able to provide appropriate and safe care to the person who used the service. We saw evidence that the care plans were reviewed monthly and changes made where necessary.

Both care records showed detailed personalised risk assessments. This meant that the risks to the person who used the service and the care staff who cared for them had been properly assessed. This ensured that people's safety and welfare was maintained.

We found that not all of the documentation within one care record was always completed. For example, one persons care records we looked at had a detailed care plan for care staff to follow when the person would not settle at night time. The daily notes reflected that the person was not sleeping and the care plan had been implemented. However, the care plan stated that care staff were required to complete a

monitoring chart. This monitoring form was not always completed, which meant that it made it difficult to track trends in the person behaviour at night.

We saw evidence that people received outside professional treatment when required. We saw evidence that people visited the doctor, dentist and physiotherapist. When their care needs changed as an outcome of these visits their care plans were changed accordingly. This showed that the service was providing appropriate care to people and providing them with the services they were entitled too and adapting their care needs as necessary.

People were cared for by a long standing care staff team, this meant that care staff knew the people they cared for well and that a good rapport had been built between the people that used the service, their families and the care staff team. This ensured that consistency of care is provided.

During our visit we found that one nurse worked alone during the night shift. We spoke to the registered manager about our concerns that one nurse worked alone during the night as the people who used the service required hoisting. The registered manager said that only the ceiling hoists were used and they required only one person to operate. We spoke to all three of the care staff who were working at the time of our visit. All care staff said that two people were required to operate the ceiling hoist. They went on to say that the afternoon care staff put people to bed before the nurse started their shift at nine o'clock that evening. This meant that people who lived at the home were not able to make their own decision in what time they went to bed in the evening. It also meant that if a person required hoisting out of bed for the toilet during the night or if they wanted to get up earlier than when the morning shift care staff started they would not be able to.

We reviewed two people's manual handling assessments, there were detailed instructions for manual handling techniques for one person, however, we did not review all of the people who lived at the service manual handling assessments. The care staff said that on arrival to the morning shifts it did not highlight that the nurse had not managed during the night time. We spoke to a nurse who used to do night shifts. They said that some nights were tiring; however, if somebody was seriously ill, then a carer would also work a night shift. We spoke further to the registered manager about our concerns. They advised that there was an on-call system should an emergency arise at the service. The registered manager also said that there was a supported living unit as part of the same organisation, across the road from the service where care staff could be used in an emergency. However, we were not able to identify what the impact would be on the people who used that service if an emergency at Rose Orchard should occur.

Our judgement
The provider was not meeting this standard. People did not always experience care, treatment and support that met their needs and protected their rights.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
We asked two people who used the service if they felt safe. The people we spoke with said they felt safe.

We spoke to care staff that worked at the service and asked them questions around safeguarding. The care staff demonstrated a good understanding of the signs of abuse and how to raise concerns with the right person.

Other evidence
People who received care from 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 looked at the recruitment files for four care staff. We saw evidence that care staff had received recent safeguarding training and had criminal record checks which had been completed before they commenced employment.

Our judgement
The provider was meeting this standard. People who used this 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.

Outcome 14:
Supporting workers

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 competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us
We did not speak to the people who used the service about this outcome. We did speak to the care staff about the support and training they received.
One care staff we spoke with said that they had received induction training before they started work. They said it was good quality training and prepared them well for their role. Care staff confirmed that they received supervisions and had team meetings. Care staff said that the registered manager was approachable and felt they could raise any concerns with them.

Other evidence
We looked at the records of two care staff. We saw evidence that induction training had been completed before care staff were scheduled to work. We saw evidence that care staff received regular training throughout the year and were currently being scheduled more training to ensure it remained up to date. This meant that care staff were provided with the most up-to date training. This ensured that they were delivering care and treatment to the people who used the service in a safe way and to an appropriate standard.

We saw that care staff had the opportunity to further their education with National Vocational Qualifications and had a wide range of health care training available to them should they require it.

We saw evidence that care staff had regular supervisions, team meetings and had an annual appraisal. This meant that care staff had regular opportunities to feedback their ideas or concerns that they may have about the service. Care staff said they felt they

had good communication with management. They also said that they felt supported by management. This meant that care staff were well supported in their role.

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.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not speak to the people who lived at the service about this outcome.

Other evidence
Every month we received completed audits of the service from the registered manager. The audits showed that the service were compliant. For example, a financial audit had taken place; this showed that the finances were in order. The auditing process highlighted areas to be addressed with an action plan in place to address these. For example, an area of the bathroom floor was deteriorating, so a plan was put in place to rectify this. This showed that the service was appropriately assessing and monitoring the quality of the service provided.

We saw evidence that care staff carried out monthly safety checks, such as slings for the hoist, mattress checks, ceiling hoists, bath hoist and call bells. This ensured that the equipment used in the service were in safe and working order. Where the safety checks showed that an item needed replacing we saw evidence that this was rectified promptly. The service had completed water temperature checks, these temperatures were within a safe range. Water temperature checks showed that the service was protecting people from risk of scalding. These safety checks were audited in May 2012 finding them to be fully compliant.

All care staff received monthly supervisions. This meant that care staff had the opportunity to discuss certain areas of their work. If areas of concern had been identified, appropriate action could be taken. This meant that care staff were listened to

and their views taken into consideration when improving the standard of the service.

Our judgement
The provider was meeting this standard. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

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 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider was not meeting this standard. People's privacy, dignity and independence were not always respected.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	How the regulation is not being met: The provider was not meeting this standard. People's privacy, dignity and independence were not always respected.	
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The provider was not meeting this standard. People did not always experience care, treatment and support that met their needs and protected their rights.	
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services

	How the regulation is not being met: The provider was not meeting this standard. People did not always experience care, treatment and support that met their needs and protected their rights.

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 28 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
Author	Care Quality Commission
Audience	The general public
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