Review of compliance

Lunan House Limited Warmley House Care Home	
Region:	South West
Location address:	Tower Road North Warmley Bristol BS30 8XN
Type of service:	Care home service with nursing Care home service without nursing
Date of Publication:	May 2012
Overview of the service:	Warmley House Care Home provides nursing and residential care for up to 58 people within the Bristol and South Gloucestershire area. The home also provides care to people living with dementia.

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

Our current overall judgement

Warmley House Care Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 Warmley House Care Home had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 09 - Management of medicines
Outcome 15 - Statement of purpose

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 14 March 2012, checked the provider's records, looked at records of people who use services and talked to staff.

What people told us

We carried out this review to follow up on the compliance actions served after our last visit. This report should be read in conjunction with the report of November 2011.

We found that the provider had taken action to rectify the areas of non-compliance within the home. Overall we saw they had achieved compliance with the outcomes reviewed. Although we found that improvements had been made in the recording of the administration of medicines, some improvements were still needed in the recording of the application of creams and ointments prescribed by a doctor.

We did not speak with people who use the service as part of this review. However, we saw that staff treated people with respect, for example knocking on their door before entering, and that people were engaged in activities.

What we found about the standards we reviewed and how well Warmley House Care Home was meeting them

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

and supports their rights

Overall, we found that Warmely House Care Home was meeting this essential standard.

The registered person makes proper steps to ensure that people are protected against the risks of receiving care or treatment that is unsafe by carrying out an assessment of their needs and by planning and delivering care to meeting those needs.

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

Overall, we found that Warmely House Care Home was meeting this essential standard.

The registered person makes suitable arrangements to ensure that people are protected from the risk of abuse.

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

Overall, we found that Warmley House Care Home was meeting this essential standard; but, to maintain this, we suggested that some improvements were made.

Although some improvements have been made people cannot be assured they are fully protected against the risks associated with the unsafe use and management of medicines. Arrangements for the recording, safe keeping and safe administration of medicines are not appropriate to ensure their safety.

Outcome 15: The service must tell us about what kinds of services it provides

Overall, we found that Warmely House Care Home was meeting this essential standard.

The registered person has kept their statement of purpose under review and up to date and has made this available to CQC.

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 to improve. We will check to make sure that the improvements have been made.

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

In a previous review, we suggested that some improvements were made for the following essential standards:

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

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.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

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 compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We did not speak with people who used the service as part of this review. However, we saw that staff treated people with respect, for example knocking on their door before entering, and that people were engaged in activities.

Other evidence
We reviewed the care records of eight people who used the service. We found they were all person centred and that assessments of peoples needs had been carried out. The assessments had been updated since our last visit to the home. We found that the care plans were individualised and reflected the needs of each person. We also saw that people's preferences were documented and that individual risk assessments had been carried out.

We saw that people had end of life care plans in place and that their preferences had been expressed within both the care plan and the assessment of their needs. Where people had expressed that they did not wish to be resuscitated we saw a "do not attempt resuscitation" order had been completed by their doctor. These had been reviewed and updated annually by the doctor. Where the person did not have capacity to make decisions about their care, there was evidence that a "best practice" meeting had occurred and that appropriate family members and healthcare professionals had been involved in the decision about the person's end of life care. One of the care records we reviewed stated that the person had not expressed any end of life care wishes. This person had recently started living in the home.

Our judgement
Overall, we found that Warmely House Care Home was meeting this essential standard.

The registered person makes proper steps to ensure that people are protected against the risks of receiving care or treatment that is unsafe by carrying out an assessment of their needs and by planning and delivering care to meeting those needs.

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 did not speak with people who used the service about this outcome.

Other evidence
We reviewed the care records for eight people who used the service. We found there was an assessment of the person's capacity to make decisions about their care and treatment in seven of the eight care records we reviewed. The other person's care record contained the documentation for the assessment of their capacity to make decisions but the assessment had not been completed.

In addition to the formal assessment of the person's capacity there was an assessment of the person's needs. This included information about their capacity to make decisions about their care and who (if anyone) was to be involved in decisions about their care. Care plans were in place in each of the care records we reviewed, which clearly stated whether the person had capacity to make decisions about their care and treatment. If they did not have capacity to make decisions about all of their care then there was clear information for staff about what they could make decisions about, for example, choices about their daily personal care needs (what they would like to wear etc.). We also saw that where a person had fluctuating capacity to make decisions about their needs (for example, if it was known that the person sometimes becomes confused) the care plan stated that decisions may need to be made in the person's best interests when they become confused.

We saw that minutes of best interests meetings were recorded in the care record with

the care plan.

Our judgement
Overall, we found that Warmely House Care Home was meeting this essential standard.

The registered person makes suitable arrangements to ensure that people are protected from the risk of abuse.

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

There are minor concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not speak with people who used the service about this outcome.

Other evidence
We reviewed the storage and documentation relating to medicines management within the home.

We found medicines were stored securely and that medicines for destruction were disposed of directly into a medicines waste container. There were appropriate processes in place for the destruction of controlled drugs. We saw records were maintained of all medicines that were disposed of and that there was a record of when the medicines waste container was removed from the home for disposal.

We reviewed the controlled drugs storage and records for the home. We found that since our last visit all of the controlled drugs had been moved to be secured in one controlled drugs cabinet. Procedures had been put in place since our last visit to ensure that it was clear to staff when the residents in the home required a controlled drug and these were now administered only by registered nurses.

The controlled drugs registers demonstrated that two registered nurses checked the administration of each controlled drug dose and administered the medication. We also reviewed the balances of controlled drugs stored within the home and found that the balance of the controlled drugs tallied with the recorded balance in the controlled drugs

register.

We reviewed the medicines administration record (MAR) sheets within the home. We found these had been completed and that where a dose had been missed a reason had been recorded. One of the MAR sheets we reviewed demonstrated that a person had received their medication at a different time than prescribed. We asked staff why this had occurred and were told that this was because the person liked to sleep in late in the morning and was not awake for the doses at 8am. This had not been recorded in the person's daily progress notes. The deputy manager confirmed that this person often slept until later in the day and said that they were looking to change the time that the medication was prescribed, in order to fit the person's preferences.

We also reviewed the records of the application of creams and ointments for people who live in the home. We found the records did not contain all of the information about the dosing schedules for administering the creams or ointments, for example, whether it was to be administered when required or regularly. Some records had a copy of the prescription for staff to refer to but some did not. The records demonstrated that the application of creams and ointments was not recorded every day. However, it was not clear whether this was because staff were not recording the application of the cream or ointment or that application was not required that day.

Our judgement
Overall, we found that Warmley House Care Home was meeting this essential standard; but, to maintain this, we suggested that some improvements were made.

Although some improvements have been made people cannot be assured they are fully protected against the risks associated with the unsafe use and management of medicines. Arrangements for the recording, safe keeping and safe administration of medicines are not appropriate to ensure their safety.

Outcome 15:
Statement of purpose

What the outcome says

This is what people who use services should expect.

People who use services:
* Will benefit from the knowledge that the Care Quality Commission is informed of services being provided.

What we found

Our judgement

The provider is compliant with Outcome 15: Statement of purpose

Our findings

What people who use the service experienced and told us
We did not speak with people who used the service about this outcome.

Other evidence
We reviewed the statement of purpose and found that it had been updated and reflected the services provided by the home. Details of the registered manager and nominated individual had been updated to reflect the current people who work for the service.

Our judgement
Overall, we found that Warmely House Care Home was meeting this essential standard.

The registered person has kept their statement of purpose under review and up to date and has made this available to CQC.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

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
	Why we have concerns: Although some improvements have been made people cannot be assured that they are fully protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording, safe keeping and safe administration of medicines.	
Diagnostic and screening procedures	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	Why we have concerns: Although some improvements have been made people cannot be assured that they are fully protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording, safe keeping and safe administration of medicines.	
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	Why we have concerns: Although some improvements have been made people cannot be assured that they are fully protected against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements for the recording, safe	

	keeping and safe administration of medicines.

The provider must send CQC a report about how they are going to maintain 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.

CQC should be informed in writing when these improvement 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.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, 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
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	Copyright © (2010) Care Quality Commission (CQC). This publication may be reproduced in whole or in part, free of charge, in any format or medium provided that it is not used for commercial gain. This consent is subject to the material being reproduced accurately and on proviso that it is not used in a derogatory manner or misleading context. The material should be acknowledged as CQC copyright, with the title and date of publication of the document specified.

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