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
Date of Publication:	October 2011
Overview of the service:	Partridge Court Nursing Home is registered to provide accommodation for for up to 117 people who require nursing or personal care. The Kingfisher and Mallard suites specialise in care of the elderly, including people living with dementia. The Eider and Teal suites offer specialist nursing care foradults requiring specialised neurological support.

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

Our current overall judgement

Partridge Court Nursing Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review to check whether Partridge Court Nursing Home had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines
Outcome 16 - Assessing and monitoring the quality of service provision

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 9 September 2011, carried out a visit on 14 September 2011, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

People living in Partridge Court Nursing Home told us there had been significant improvement throughout the home in such areas as cleanliness, food provision, laundry and staffing levels. People with whom we spoke said "There seems to be a lot more staff than there used to be. In a way it doesn't really affect me at all because I can do most things myself."
Relatives, with whom we spoke, made positive comments about general improvements in the service provided for the people living in Partridge Court Nursing Home. One person said "We have really noticed so much improvement in the cleanliness, staffing numbers and the general care."
People told us they were offered some social stimulation, one person said "Last week we went in to town with a couple of carers. We went around the shops and had lunch in a café, ending up with ice creams. We thoroughly enjoyed ourselves. We have asked when we could do it again; they said they needed to make sure that everyone gets a chance to go out. This is the first time I have been out of the home in 18 months."

Relatives told us that they had noticed the difference in the premises at how much cleaner it is now. People said that the "Staffing levels were much improved" and they didn't ever

worry that their relative was not cared for and never felt uncomfortable. They never saw people distressed and not attended to. They identified however that "There is a better atmosphere now." They said were satisfied with the care provided for their relative.

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

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

The provider is compliant with this outcome. People receive safe and appropriate care according to their assessed needs. Improvements are needed however, to ensure that care plans and care practice continue to be monitored to ensure people consistently benefit from good care.

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

People who use the service can be assured that their medicines are stored and handled safely and that they are given them as prescribed. However, improvements are needed to ensure any identified discrepancies in the medication records are resolved promptly and a record made of this.

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

The provider is compliant with this outcome. The quality of service is now being audited to ensure people using the service receive safe and appropriate care and support to meet their needs. Improvements are needed to ensure the audit systems are sustained.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

In a previous review, we found that improvements were needed for the following essential standards:

- Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it

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

- Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

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

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

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

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

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

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

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

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

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

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

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
People with whom we spoke said "There seems to be a lot more staff than there used to be. In a way it doesn't really affect me at all because I can do most things myself." People told us they were offered some social stimulation, one person said "Last week we went into town with a couple of carers. We went around the shops and had lunch in a café, ending up with ice creams. We thoroughly enjoyed ourselves. We have asked when we could do it again, they said they needed to make sure that everyone gets a chance to go out. This is the first time I have been out of the home in 18 months."

Relatives with whom we spoke told us that they had noticed the difference in the premises and how much cleaner it is now. People said that the "Staffing levels were much improved" and they didn't ever worry that their relative was not cared for and never felt uncomfortable. They never saw people distressed and not attended to. They identified however that "There is a better atmosphere now." They said were satisfied with the care provided for their relative.

Other evidence
At our previous inspection visit to Partridge Court Nursing Home in July 2011 we found that people were not always receiving the care and support they needed to keep them safe and well.

This visit, carried out on 14 September 2011, was to assess improvements that the provider had made following our visit on 14 July 2011 and the service of a warning notice about the provision of safe and appropriate personalised care.

We did this by looking at the care records held by the home, observing care practice throughout the home and by talking with people using the service and their relatives.

We found that care records had been reviewed to ensure risks to people's health and well being were identified and planned for. The care records provided staff with the information they needed to support people appropriately and safely. Some areas of the records would be improved by more detailed information. The Rushcliffe senior management representative in charge of the home on the day of our visit acknowledged the need for more detail and confirmed this was work in progress.

Each care plan we saw had a photograph of the person at the front. In many cases the photograph did not represent the person in a respectful manner, in many of the images we saw the person was not well groomed and appeared unkempt. This did not accurately reflect how people appeared on the day of our visit. This was discussed with the Rushcliffe senior manager on duty in the home on this day. They agreed that this was not dignified and undertook to have up to date photographs taken of people.

Our observations throughout the home were of a calm and relaxed environment. People look well presented, their clothes were clean and matching, hair and nails were clean and tidy.

Throughout the home we saw that drinks were available within people's reach where appropriate. In one unit we saw that staff sat with people and encourage them to drink, staff noticed when drinks were finished and replenished them. We noted people were not offered a choice of tea or coffee, they were just given tea. We spoke with the member of staff giving out the drinks who confirmed that nobody had been offered coffee and confirmed there was no coffee on the trolley. This practice does not allow people to make meaningful choices.

We saw that people were given plates of biscuits with their mid morning drink. These were well received by people during our observations. This practice demonstrates treating people with respect and dignity and also taking the opportunity to support additional calorie intake, often so important in units for people with dementia. We noted a staff member sat with a person using the service and supporting them to eat biscuits by helping them to dip the biscuit in their tea.

We noted that when staff had the need to leave a communal area for any reason they confirmed with other staff members that they would remain to supervise people. This has helped to ensure that people are not left in communal areas unattended, at risk of falls and isolation.

We saw medication being administered in a gentle, unrushed and sensitive manner, staff sat with people calmly whilst they took their medication.

We saw some examples of good care practice during our visit. One example being where a person using the service was escorted into the communal lounge area by two care staff members. A nurse on duty noted the person had not had a shave. They addressed this by gently stroking the person's face and talking with them about why they had not had a shave today. The nurse also checked with the care staff who were able to give the reason why this person had not had a shave.

We saw that one person was becoming anxious when another person had taken their armchair. Staff smoothly calmed the situation down by using distraction techniques to create a diversion which diffused the situation.

We saw a staff member gently escorting a person who was becoming agitated out into the corridor. They then discretely explained to the person that their clothing was soiled and they would be more comfortable with clean clothes. The person was then content to accompany staff to have support to change their clothes. This showed staff promoting people's dignity.

These were just some of the examples of person centred care that we observed the staff team providing during the course of our inspection visit.

Our judgement
The provider is compliant with this outcome. People receive safe and appropriate care according to their assessed needs. Improvements are needed however, to ensure that care plans and care practice continue to be monitored to ensure people consistently benefit from good care.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
On this visit we did not speak to anyone who uses the service about the way that the home manages their medicines.

Other evidence
Ours visit on 09 September 2011 was to assess improvements that the provider had made following our visit on 14 July 2011 and the service of a warning notice about the safe use, management and recording of medicines. We received an action plan which detailed the actions taken by the owner to ensure compliance with the warning notice.

Medicines were stored securely for the protection of people who use the service. The temperatures of the areas where medicines were stored were monitored and recorded regularly and were within acceptable limits. In all but one of the areas visited, staff told use that the room temperatures were taken from the wall thermometers in place, not from the air conditioning controller as found on our previous visit. In the action plan, the owner told us that the "controlled drug cupboards are in the process of being reattached to the walls according to the regulations". None of the cupboards inspected on our visit had been fixed in the way required by the regulations.

Procedures were in place to record when medicines were received into the home, when they were given to people and when they were disposed of. In general, these were improved since our last visit and had very few discrepancies. This accounts for medicines in use and demonstrates that people receive their medicines as prescribed.

In the action plan, the owner told us "the medication is now cross checked on a regular basis and an audit should be completed weekly". We found evidence to support that this was being done in most areas, but in one area the weekly check had not been carried out. This was confirmed by a member of staff. Where such checks had been carried out and omissions had been found, there was not always a record made of what actions were taken as a result of the discovery of the omission.

Our judgement
People who use the service can be assured that their medicines are stored and handled safely and that they are given them as prescribed. However, improvements are needed to ensure any identified discrepancies in the medication records are resolved promptly and a record made of this.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
Relatives with whom we spoke made positive comments about general improvements in the service provided for the people living in Partridge Court Nursing Home. One person said "We have really noticed so much improvement in the cleanliness, staffing numbers and the general care."

Other evidence
When we visited the service in July 2011 we found that management systems had not been effective to ensure a good quality service. This visit, carried out on14 September 2011, was to assess improvements that the provider had made following our visit on 14 July 2011 and the service of a warning notice about assessing and monitoring the quality of the service provision.

At our inspection visit of 14 September 2011 we found significant improvements had been made. Systems were now in place to assess the safety of the home and the quality of care was being monitored. The manager and provider must now ensure that the good systems are sustained and further developed.

At our visit of July 2011 we were concerned that the views and opinions of people living there and their relatives had not been asked for. At our inspection visit of 14 September 2011 we looked at the minutes of recent meetings held with people living in the home and their relatives. We read that discussions had taken place about food, laundry arrangements, activities and a discussion about what had been happening with the management of the home. These meetings confirmed that the views and opinions

of the people living there were sought so they can contribute towards the improvement and development of the home.

Relatives told us there had been meetings to address specific areas of the service delivery. They told us of a meeting that was due to take part later on this day to discuss the activity provision within the home.

Visitors to the home shared positive views around improvements that were gradually taking effect in Partridge Court Nursing Home. These included areas such as food, laundry, the overall cleanliness of the home and staffing levels.

We saw that a system was in place to monitor incident and accidents. This should ensure that action will be taken by the manager to pick up on any trends in the home and minimise the risks to people's safety.

Quality audit systems had recently been implemented by members of Rushcliffe senior management team who have been supporting the service over recent weeks. This should ensure that audits take place and areas of concern are quickly identified and action taken. This included general health and safety checks so a safe environment is provided for people to live in. We saw that care plans were being audited to ensure that staff had clear information to follow so they can provide the care and support that people need to keep them safe and in the manner they want.

Risk assessments had improved so that staff had the necessary information they needed to keep people safe. We noted that some risk assessments would benefit from more detail. The Rushcliffe senior manager present during the inspection acknowledged that this was work in progress.

We were told that regular staff meetings now take place. We saw the minutes of the last meeting and these indicated that information about the running of the home is passed on to staff and they have the opportunity to discuss any issues.

Our judgement
The provider is compliant with this outcome. The quality of service is now being audited to ensure people using the service receive safe and appropriate care and support to meet their needs. Improvements are needed to ensure the audit systems are sustained.

Action
we have asked the provider to take

Improvement actions

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

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	Why we have concerns: The provider is compliant with this outcome. People receive safe and appropriate care according to their assessed needs. Improvements are needed however to ensure that care plans and care practice continues to be monitored to ensure people benefit from consistent good care.	
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	Why we have concerns: People who use the service can be assured that their medicines are stored and handled safely and that they are given them as prescribed. However, improvements are need to ensure any identified discrepancies in the medication records are resolved promptly and a record made of this.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	Why we have concerns: The provider is compliant with this outcome. The quality of service is now being audited to ensure people using the service receive safe and appropriate care and support to meet their needs. Improvements are needed to ensure the audit systems are sustained.	

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.

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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