Review of compliance

Rushcliffe Care Limited **Partridge Court Nursing Home**	
Region:	East
Location address:	Partridge Road Harlow Essex CM18 6TD
Type of service:	Care Home Service with Nursing
Publication date:	10 March 2011
Overview of the service:	Partridge Court Nursing Home is registered to provide accommodation for persons who require nursing or personal care for up to 117 people. The Kingfisher suite specialises in care of the elderly, including people living with dementia. The Mallard suite offers specialist nursing care for adults requiring specialised neurological support.

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

What we found overall

We found that Partridge Court Nursing Home was not meeting one or more essential standards. Improvements were needed.

The summary below describes why we carried out the 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 10 March 2011, observed how people were being cared for, talked with people who use services, talked with staff, checked the provider's records, and looked at records of people who use services.

What people told us

Where people were unable to provide a verbal response or tell us verbally their experiences, for example as a result of their limited verbal communication or poor cognitive ability, we noted their non verbal cues and these indicated that people were generally relaxed and comfortable.

Relatives, health and social care professionals and staff members with whom we spoke during the course of this review had differing views on the quality of the care and support provided for the people living at Partridge Court Nursing Home.

One relative with whom we spoke confirmed they were happy with their relative's care and support and found staff to be kind and caring. They told us, "We have

nothing but praise, can't fault it!" and "The food's good, the care's good, it's clean at all times."

One relative said that they felt their relative was at risk from challenging outbursts from other people living in the home, from the lack of staff to care for people and from poor hygiene practices. They said that they felt that the staff members giving the person the care were doing their best in the circumstances.

People living at Partridge Court Nursing Home with whom we spoke during our visit on 10 March 2011 told us "The food is magnificent" and "On the whole we are pretty happy with things."

People living in the home told us that they found the environment to be clean and tidy. Others told us they liked their personal room and were able, when they moved in, to bring in personal belongings and, where appropriate, small items of furniture, so as to make it homely.

Relatives of people living in the home, health and social care professionals and staff members with whom we spoke told us that they believe there to be insufficient staff at the service to safely meet the needs of the people living there. One relative with said, in respect of one of the units providing support to people with dementia, "The problem is with consistency, a person gets used to staff and takes to them and then they are moved around to other units, and this affects the person. Staffing levels are not always enough, sometimes at weekends for example there are only two staff on this unit. If they have to go and deal with personal care in someone's room, there are no staff left to supervise those people in the lounge. It's not really safe."

Relatives of people living in the home told us they knew how to make a complaint.

What we found about the standards we reviewed and how well Partridge Court Nursing Home was meeting them

Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

In general, people who live in Partridge Court Nursing Home have their privacy and dignity respected. However, there is evidence to suggest that further improvements are required in respect of the laundry service.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 2: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

There was a system in place to gain consent from people who use services about their care, treatment and support. However, the system did not always transfer into practice and more than 50% of the staff team had not been provided with the training necessary to ensure people's human rights are respected and taken into account.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

People using the service may not have enough staff available to provide support and meet their needs and to keep them safe. The staff team have not all received the training they need to ensure they have the skills and knowledge to provide care and support for people living with dementia.

- Overall, we found that improvements are needed for this essential standard.

Outcome 5: Food and drink should meet people's individual dietary needs

The food in the home is of a satisfactory quality. People are supported to have their nutritional needs met and, where there are concerns, action is taken so as to ensure positive outcomes.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard.

Outcome 6: People should get safe and coordinated care when they move between different services

The service works with other agencies to ensure there is joint working and that outcomes for people who use the service are positive.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard.

Outcome 7: People should be protected from abuse and staff should respect their human rights

The management team at Partridge Court Nursing Home has not demonstrated a sound understanding of adult safeguarding procedures, for example by failing to refer relevant incidents arising at the home to the appropriate authorities for consideration. Therefore, there is potential for people living in the home to be at risk.

- Overall, we found that improvements are needed for this essential standard.

Outcome 8: People should be cared for in a clean environment and protected from the risk of infection

Arrangements are in place within the service to prevent and control infections. However, improvements need to be made to the management audit to ensure people's safety and welfare continues to be promoted.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 9: People should be given the medicines they need when they need them, and in a safe way

Medication practices and procedures within the service require strengthening and improvement, so as to ensure that people who use the service can be confident that they will receive their prescribed medication and that medication will be securely stored and will be administered by trained staff.

- Overall, we found that improvements are needed for this essential standard.

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

People who use the service live in a home environment that is comfortable and which meets their needs. Improvements are required to ensure that decoration in all areas of the home is age appropriate and respectful to the people living there.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 11: People should be safe from harm from unsafe or unsuitable equipment

Equipment for people's use is not always available when needed. Evidence suggests that, in some cases, this has compromised people's dignity and comfort.

- Overall, we found that improvements are needed for this essential standard.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job

People living in Partridge Court Nursing Home are cared for by staff who have been safely recruited.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard.

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

Staffing deployment and arrangements within the service require strengthening and improvement so as to ensure that people who use the service are supported and supervised at all times and benefit from social interaction with staff.

- Overall, we found that improvements are needed for this essential standard.

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

Staff training is available; however, shortfalls in all areas need to be improved so as to ensure that people who use this service are properly supported by a competent staff team. There are opportunities for staff to discuss their role and how they support people using the service; however, staff need to feel able to freely raise any concerns they have and for these to be listened to.

- Overall, we found that improvements are needed for this essential 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

There is little evidence that a meaningful quality assurance process is undertaken at Partridge Court Nursing Home to ensure that the people living there are getting the best possible care and support to meet their needs.

Overall, we found that improvements are needed for this essential standard

Outcome 17: People should have their complaints listened to and acted on properly

People living in the home, and their families, feel generally confident that any concerns or complaints they raise will be listened to and acted upon. However, when staff raise concerns about the care and support provided for people living at the home they do not feel they are listened to.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

People who live or work in the home cannot be confident that their personal records are held securely and remain confidential.

- Overall, we found that Partridge Court Nursing Home was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Action 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 in relation to outcomes 1, 2, 4, 7, 8, 9, 10, 11, 13, 14, 16, 17 and 21. We will check to make sure that the improvements have been made.

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 1:
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

There are minor concerns

with outcome 1: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People with whom we spoke told us they found staff to be polite and respectful when staff spoke to them and that they were able to express their views. People told us they could make decisions about what they do each day, or where they spent their time. People confirmed that their privacy and dignity was respected. People told us they could have a key to their room if they wanted to.

One person said, “They ask me what I want to wear each day" and "Staff will always take you back to your room any time you want."

We saw that people were generally relaxed and comfortable at Partridge Court Nursing Home.

Other evidence
The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

The care records that we looked at confirmed that people had an assessment of their needs prior to admission to the home. We saw evidence that families had visited to view the home and the information recorded indicated whether they had received a statement of purpose.

During our visit we found that people's privacy and dignity was upheld and that staff treated people with respect. We saw that staff knocked on people's doors before entering, used the term of address favoured by the individual and provided information or an explanation to people who use the service about the care and support being provided. Where people received assistance with personal care, this was undertaken in the privacy of their own room or bathroom, with the door shut. We saw an example of people's privacy and dignity being respected when a person was taken back to their own room to assist with re-arrangement of their clothing.

We saw staff interacting with people in a calm, caring and respectful manner. An example of this involved a person who had buttoned up their clothing incorrectly; we saw staff gently helping them to put this right, thus promoting their dignity and self respect.

One unit, whilst bright and cheerful, appeared 'childlike' with murals depicting Disney's Nemo and other contemporary children's storybook characters. This was not respectful to the people living on the unit.

In the laundry we saw boxes labelled 'tights', 'girly socks' and 'boys socks'. Staff confirmed that these items were not labelled and were used "where needed". We saw net pants, which are worn with incontinence pads, that had been washed ready to be re-used. These items were not individually named; staff told us, "Anyone has net nicks after washing." These practices did not serve to promote people's dignity and self respect.

Our judgement

In general, people who live in Partridge Court Nursing Home have their privacy and dignity respected. However, there is evidence to suggest that further improvements are required in respect of the laundry service.

Outcome 2:
Consent to care and treatment

What the outcome says

This is what people who use services should expect.

People who use services:
- Where they are able, give valid consent to the examination, care, treatment and support they receive.
- Understand and know how to change any decisions about examination, care, treatment and support that has been previously agreed.
- Can be confident that their human rights are respected and taken into account.

What we found

Our judgement

There are moderate concerns

with outcome 2: Consent to care and treatment

Our findings

What people who use the service experienced and told us

During our visit of 10 March 2011, we did not speak with any of the people living in Partridge Court Nursing Home about this outcome.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

The deputy manager told us that some people who use the service did not have the capacity to consent to their care. Where this was the case, people had the support of their relatives or independent advocates may be involved. Staff with whom we spoke told us that, as far as possible, people were involved in making decisions about their care.

The deputy manager told us that staff used different approaches to the management of restricting a person's access to and use of tobacco and alcohol. They confirmed that no assessment had been undertaken as to the person's capacity to make their

own decisions in relation to this matter, no multidisciplinary meeting had been undertaken to support the view and there was no clear agreed approach to this in their plan of care.

The owner told us at the time of their registration application: 'Our policies and procedures all take account of equality, diversity and human rights including issues such as Deprivation/Restriction of Liberty and Mental Capacity.' This did not concur with our findings.

Training records showed that, of the 101 staff employed to work at Partridge Court Nursing Home, 45 people had received training in relation to the Mental Capacity Act. These included: 26 care staff, five senior carers, five qualified nursing staff, two activity co-ordinators, a maintenance person, two cooks, one domestic, two admin staff and the home's dedicated trainer.

Training for 15 staff members was to have taken place on the day of our site visit. At least four of these staff members were recorded on the rota as being on duty supporting residents. Rotas did not always include people's surnames so it was not possible to be certain how many other staff members were to attend training but were also on duty. At the end of our visit we were told that this training had not occurred; no clear information was provided to explain this, despite our asking for clarification.

Our judgement
There was a system in place to gain consent from people who use services about their care, treatment and support. However, the system did not always transfer into practice and more than 50% of the staff team had not been provided with the training necessary to ensure people's human rights are respected and taken into account.

Outcome 4:
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

There are moderate concerns

with outcome 4: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us

People with whom we spoke had differing views about the care and support provided at Partridge Court Nursing Home. Many people told us they were satisfied with the care they received. Comments included, “The care is fine, I am happy with the way they are looking after me”, “We are happy with the care here” and “I am going to the musical entertainment that’s on downstairs today.”

People told us that they had enjoyed a pantomime that had been put on in the home by people from Cambridge University and a visit to the home by people from the Salvation Army. Relatives told us that activities had improved considerably.

A visitor told us, “I felt my relative was at risk from aggressive outbursts from other residents on the unit and the lack of staff and poor hygiene practices. The staff that gave my relative care were doing their best in the circumstances.”

Visitors with whom we spoke confirmed they were able to see their relative’s care plan in order to be sure it was appropriate to meet their needs.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

During our visit on 10 March 2011, we looked at the care records for five people living on different units around the home. We saw that detailed assessments of needs were undertaken prior to people being admitted to the home. These assessments were then developed into care plans to address any area of care or support required.

We saw care plans for areas such as maintaining a safe environment, communication, eating and drinking, personal cleansing and dressing, sleeping, medication, lifestyle, challenging behaviour and diabetes. The care records we saw had been evaluated monthly to ensure they remained appropriate to meet people's needs. They contained documents entitled 'Getting to know you', which covered all aspects of people's personal and spiritual lives and likes and dislikes.

Records also showed where health professionals such as the GP, chiropodist and physiotherapists had been involved with people's care. We saw records confirming that family members had been kept informed about the care of people living in the home and informed of any incidents, such as falls. Monthly weights were recorded and, where issues of weight loss or gain were indicated, there were appropriate risk assessments and action to take to promote people's well being. We saw that risk assessments were in place for areas such as falls, nutrition, moving and handling and pressure areas. Records indicated that these were reviewed monthly and amendments made to people's care regimes where necessary.

People generally praised the care staff on the quality of support and the kindness they afforded the people living at the home. However, a common theme of concern was raised by relatives, visiting health professionals and staff members over the numbers of staff available to support people with their care needs and to supervise the people in the communal areas of the home. Please see outcome 13 in this report for information on staffing levels.

Health professionals with whom we spoke, both during this visit and subsequent to the visit, told us they had concerns around the staffing levels on the dementia units and that they felt two staff to support 19 people living with dementia was not a safe ratio. They also told us they had concerns with the training provided, in that not all staff had received dementia training or education to support them to meet the needs of people who may experience aggressive outbursts or times of extreme agitation. A visiting health professional with whom we spoke told us, "Some staff are very responsive to our instruction and are very caring however they are stretched to the limit" and "Staff have always been attentive and followed advice we have given."

During our visit we saw a member of staff in the day room on one unit writing the daily care records for the people living on the unit. When asked, the person agreed they had not personally delivered the care that they were reporting on but that it was their job to write the records. This does not reflect good practice; some important information may be missed from this style of third party record keeping and it does not demonstrate that people's health and welfare was being accurately monitored.

There were two staff members on duty at this time to attend to the care and support

of 20 people living with dementia. A third staff member was on the rota but had been allocated to accompany a person to hospital. The second member of staff was busy re-stocking people's rooms with towels and flannels and making beds. This meant there were no staff members available to support people in the communal areas, to interact with people and to provide social stimulation or to ensure those people that chose to remain in their own rooms were safe and comfortable. Later in the day we noted that the two staff members were engaged in supporting people with personal care and people were alone in the communal lounge in excess of 30 minutes, with no staff in attendance.

Partridge Court Nursing Home employed a total of 103 people, including two members of the management team, at the time of our visit on10 March 2011. The service is registered to support and care for up to 117 people. Kingfisher 1 and 2 accommodated 40 people needing residential care and dementia care. Mallard 1 and 2 accommodated 40 people with nursing and dementia needs. Training records indicated that just 32 staff members had received in-house dementia training or were in the process of undertaking a distance learning course of dementia care training. This group of staff included people from all areas of the home, including four nursing staff, 17 care staff and three senior care staff. Some staff with whom we spoke did not demonstrate a good awareness of caring for people with dementia. On one dementia unit, we heard staff loudly refer to a person they were seated with as "X is just a bit confused today." The person in question was distressed and agitated. This approach did nothing to calm or reassure the person.

People living with dementia can sometimes become agitated and distressed, resulting in periods of challenging behaviours. Staff should receive the necessary training to be able to reassure people and calm difficult situations. We saw training records that indicated that 15 of the 103 people working at Partridge Court had received this training. Staff rotas showed that staff members working on the dementia unit on the day of our visit had not received this training.

There had been a lot of progress in relation to activities, since the previous inspection of Partridge Court Nursing Home in October 2009. We saw that a reminiscence room had been created on one of the dementia units. It was full of items that people would recognise from earlier in their lives such as Singer sewing machines, many 'nick-nacks' in an old fashioned glass cabinet, old style telephone, standard lamp etc.

We saw one person involved with sweeping the dining room floor after the lunch service. It was evident they were happy doing this and staff unobtrusively supervised this activity.

Our judgement
People using the service may not have enough staff available to provide support and meet their needs and to keep them safe. The staff team have not all received the training they need to ensure they have the skills and knowledge to provide care and support for people living with dementia.

Outcome 5:
Meeting nutritional needs

What the outcome says

This is what people who use services should expect.

People who use services:
- Are supported to have adequate nutrition and hydration.

What we found

Our judgement

The provider is compliant

with outcome 5: Meeting nutritional needs

Our findings

What people who use the service experienced and told us

People with whom we spoke told us that they were satisfied with the meals served at Partridge Court Nursing Home. One person said, "The food is fine. I don't know what's for dinner today but I do know that it's written on the whiteboard and there is a choice." They also told us of the set times that hot drinks were provided; this was structured and not responsive to people's specific needs and choices.

Relatives told us that the food seemed 'good' and that there was plenty of it. Another person confirmed that diversity is respected in the food provided.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

The previous inspection report for this service, from October 2009, stated: 'We observed the activities person consulting with people about their meal choices for the following day. People living with dementia would not necessarily be able to remember these choices from one day to the next. Aids such as picture menu cards showing the day's meal choices would help to stimulate people's interest in food, as it is helpful to see what food looks like, and help them make meaningful choices about what they want to eat.'

At our visit of 10 March 2011, we found that the situation remain unchanged. People living with dementia were still asked to select their meal choices for the following day and there were no pictorial menus available to assist people in making meaningful choices.

We saw daily task lists in the kitchenettes on the units. These stated: ’11 am tea round’ and ‘3pm tea round’ indicating that individual choice was not promoted. We saw jugs of cold drinks available for people in the communal lounges during the course of the day.

Some relatives of people living in the home told us that they visited regularly at mealtimes to support their relative with meals and relieve pressure on staff as it could take up to an hour to assist one person with their meal. We saw staff seated with people to provide sensitive assistance, where needed, and encouragement for others.

We saw a copy of a quality assurance survey undertaken by the manager in November 2010. In their responses to the survey, people had indicated that food could be disappointing, with 50% stating the food was good or very good and 50% stating that it was fair or poor. The manager’s action plan in response to the survey results stated: ‘The kitchen supervisor needs to make self more available to residents and relatives to receive and review comments about the catering department’. The notes from residents’ and relatives’ meetings showed there had been several discussions about meals provided at the home and how they were often cold by the time they reached the individual units and served to people. Relatives told us that the kitchen staff had made attempts to rectify this, for example by warming the plates before they left the kitchen; however, this did not appear to be effective.

Records showed that people’s nutritional needs were assessed and recorded and that, where someone was identified as being at risk of poor nutrition, action was taken to monitor this and a referral made to a suitable healthcare professional. Care records showed that people’s weights were regularly recorded and any fluctuation was acted upon accordingly.

Our judgement
The food in the home is of a satisfactory quality. People are supported to have their nutritional needs met and, where there are concerns, action is taken so as to ensure positive outcomes.

Outcome 6:
Cooperating with other providers

What the outcome says

This is what people who use services should expect.

People who use services:

- Receive safe and coordinated care, treatment and support where more than one provider is involved, or they are moved between services.

What we found

Our judgement

The provider is compliant

with outcome 6: Cooperating with other providers

Our findings

What people who use the service experienced and told us

Relatives with whom we spoke told us that the staff monitor people's health and regularly contact their GP and other health professionals as required. People also told us that staff kept them informed and that is important to them. One relative said, of the care and communication in respect of their family member, "They do look after them; they call the doctor if they are not well and they always tell me."

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

Each of the care files that we looked at provided proof of joint working between the management team of the service and local external agencies to provide appropriate care and support to people in relation to their healthcare needs. One visiting healthcare professional with whom we spoke told us they find the care staff to be co-operative and responsive to advice and instruction.

We were told that people attending hospital or other appointments were accompanied by staff or family members and that additional staff would be rostered

to provide the necessary support. On the day of our visit, one staff member had escorted a person to a scheduled hospital appointment. Additional staff had not been rostered to ensure stated staffing levels were available to meet the needs of people living at the home.

Our judgement

The service works with other agencies to ensure there is joint working and that outcomes for people who use the service are positive.

Outcome 7:
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

There are moderate concerns

with outcome 7: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us

A relative told us that they felt their relative was at risk from aggressive outbursts from other people living at the home and the lack of staff and hygiene practices.

Of the people living in the home, those who could verbally communicate with us told us that they were happy with the care they received.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

Staff with whom we spoke confirmed that they had attended training on safeguarding vulnerable people. They were able to tell us about types of abuse but also ways in everyday practice that can be abusive, such as not listening to people or not asking them what they would like. We asked some staff members what they would do if they had cause to believe people were at risk from abuse. They told us that they would report it to the management team and, if they did not feel they were listened to, they would report higher in the organisation. They were not clear about how or when to contact the local authority's adult safeguarding unit or where they

could access the contact details should the need arise.

We looked at the monthly audit of accidents and incidents. We saw that incidents of aggressive outbursts between people living at the home that resulted in injuries being sustained had not been considered for referral to the local authority's adult safeguarding unit.

The deputy manager was able to confirm that there was an up to date policy and procedure in place for safeguarding vulnerable people. Staff members we spoke with could not tell us where they could find this.

Discussion with the deputy manager indicated that there was no understanding in the management team that these assaults should be reported to the safeguarding team for its consideration. Training records did not confirm that the manager of the deputy manager had attended training in safeguarding of vulnerable adults. Records indicated that 28 of the 103 people employed to work at Partridge Court Nursing Home had not received this training.

Our judgement

The management team at Partridge Court Nursing Home have not demonstrated a sound understanding of adult safeguarding procedures, for example by failing to refer incidents arising at the home to the appropriate authorities for consideration. Therefore, there is potential for people living in the home to be at risk.

Outcome 8:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

There are minor concerns

with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
People with whom we spoke during our visit on 10 March 2011 held differing opinions about the cleanliness of the home. A relative told us, “The toilet was dirty, there was faeces on <Person>’s hands, stains on the floor. We were told that cleaner had been taken ill. For £700 per week you would think they would have more than one cleaner.”

Another person also told us that they felt their relative was at risk because of poor hygiene practices in the home.

One person said of the home, “It’s clean.”

Other evidence
The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

During our visit on 10 March 2011, we looked around all of the units within the home. The home generally appeared to be clean and fresh. We had an occasion to alert a domestic assistant to a soiled toilet facility and this was dealt with immediately.

We saw a cleaner’s trolley, complete with cleaning chemicals, left unattended in the

doorway of one unit. This is not safe practice as people living at the home could access the chemicals and come to harm.

In July 2010, a healthcare professional had identified major shortfalls in infection control practice at Partridge Court Nursing Home. A representative from the Primary Care Trust worked with the staff and management team to ensure the home had the correct equipment and facilities in place and that staff had the knowledge and education to maintain appropriate hygiene standards.

The local authority's Quality and Monitoring review report of February 2011 stated that hygiene standards had improved considerably. Whilst we acknowledge that the hygiene standards in the home have improved, it remains a concern that this improvement had to be driven by a visiting professional and not by the day to day management and audit processes within the home.

The staff training matrix showed us that, of 103 members of staff employed to work at Partridge Court Nursing Home, 19 had not received infection control training.

We saw that staff members were using personal protective clothing to deliver personal care and also whilst serving food.

Visitors to the home on the day of our visit held differing views about the cleanliness and hygiene practices at the home. We received reports of carpets left stained with faeces for a number of days and reports of personal protective clothing, such as aprons and gloves, stored on the floor of a person's bathroom. A health professional alerted us to the fact that one unit in the home, accommodating 20 people, had just one shower chair for everyone to use. We confirmed this with the deputy manager who acknowledged that this was not an ideal situation but was unable to clarify what actions were going to be taken to meet this need.

A report of a survey of people's views, undertaken by the manager in November 2010 as part of the service's own quality assurance, showed that concerns were raised in relation to the laundry. A report, summarising people's responses, was forwarded to us by the manager. The report stated: 'Most respondents felt that the kitchen, laundry and activities could be improved upon'. The manager's action plan stated that the kitchen/domestic/laundry supervisors 'need to make themselves more available to people living at the home and their relatives to receive and review comments about their departments'. Minutes of a meeting, held on 01 February 2011, for the people living in the home and their relatives included comments about the laundry service. Relatives reported finding other people's clothes in their relative's wardrobe and the laundry system being under such staffing pressure that some relatives were taking their relative's laundry home to wash.

The manager used the Department of Health self assessment tool to audit the infection control arrangements in the home and we were provided with a copy of the assessment undertaken in February 2011. The audit identified domestic and laundry staff shortages and that, as the number of people living in the home increased, the laundry/cleaning capacity needed to be re-assessed. The audit confirmed that each member of the domestic team had a weekly cleaning schedule; however, there was not a routine audit undertaken of this. The audit also identified that there was no

policy in place for the decontamination of medical devices and equipment and no designated key worker for infection control within the home. The assessment showed that the next self assessment for infection control was planned for August 2011.

Our judgement
Arrangements are in place within the service to prevent and control infections. However, improvements need to be made to the management audit to ensure people's safety and welfare continues to be promoted.

Outcome 9:
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 9: Management of medicines

Our findings

What people who use the service experienced and told us

One person with whom we spoke told us that staff manage their medication for them and that this suits them.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

We looked at how medication was stored and administered within one unit at the home. We saw that boxes of tablets were signed and dated to indicate when they had been opened, thereby contributing to an audit trail of the medications kept at the home. We saw that homely remedies were recorded appropriately and the medication room was air conditioned, ensuring that medications were not at risk of spoiling from being too warm. We noted there were no records to confirm that the temperatures of the treatment room and the medication fridges were monitored. We did not get the opportunity to ask staff if these records were held elsewhere as there were only two staff on duty on the unit and they were fully engaged with the care and support of people living on the unit.

Most of the medications were stored in a lockable cabinet within the treatment room, which was kept locked. Not all the medications for one unit were able to fit into the mobile cabinet and some were stored in a cupboard in the treatment room. We found that this was not locked.

Records showed that staff had taken advice from the GP when a person had begun to refuse some of their medications. Changed instructions were found to be recorded in the person's care records but were not clear in relation to one medication. The medication was not readily available in the medication room with the person's other medications, although it had been signed for as received. This unit was running short of staff during the afternoon of the site visit. The person responsible for medication could not take time away from supporting people using the service to assist us with our review of medication.

We looked at the medication administration recording (MAR) sheets. These were well organised. They included a picture of each individual person along with their name and relevant information. This helped to ensure that the right medication is given to the right person. No omissions were seen on the MAR sheets, indicating that people were given their prescribed medications. However, while lunch service was taking place in one dining room, one person was asleep at a dining room table in another diner/lounge. We found a tablet on the floor underneath this table. Staff told us that it did not belong to this resident as they do not have any prescribed medications. This showed that staff did not ensure that people took their medications.

The training records showed that 11 staff members had received medication training or refresher training since January 2010. The staff members attending this training were two of the seven senior care staff members, six of the 19 qualified staff, two care staff and a care team leader. The staff on duty on the day of this visit and who were responsible for the administration of medication had attended refresher training. We were not able to accurately assess if this was always the case as rotas for three of the units were handwritten and unclear and did not include surnames of individuals.

We were provided with a copy of a pharmacist monitoring report from August 2010. The report did not identify any concerns with the medication administration systems at Partridge Court Nursing Home and indicated that evidence of staff training had been seen.

Our judgement

Medication practices and procedures within the service require strengthening and improvement, so as to ensure that people who use the service can be confident that they will receive their prescribed medication and that medication will be securely stored and will be administered by trained staff.

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are minor concerns

with outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us

People with whom we spoke told us that they were happy with the premises. They particularly spoke of their own rooms and that they had been able to bring some of their own possessions to make them more personal. A relative with whom we spoke told us that the home is clean and that their family member has a nice room. People were complimentary about the maintenance worker, describing him as a 'cracking chap' and saying, "You only have to mention you want a job doing and he does it straight away."

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

We toured the building during our site visit on 10 March 2011. We found the physical environment was generally safe to meet the requirements and needs of the people who live at Partridge Court Nursing Home.

Since our last visit to the home, a pleasant reminiscence room had been created, full of items that people would recognise from earlier in their lives, such as Singer sewing machines, many ornaments in a vintage glass cabinet, an old style

telephone and standard lamp.

We saw a number of notices around the home relating to staffing matters. The communal lift, used by relatives and other visitors to the home, had notices relating to staff training and immigration issues. The management of the home need to remain aware that Partridge Court Nursing Home is home for the people living there and that staff notices, such as these, may not be appropriate for display in communal areas.

We saw some good examples of personal room signage to enable people to recognise their own space and to be able to locate bathroom facilities.

The décor in the communal hallway on the dementia units had been brightened up, moving away from the bland appearance we found at the last visit; however, we noted there was still no effective use of colour or tactile experiences, in line with current good practice guidelines.

Our judgement
People who use the service live in a home environment that is comfortable and which meets their needs. Consideration should be given to the removal of notices relating to staffing issues from the communal areas of the home in which people live.

Outcome 11:
Safety, availability and suitability of equipment

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
- Are not at risk of harm from unsafe or unsuitable equipment (medical and non-medical equipment, furnishings or fittings).
- Benefit from equipment that is comfortable and meets their needs.

What we found

Our judgement

There are moderate concerns

with outcome 11: Safety, availability and suitability of equipment

Our findings

What people who use the service experienced and told us

We did not speak with any of the people living at Partridge Court Nursing Home about this outcome during the visit of 10 March 2011.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

People have access to a range of aids and equipment that meet their needs, such as walking frames, wheelchairs, bed rails and pressure relieving equipment.

We saw a cleaning trolley left unattended inside the entrance of Mallard 2. There were cleaning products on the trolley that could potentially cause harm to people living on the unit.

Health professionals told us, and the deputy manager confirmed, that there was just one shower chair on the ground floor unit accommodating 20 people.

We noted some people living in the home had swollen ankles. There were no footstools provided for people to elevate their feet in this instance. The footstools we did see on the unit had been provided by relatives. Health professionals, with whom we spoke during our visit on 10 March 2011 and subsequent to the visit, told us this issue had been raised with the management of the home previously and they were concerned that no positive action had been taken to address this.

We saw that there was a lack of over chair/bed tables for people to be able to sit in bed or in their chair comfortably and have a drink or a meal. Relatives told us this had been a particular concern when people were not able to leave their bedrooms to eat in the dining room. They told us that low coffee tables were the only available tables that staff could provide for people to eat at in such instances.

Relatives with whom we spoke indicated that it was a disappointment to them that the Hydrotherapy pool, advertised by the service, had not been in use since the home opened in May 2009. They told us that the pool was part of the reason they chose Partridge Court Nursing Home as a care home for their relative.

We saw that equipment, such as hoists and fire extinguishers, were in place and were regularly serviced.

Our judgement
Equipment for people's use is not always available when needed. Evidence suggests that, in some cases, this has compromised people's dignity and comfort.

Outcome 12:
Requirements relating to 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 staff who are fit, appropriately qualified and are physically and mentally able to do their job.

What we found

Our judgement

The provider is compliant

with outcome 12: Requirements relating to workers

Our findings

What people who use the service experienced and told us

We did not speak with the people using the service about this outcome during our visit on 10 March 2011.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

At the previous inspection of this service, in November 2009, documentary evidence was provided to show that people had been safely recruited to care for the people living in Partridge Court Nursing Home.

At a local authority monitoring review visit in February 2011, files of newly recruited staff were seen and found to contain all the information needed to confirm that people were safely recruited. This assured us that good practice in this area has been maintained.

Our judgement
People living at Partridge Court Nursing Home are cared for by staff who have been safely recruited.

Outcome 13:
Staffing

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 sufficient numbers of appropriate staff.

What we found

Our judgement

There are moderate concerns

with outcome 13: Staffing

Our findings

What people who use the service experienced and told us

We received many comments of concern from visitors and health professionals regarding staffing levels at the home. One relative with whom we spoke said of one of the units providing support to people with dementia, "The problem is with consistency, a person gets used to staff and takes to them and then they are moved around to other units, and this affects the person. Staffing levels are not always enough, sometimes, at weekends for example, there are only two staff on this unit. If they have to go and deal with personal care in someone's room, there are no staff left to supervise those people in the lounge. It's not really safe."

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

We were told that, if a person living in the home had a planned hospital appointment and needed to be escorted, an extra staff member would be on duty. On the morning of our visit, we observed that, on one unit, only two staff members were available to support 19 residents instead of the expected three. The third rostered staff member had accompanied a person to a hospital appointment and no additional support had been brought in to provide cover for their absence.

On the afternoon of our visit, we again saw that just two staff members were available on a unit to support people, for the same reason. One staff member was busy making beds and distributing towels and flannels to people's rooms. The other member of staff was sitting in the lounge writing up records. People living on the unit were left to their own devices, with no social stimulation or interaction with staff. We saw some people seated staring into space while others were wandering to and fro, some in an agitated manner.

Later in the afternoon, we saw that no staff members were present in the lounge for a period of at least 30 minutes. The two staff on duty were actively engaged in providing support to people in their own rooms. Relatives reported that this was often the case and that they felt this was unsafe and their relatives were at risk in this situation.

Staff told us they 'felt bad' that people on the unit were left unattended and without stimulation whilst they were involved with tasks but they felt they had no option.

Staff with whom we spoke told us that staffing levels were insufficient to meet the needs of the people using the service and that no agency staff were used at the home and the bank staff team was limited, especially for care staff. Staff told us that, if sickness occurs, then the shift runs short of staff. This meant that, on many occasions, the units were not staffed to the levels agreed. One person said, "Some really good dedicated staff here, they create a nice buzz in the home but low staffing levels eat away at their morale."

A member of the senior management team told us, subsequent to this visit, that there was no 'tool' yet available for managers to evaluate the dependency levels of the units in the home and determine the required staffing levels on the basis of findings. All of the care files we looked at included an individual dependency assessment for the person but there was no method of collating these to assess if the staff provision on the unit was adequate to meet the assessed dependency of the people living there.

We were told that, if people's needs increased, a nursing needs assessment would be undertaken so they could be moved to the nursing unit. Staff told us that the management team at the home did not have the authority to obtain agency staff or increase the staffing levels in the home without agreement from the organisation's head office. A member of the senior management team told us, subsequent to this visit, that it was the responsibility of the management of the home to determine the staffing requirements for the home and to take any concerns to the senior management team for authorisation for more staff.

It is a concern that the management of the home does not have the autonomy at a local level to respond with flexibility to the support needs of the people living at Partridge Court Nursing Home.

During our visit to the home, we were alerted to an incident in which a person living at the home had fallen and may have needed hospital treatment. The person would have needed two staff members to accompany them to hospital, which would have

left the unit short staffed. Fortunately, in this instance, the paramedics were able to attend to the person's minor injury, removing the need for a hospital visit.

We looked at the staff rota. There was nothing on the rota to indicate that people were away from the home supporting people with hospital appointments and it did not, therefore, accurately reflect the number of staff in the home supporting people. As a result, we could not be confident that the rotas accurately reflect the staffing levels in the home. Staff and relatives told us that the units are frequently short staffed; however, the rotas reflect consistent numbers. Staff rotas for three of the units in the home did not include the full name of the people working, often just people's first names.

Relatives with whom we spoke told us they found staff did not always wear name badges so they didn't always know to whom they were speaking. We noted that many of the staff team did not wear a name badge. Some told us they were still waiting for name badges, which they had been told had been ordered more than a month ago.

Our judgement

Staffing deployment and arrangements within the service require strengthening and improvement so as to ensure that people who use the service are supported and supervised at all times and people benefit from social interaction with staff.

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

There are moderate concerns

with outcome 14: Supporting workers

Our findings

What people who use the service experienced and told us

People living in the home and their visitors with whom we spoke made very favourable comments about the staff who supported them, describing them as ‘very good’, ‘so good’ and ‘nice’.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

Prior to our visit on 10 March 2011 we received information that staff did not feel competent and sufficiently trained to meet the needs of people who may display aggressive behaviours.

We requested a copy of the service’s staff training matrix. This showed that 15 of the 103 people employed to work at Partridge Court Nursing Home had received training to give them the skills to manage these behaviours and 32 staff members had received, or were currently undertaking, training in dementia care. The matrix also showed there were many shortfalls in basic core areas of training, including moving and handling, adult safeguarding, mental capacity and the control of infection.

Mental Capacity Act and Deprivation of Liberty training was scheduled for the day of this visit; however, this was cancelled as only one person attended. We looked at the staff rotas and, whilst these were unclear, it was evident that at least four of the 15 people booked to attend this training were on duty providing care and support to residents on this day.

The training matrix indicated that 13 of the 52 care staff employed to work at the home either had achieved, or were working towards, the NVQ 2 in care. Two of the seven senior care staff had achieved or were undertaking this qualification, as was a care team leader.

The training matrix showed that some training was provided to give the staff team the skills and knowledge to meet people's specific health needs. These included tracheotomy care (13 staff members), respiratory training (12 staff members), diabetes awareness (13 staff members) and Huntington's disease (six staff members).

The owner of the service advertises on their website: 'All staff receive training relevant to their job role, as well as training specific to the resident group i.e. Understanding Dementia' and that 'Healthcare Support Workers (educated to NVQ Level 2 minimum)' . These statements do not concur with our findings at the site visit.

The owner told us, during their transitional registration, 'When planning service delivery we ensure that staff have the training, knowledge and skills to meet the varying needs of the population served.' Again, this does not concur with our findings at the site visit.

Staff told us that one negative issue with training was that staff rostered on duty were sometimes expected to attend training, leaving the unit short staffed.

Staff with whom we spoke were able to confirm they had attended fire awareness, moving and handling, food hygiene and Care of Substances Hazardous to Health (COSHH) training. Some staff told us they had indicated at supervision that they needed dementia training and were keen to undertake an NVQ but, to date, nothing had happened. A staff member working on a dementia unit on the day of this visit had not received any training in supporting people with dementia or managing behaviours that challenge.

The local authority's monitoring review visit in February 2011 confirmed that an appropriate supervision system was in place at Partridge Court Nursing Home. Staff with whom we spoke confirmed they received regular supervision with a line manager. However, information received prior to, and during, this visit indicated that staff did not feel able to highlight any concerns they may have about the service provided for people living in Partridge Court Nursing Home and felt that the management team did not listen to them.

The staff members with whom we spoke held differing views about the support they received from the management team. Some people told us they had “no problems with the management of the unit” and felt supported; however, others said they felt that the management does not listen and does not have time for the staff.

The owner advertises on the Internet and in the home’s Statement of Purpose that there is a hydrotherapy pool for the use of people living in the home and that the service employs a dedicated occupational therapist as part of the Multi Disciplinary team. Staff confirmed that the hydrotherapy pool has never been used since the facility opened in May 2009 and the service does not employ an occupational therapist.

Our judgement

Staff training is available; however, shortfalls in all areas need to be improved so as to ensure that people who use this service are properly supported by a competent staff team. There are opportunities for staff to discuss their role and how they support people using the service; however, they need to feel able to freely raise any concerns they have and for these to be listened to. Some of the statements made by the owner in respect of the service and its staff were found to be inaccurate.

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

There are minor concerns

with outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us

Visitors with whom we spoke told us that relatives' meetings were held to enable people to be involved in the running of the home. These meetings were held at 5.00 p.m. on a weekday. Relatives told us this was not very useful as many were not able to attend at this time and it would be more convenient if these meetings could be held later in the evening or at weekends so that more people could attend.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

Prior to our visit to the home on 10 March 2011 we had been provided with a copy of the Partridge Court Nursing Home annual survey results from November 2010. The report indicated the percentage of respondents' views about various areas of the home's service. It was reported, for example, that '50% of respondents felt the food was good or very good and the remaining 50% felt it was fair or poor.

However, there was no indication of how many people had taken part in this survey so the results do not provide a meaningful overview of people's views of the service provision. The manager had developed an action plan to address areas of the service provision that had received negative feedback. Shortfalls identified included staffing levels, the quality of the food and the laundry service. For example, in relation to staffing levels, the manager's action plan stated: 'In January 2011 there should be a report on dependency levels in the residential service and discussions will take place with senior managers on how to increase levels in that service'. We requested a copy of this report; however, this was not made available to us.

The service does not currently undertake a survey of views from external parties involved in the care of the people living in the home, such as health professionals or social workers nor are the staff team involved in this process.

Records showed there were regular staff meetings, with the most recent held on 02 November 2010. The staff meeting minutes showed that just 17 of the 103 staff employed at the home attended the meeting and confirmed the issues discussed.

The owner has systems in place to audit the performance of the home in many areas, such as medication administration, infection control and care planning. However, it is not clear how the results of these audits, together with the outcomes of complaints and safeguarding investigations, annual surveys results and feedback from such things as staff meetings and relatives' meetings feed into an overall quality assurance process.

Following our previous inspection of this service in October 2009, the manager provided us with an action plan outlining how they would meet identified shortfalls and in what timeframe this would take place. There is evidence to show that some stated improvements in action plans are misleading and failing to have the desired impact.

The action plan submitted to us in May 2010 in response to our inspection of October 2009 told us that the deputy manager oversees the centre's complaints processes and that every complaint is acknowledged and complaints are handled as per company policy. Evidence from our discussions with the staff team shows that their complaints have not been handled in line with company policy.

The action plan also stated that all staff would have received any outstanding training by 28 May 2010. While this may have been done with the staff team in post at that time there has clearly been no continued commitment to ensure that staff have the necessary skills and knowledge to meet the needs of the people they are supporting.

Our judgement

There is little evidence that a meaningful quality assurance process is undertaken at Partridge Court Nursing Home to ensure that the people living there are getting the best possible care and support to meet their needs.

Outcome 17: Complaints

What the outcome says

This is what people should expect.

People who use services or others acting on their behalf:

- Are sure that their comments and complaints are listened to and acted on effectively.
- Know that they will not be discriminated against for making a complaint.

What we found

Our judgement

There are minor concerns

with outcome 17: Complaints

Our findings

What people who use the service experienced and told us

People using the service told us that they would feel able to raise concerns. Many of the people with whom we spoke said that they would be able to approach the deputy manager, who they believed was the manager at the home. Some said they did not find the area manager, who is actually the registered manager of the home, to be approachable and one person said, "Anyway they are not here very often."

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

The service has a complaints policy and procedure in place

There were records of concerns raised by relatives of people living in the home; these had been recorded appropriately and responded to in line with the home's policies and procedures for dealing with complaints.

Concerns raised by staff members were not recorded and dealt with accordingly. Various members of staff, both on duty on the day of the visit and others that were not on duty at this time, told us they had raised complaints with management. There were no records available to show how these had been dealt with.

Our judgement
People living at the home and their families feel generally confident that any concerns or complaints they raise will be listened to and acted upon. However, when staff raise concerns about the care and support provided for people living in the home, they do not feel that they are listened to.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are minor concerns

with outcome 21: Records

Our findings

What people who use the service experienced and told us

We did not speak with the people using the service about this outcome during the visit on 10 March 2011.

Other evidence

The owner told us, at the time of their registration application, that they were meeting this outcome. No concerns were identified by our review carried out at that time.

During the site visit, we found the manager's office, which is in close proximity to the visitors' lift, to be unlocked. Filing cabinets in this room, which contained information relating to staff and residents, were also unlocked. We saw that people's personal care records were in unlocked and unsupervised offices on each of the units. The personal care records of a recently deceased person were left on the unit inside the unlocked door of their room.

Our judgement
People who live or work in the home cannot be confident that their personal records are held securely and remain confidential.

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	17	1: Respecting and involving people who use services.
	Why we have concerns: In general, people who live in Partridge Court Nursing Home have their privacy and dignity respected. However, there is evidence to suggest that further improvements are required in respect of the laundry service.	
Accommodation for persons who require nursing or personal care	18	2: Consent to care and treatment.
	Why we have concerns: There was a system in place to gain consent from people who use services about their care, treatment and support. However, the system did not always transfer into practice and more than 50% of the staff team had not been provided with the training necessary to ensure people's human rights are respected and taken into account.	
Accommodation for persons who require nursing or personal care	12	8: Cleanliness and infection control.
	Why we have concerns: Arrangements are in place within the service to prevent and control infections. However, improvements need to be made to the management audit to ensure people's safety and welfare continues to be promoted.	

Accommodation for persons who require nursing or personal care	22	13: Staffing
	Why we have concerns: Staffing deployment and arrangements within the service require strengthening and improvement so as to ensure that people who use the service are supported and supervised at all times and people benefit from social interaction with staff.	
Accommodation for persons who require nursing or personal care	19	17: Complaints
	Why we have concerns: People living in the home, and their families, feel generally confident that any concerns or complaints they raise will be listened to and acted upon. However, when staff raise concerns about the care and support provided for people living in the home they do not feel that they are listened to.	
Accommodation for persons who require nursing or personal care	20	21:Records
	Why we have concerns: People who live or work in the home cannot be confident that their personal records are held securely and remain confidential.	

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 within 14 days of this report being received.

CQC should be informed in writing when these improvement actions are complete.

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	9	4: Care and welfare of people who use services
	How the regulation is not being met: People using the service may not have enough staff available to provide appropriate care and support, meet their needs and to keep them safe. The staff team have not all received the training they need to ensure they have the skills and knowledge to provide care and support for people living with dementia.	
Accommodation for persons who require nursing or personal care	**11**	7: Safeguarding people who use services from abuse
	How the regulation is not being met: The management team at Partridge Court Nursing Home has not demonstrated a sound understanding of adult safeguarding procedures, for example by failing to refer incidents arising at the home to the appropriate authorities for consideration. Therefore, there is potential for people living in the home to be at risk	
Accommodation for persons who require nursing or personal care	13	9: Management of medicines
	How the regulation is not being met: Medication practices and procedures within the service require strengthening and improvement, so as to ensure that people who use the service can be confident that they will receive their prescribed medication and that medication will be securely stored and will be administered by trained staff.	
Accommodation for persons who require nursing or	16	11: Safety, availability and suitability of equipment.

personal care	**How the regulation is not being met:** Equipment for people's use is not always available when needed. Evidence suggests that, in some cases, this has compromised people's dignity and comfort.	
Accommodation for persons who require nursing or personal care	23	14: Supporting workers
	How the regulation is not being met: Staff training is available; however, shortfalls in all areas need to be improved so as to ensure that people who use this service are properly supported by a competent staff team. There are opportunities for staff to discuss their role and how they support people using the service; however, staff need to feel able to freely raise any concerns they have and for these to be listened to.	
Accommodation for persons who require nursing or personal care	10	16; Assessing and monitoring the quality of service provision
	How the regulation is not being met: There is little evidence that a meaningful quality assurance process is undertaken at Partridge Court Nursing Home to ensure that the people living there are getting the best possible care and support to meet their needs.	

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 14 days of this report being received.

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.

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

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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