Care Quality Commission

Inspection Report

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

Regents Court Care Home

128 Stourbridge Road, Bromsgrove, B61 0AN

Tel: 01527879119

Date of Inspection: 30 October 2012

Date of Publication: January 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	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Cleanliness and infection control	✔ Met this standard
Staffing	✖ Action needed
Assessing and monitoring the quality of service provision	✔ Met this standard

Details about this location

Registered Provider	Manor Care Home Limited
Registered Manager	Mrs. Becky Dallimore
Overview of the service	Regents Court is located in Bromsgrove and provides accommodation and personal care for up to 36 people. Nursing care is not provided.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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'.

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 October 2012, observed how people were being cared for and talked with people who use the service. We talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

When we inspected Regents Court 32 people were using the service. During our inspection we spent time with people who used the service while they were in the dining room and in the lounge.

We found that relatives had raised concerns following a recent reduction in the number of care workers employed on each shift. Although staff were aware of people's needs we saw times when people were not sufficiently supported in order to have their needs meet. When care workers were supporting people we found that choice was offered and their dignity respected.

We saw three recorded entries of incidents between people who used the service. The registered manager was not aware of these events and no referral to safeguarding had taken place.

During this inspection we saw that systems were in place to manage the prevention and control of infection within the home.

The new provider had systems in place to assess and monitor the quality of care provided and as a means to identify any improvements needed. Further systems were to be introduced.

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

What we have told the provider to do

We have asked the provider to send us a report by 17 January 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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 choice were being respected.

Reasons for our judgement

Information was on display around the home regarding dignity and about a 'zero tolerance' of staff not upholding this. Some staff held the role 'Dignity Champions'. These members of staff held special responsibilities for making sure the dignity of people who used the service was respected.

People's privacy and dignity were respected. We saw signs on bathroom doors saying 'Do not disturb preparing myself for the day. Please respect my privacy and dignity'. Care workers confirmed that these signs were used as a way of preserving people's right to privacy while personal care was taking place and that they would make sure that doors and curtains were closed when helping a person with their personal care. During our inspection we saw staff escorting people to either a bathroom or their own bedroom in order to provide personal care if needed. We saw members of staff including care workers knocking on doors before they entered.

A small dining room had been converted to resemble a traditional public house. Bottles with optics were displayed containing fake alcoholic drink (cold tea). We were informed that the room was used for involving people in occasional 'pub evenings'. Menus were available within this dining room. These looked like menus seen in restaurants and showed people what choices of meals were available each day of the week. Throughout our inspection we saw staff offering people a choice of different hot drinks. During the morning we saw care workers offering people a choice of breakfast. At lunch time we saw care workers offering people a choice of food and giving people sufficient time to respond. We saw people being offered salt and pepper with their meal. This meant that people were offered a range of choices around meals and drinks during the day.

The registered manager brought to our attention life histories that they had prepared with the support of people's representative. We saw information displayed in some bedrooms and in memory boxes displayed outside bedroom doors. These contained important information or objects from people's past. This meant that care and support provided to people considered their preferences and people's interests and background.

During our inspection we saw a small number of people taking part in activities such as reading a paper or doing household tasks such as washing up. One care worker was seen painting people's nails. This meant that there was opportunity to take part in some events during the day.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not always experiencing the care and support they required to meet their needs and protected their rights.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

People who used the service and visitors we spoke with were complimentary about the care they or their relative had received. One person described the staff as, "Very friendly". Other comments included, "Couldn't complain about them they are very good nothing is a trouble to them". We also spoke with members of staff who were on duty at the time of our inspection.

Many of the people who used the service were unable to tell us about their experiences due to their dementia. Therefore during the inspection we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spent other periods of time observing what people were experiencing in the communal lounge areas of the home.

When we were carrying out the SOFI as well as during other observations we saw periods of time when people were not receiving the attention they required in order to meet their needs. We saw people who were showing signs of distress or in need of staffing input and not receiving it. For example, people calling out seeking assistance, people needing the toilet or cleaning a surface without a cloth.

We observed a period of half an hour observing what was happening. One person was disengaged throughout this period of time although staff were coming into the area bring other people for their breakfast and clearing tables. Another person was walking around the room at times distressed at other times rubbing furniture. We observed staff guide the person away from a door as they needed to gain access but no interaction took place.

Care plans and risk assessments were in place. These in place were up to date and offered guidance to care workers about identified care needs. We saw information in the daily notes however no care plan was in place. For example we some reference to monitoring one person's bowels. No record was in place. We asked a care worker would told us that they would remember when the person had used the toilet.

The care plan for one person stated that they needed to be on a pressure relieving cushion in order to prevent pressure ulcers developing. We saw a cushion was on another chair being used by a person who did not require this equipment. The person who required this piece of equipment did not use it throughout the morning of our inspection. We spoke with care workers about this and found that they were aware that the cushion was needed and acknowledged that they had not used it as detailed within the care plan. This meant that a care need had not been met leaving the person at risk of developing pressure damage.

Safeguarding people who use services from abuse ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse as staff were not always protecting people from potential abuse.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We were unable to speak with most of the people who used the service about this standard because of their levels of dementia. People we did speak with did not raise any concerns. One person told us that "They (the staff) look after you".

We spoke with one professional who was visiting the service. They told us that they had, "No concerns" with the care provided at the home. A visitor told us that they had, "No worries" and that their relative was, "Looked after."

There was a safeguarding policy in place. We were informed that this needed to be amended as a new provider was managing the home.

During discussions with care workers we asked them to describe what action they would take if they witnessed or suspected abuse. The staff we spoke with demonstrated a good understanding of their responsibilities and understood different types of abuse may occur.

We saw reference to some incidents between people who lived at the home. Neither the registered manager nor the deputy manager were aware of these incidents until we brought them to their attention. This meant that people who lived at the home could not be assured that suitable and appropriate action would always take place to protect their safety and well being.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because people were cared for in a clean, hygienic environment.

Reasons for our judgement

People and visitors had facilities to wash their hands and dispose of paper towels. Hand gel dispensers were available in corridor areas as a further means of giving staff and visitors the opportunity to keep hands free of potential infections.

The majority of areas we looked at we found to be clean, this included a commode in one bedroom. We brought to the attention of the registered manager a couple of areas where some improvement was needed in one of the toilets. The lid of a bin had a brown substance on it and the underneath of a bath seat was also dirty. The provider may wish to note that we checked these areas again towards the end of our inspection and found that although domestic staff had been on duty during the day these areas remained unchanged.

We saw that staff had access to personal protective equipment (disposable gloves and aprons). During our inspection we saw staff using these items appropriately. Different colour disposable gloves were used when staff were handling food. This meant that systems were in place to reduce the risk and spread of infection.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff available to meet people's needs.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We were informed by the registered manager that staffing levels at Regents Court were recently reviewed by the new provider and that changes had taken place. We were informed that dependency levels had not changed and therefore people's care needs remained the same.

As a result less care workers were available during the day time to meet the needs of people who used the service. The registered manager informed us of a planned increase in the number of hours designated for activities within the home. Staffing levels in the home especially in the afternoon were described as, "Busy", due to the, "Increased work to do."

The registered manager informed us that the number of hours available for staff to clean the home had also recently reduced. This meant that there was less time for staff to keep the home clean and manage infection control procedures.

During our inspection we saw comments made by relatives during a meeting with the providers in September 2012 that concerns had been raised about staffing levels. The providers believed staffing levels to be adequate however they had agreed that they would be reviewed at the end of November.

The registered manager informed us that staffing levels would be increased during the afternoon in the event of the home been fully occupied. In addition the provider may wish to note that during our inspection we saw periods of time when staff were not available to attend to people in the communal areas of the home.

During our inspection we observed that people were not attended to a timely way. For example we saw people in a communal lounge who were showing signs of distress and seeking members of their family who were familiar to them. During this time care workers were not available as they were attending to other people

No systems were in place to regularly establish the dependency levels of people who were using the service. This meant that there were no means of measuring the level of care input required in order to fully meet people's needs.

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.

Systems were in place to assess and monitor the quality of service provided to protect people from the risk of inappropriate care.

Reasons for our judgement

During this inspection the registered manager was able to demonstrate that there were a range of systems in place to monitor the quality of the service provided. There was new provider in place and they were putting new systems place to assess and monitor the service provided.

No satisfaction surveys had been sent out since the new provider took over the management of the service during the early part of August 2012. A meeting with relatives had taken place during early September 2012 and a further meeting for people to discuss the service provided was scheduled to take place.

Medication audits were in place to check that the correct amounts of medicines were held in the home. These audits took place on a regular basis. Accident audits had taken place and had demonstrated when professional input was needed to identify methods to reduce falls. This meant that systems were in place to ensure the health and welfare of people who used the service.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People were not always experiencing the care and support they required to meet their needs and protected their rights. Regulation 9 (1) (b) (i) (ii).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: People who used the service were not protected from the risk of abuse as staff were not always protecting people from potential abuse. Regulation 11 (1) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not enough qualified, skilled and experienced staff available to meet people's needs. Regulation 22.

This section is primarily information for the provider

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 by 17 January 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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