Review of compliance

Careplex Tudor Rose Rest Home	
Region:	West Midlands
Location address:	671 Chester Road Erdington Birmingham West Midlands B23 5TH
Type of service:	Care home service without nursing
Date of Publication:	March 2012
Overview of the service:	Tudor Rose Rest Home is registered to provide accommodation and personal care for up to 27 older people.

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

Our current overall judgement

Tudor Rose Rest Home was not meeting one or more essential standards. Improvements are needed.

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

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 9 February 2012, observed how people were being cared for, looked at records of people who use services, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with nine people who live in the home. We observed the care that people received. People were positive about their experiences of living at the home and the care they received. Three people told us that they are "Very happy here."

People told us that if they had any concerns they would speak to a member of staff. Some people said they would speak to the manager calling her by name. People felt confident that they would be listened to. One person told us that "I don't have to put my complaint in writing. If I have a problem the staff sort it out straight away."

When we looked around the home we saw that most bedrooms were clean and suitably furnished. Some people with the support of their family had personalised their bedrooms and had brought in small items of their own furniture.

We saw that care staff treated each person as an individual. There was a good atmosphere in the home. There was good interaction and a positive relationship between people living in the home and staff working in the home. People who had good mobility were seen to move around the home freely.

What we found about the standards we reviewed and how well Tudor Rose Rest Home was meeting them

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

People using the service are treated respectfully and enabled to make choices about their daily lives and how they live in the home.

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

The care plan documentation does not provide care staff with clear and detailed guidance on how people's care needs should be met.

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

People using the service are protected from abuse, or the risk of abuse.

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

There is not sufficient care staff working in the home at different times of the day and night.

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

People's health and safety are promoted because systems are being implemented to monitor the quality of the service provided.

Actions we have asked the service to take

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

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

Other information

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
Some people living in the home were unable to engage in meaningful conversation due to their episodes of confusion and or complex needs. We spoke with nine people who told us they were happy living in the home. People told us that care staff spoke to them nicely and were never rude. Comments we received include:

"They (Care staff) are always kind they ask me what I want."
"I get my things ready in the morning and then they (care staff) help me to have a wash."
"I can do a lot for myself I call someone if I need them."

We received information that people looked despondent, and neglected. Their observations were that people looked "unkempt with stained clothing." On the day of our visit we observed that people looked clean, appropriately and well dressed for the time of year.

We observed care staff addressing people by their preferred names. Care staff were seen to engage in conversations with people living in the home. Personal care was carried out in private. We saw that care staff were discreet when asking people about their care needs. Two people told us that care staff asked them how they wanted to be

helped.

We observed staff sitting with people during a meal time. Care staff prompted some people to support them to eat their meal independently and gave sensitive assistance to people who needed to be fed.
We observed that care staff encouraged people to make decisions about how they spent their time. We saw that people preferred to stay in the home. People enjoyed watching the television, listening to music, staying quietly in their bedroom or socialising with other residents and care staff. There were five people sitting in the main lounge enjoying a film on the television. People told us that they enjoyed watching the soaps and quizzes on the TV. One person told us they enjoyed going to the local shops.

Care staff told us that some people do not like to go out of the home. Care staff encourage and support people to go on short walks. This helps to encourage people to mix with other people and maintain access to the community in a supportive way.

Other evidence
The manager told us they carry out an assessment and meet with people before they come to live at the home. We saw that care files contained details of the outcome of each person's pre-admission assessment. Care Staff were able to tell us about the needs of people and what they could do for themselves and what they needed support with.

When we looked around the home we saw that people had been able to personalise their rooms and bring in small items of their own furniture if they wished. Some bedrooms were sparse and did not look homely and comfortable.

A further concern raised in the information we received told us that one of the bedrooms used as a shared bedroom was very small. This provided the two people who lived in the bedrooms with very little personal space. There were five shared bedrooms in the home. We observed that these were not presented so as to give two clearly defined to give sufficient individual and personal spaces to the people whose bedrooms they were.

The manager told us about the plans to refurbish the bedrooms and that reviewing shared bedrooms are included in the refurbishment plans. She showed us two bedrooms that had been refurbished. Both bedrooms were well presented, looked comfortable and had been re-decorated with the support of the resident whose bedroom it was.

Our judgement
People using the service are treated respectfully and enabled to make choices about their daily lives and how they live in the home.

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

There are moderate concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spent time in one of the lounges observing people's experience. We looked at their mood, how they spent their time and how staff interacted with them. People spoken with told us they were happy with the care they received. Their comments included:

"It's nice here, there is no place like your own house, but I can't look after myself."
"The staff let me do small jobs."
"People are good company."
"I feel safe here. I can't think of anything they could do better."
"The staff are kind and friendly and they do their best."
"The food is nice."

We observed several interventions when staff helped people to move safely around the home. Staff explained what they were doing and gave sensitive assistance at a pace appropriate for each person. We saw that people were enabled to walk around the home unsupported. Work had started on sign posting in the home, for example toilet doors had been painted in a bold primary colour. There was a sign on the door showing a picture of a toilet. This helped people to immediately recognise where toilets were located in the home.

The environment was clean. It was a cold day and we found that all the areas of the home was not warm. Some of the residents sitting in the lounge said they were cold. Care staff put additional heaters in the lounge, which helped to warm the bedroom up. When the door to the lounge was shut the room retained the heat. It was difficult to

keep the door shut as residents wondered in and out of the lounge all the time. We were told that if people get cold in their bedrooms especially at night additional electrical heaters can be used. The heaters have been tested to make sure they are safe to be used.

People told us that they were very happy with the care at the home. They said that they felt everyone received plenty to drink, that the food was good with a varied menu. "Nobody is ever rushed to finish their meal. Staff are so patient."

Birmingham Social services shared information with us about a complaint they received. The complainant expressed their concerns about there not being any food in the home and their relative was hungry. In their letter the complainant had said that they had to go out and buy some food.

The cook told us about the food and meals available in the home. The cook told us about the food ordered and who from. The pantry was well stocked and there was fresh food such as bread and vegetables available in the home. The lunch for the day was shepherd pie and vegetables. The food was well cooked, well presented and people enjoyed were seen to enjoy their meal.

We observed that care staff transported meals uncovered and without a tray to people in their bedrooms. This could expose meals to cross contamination and getting cold. People told us and were seen to enjoy their meals. People told us that they had plenty to eat. We saw that snacks, sweets and drinks were given out during our visit. We saw copies of the menus; these showed varied meals were provided based on people's preferences.

Other evidence
We looked at two people's care files in depth and two care files briefly. This was so that we could see how staff assessed and planned to meet the care needs of people living in the home. We found that care file records relating to care, assessment of needs and plans of care to be incomplete.

We saw that care staff had completed an initial assessment of people's needs and had carried out monthly reviews of people's care. We saw that if people were unwell they were referred to professionals for advice. One person who they suspected had a urine infection was referred to their GP for tests. The care staff then followed this through so that they knew what the result was and if any treatment was needed.

We found that care staff had not used the information available to them for example assessments to develop appropriate care plans. Care plans and risk assessments lacked the detail in both cases on what support care staff should provide to help each person to meet their assessed needs. Where an element of risk was noted this was assessed but there was not a detailed care plan to show what support should be given to enable the person to maintain independence wherever possible.

For example a person diagnosed with mental health problems did not have a detailed care plan to provide care staff with clear instructions on how to support this person if they showed behaviour problems. One of the residents was a diabetic. There was very little information in their care plan to provide care staff and the cook with information on their diet. For example foods they can and cannot eat.

Our observations and discussions with people during our visit indicated that care staff were aware of the level of care and support that was needed for each person. What was written in care records did not give an accurate reflection of the person's needs. We spoke with three care staff and the home manager who demonstrated they had a clear understanding of the care and support people need.

We observed people being supported during lunchtime. Individuals who required support with eating their food were provided with assistance in a sensitive and dignified way. People were offered choices of what they wanted to eat and drink. Care records showed that people have their weight measured which enables staff to monitor weight loss or gain.

We examined the medication records for both people. The medication records were complete and had been signed to show that people had been given their medication as prescribed. Medication charts showed the name of the drug, how much should be given, how the medicines should be given and when. Medicines were stored within a locked cupboard.

Our judgement
The care plan documentation does not provide care staff with clear and detailed guidance on how people's care needs should be met.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
We asked people about their life in the home and if they felt they were treated as they would expect and with respect. People told us they felt safe living at Tudor Rose Rest Home. People said that they would feel confident raising any concerns they may have. All of the people we spoke with said the manager and care staff treated them well. We were told by one person, "Everyone is kind." "We can have a laugh and joke with the staff." People told us they have not seen anything that worried them.

Care staff spoken with told us that they would raise any concerns they had about risks to the people living there or poor practice, with the manager. They said that if these were raised the manager or deputy would act on it.

Other evidence
We talked with some members of care staff about safeguarding. They were able to tell us what they would do if they saw or suspected abuse. They knew who to contact and how to do this to ensure people's safety. The home had policies in place that offer additional guidance to staff about dealing with safeguarding and abuse. Care staff were aware of the details of the local authority safeguarding team. The manager was aware of her role and responsibilities in responding to suspicion and allegation of abuse.

We looked at the training records the home holds for staff and we could see that all staff had taken part in safeguarding vulnerable adults training. We saw that training in the Mental Capacity Act and the Deprivation of Liberty. This should mean that staff

have the knowledge to act in people's best interests when people may not be able to make decisions for themselves.

We discussed the recruitment process with a recently appointed member of staff to confirm that all necessary security checks had been undertaken before they were employed. We looked at the staff files for two recently appointed care staff these showed that an enhanced ''Criminal Record Bureau'' disclosure and two references were in place before they commenced working in the home. Robust recruitment and employment procedures help to ensure that people are safe and that staff are fit to do their job.

Our judgement
People using the service are protected from abuse, or the risk of abuse.

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 minor concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We spent time in two of the home's communal lounges observing people's experience. We looked at their mood, how they spent their time and how staff interacted with them. The home had a calm, friendly and relaxed environment.

We saw that people were left unattended in the lounge areas for varying lengths of times. There was a staff presence in corridors and communal areas. We asked people if they felt there were enough staff in the home to attend to their needs. Some of the comments people made included:

"The staff are good to me they all do what you want them to."

People looked comfortable in approaching staff with their requests and care staff responded quickly. Staff gave sensitive explanations when they were helping people, speaking to them at a pace and level appropriate to their individual needs.

Other evidence
A recently employed member of care staff told us that they had an induction into the home. Their training included all mandatory training, such as, moving and handling, food hygiene and health and safety.
The manager told us that she is not supernumerary. We saw that there are catering, cleaning, maintenance and administrative staff employed in the home. Laundry staff are not employed in the home which means care staff spend undue lengths of time undertaking non-caring tasks. The time to undertake this task is not identified

separately on the staff rota.

It had been identified that people's care needs had changed and more people are dependent on the support of care staff. Based on the increase in people's dependency there was no information to confirm that the number of care staff on duty particularly at night. Consideration had not been given to whether care staff should undertake laundry duty which takes them away from caring for people living in the home..

We discussed the duty rota with the home manager as it did not clearly demonstrate what times the staff are actually working in the home. The duty rota showed the number of hours worked by each member of staff in the morning, afternoon and night but not the start and finish time of each shift. The manager and deputy manager said this would be looked at.

Our judgement
There is not sufficient care staff working in the home at different times of the day and night.

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
People told us they were asked about how improvements could be made to the service. People commented; "I am happy here, it's lovely and comfortable." The deputy manager told us that meeting are held for residents and staff. People are supported to express their views and have say on for example how their bedrooms are decorated and what food is provided.

Other audits that are carried out included an audit of medicines in the home. We looked at the latest audit carried out by the deputy manager. The document did not contain sufficient detail to show what information had been looked, what the outcome was and if any action was needed. We discussed these issues with the deputy manager.

Other evidence
The provider has employed the services of a Consultant to support him in improving the services delivered in the home. We spoke with the provider and the consultant on the day of our visit. We were told that internal audits had taken place. The outcome of these had been used to start to make changes in the way the home was run. One aspect of the assessment has been to make sure that the home is accessible to people with confusion or have dementia. As a result changes had been made to the environment. For example corridors in the home have been painted different colours. This has created zones that will help people to recognise which area of the home they are in.

Our judgement
People's health and safety are promoted because systems are being implemented to monitor the quality of the service provided.

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 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	Why we have concerns: There is not sufficient care staff working in the home at different times of the day and night.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 14 days of the date that the final review of compliance report is sent to them.

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

Compliance actions

The table below shows the essential standards of quality and safety that **are not being met**. Action must be taken to achieve compliance.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: The care plan documentation does not provide care staff with clear and detailed guidance on how people's care needs should be met.	

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 the date that the final review of compliance report is sent to them.

Where a provider has already sent us a report about any of the above compliance actions, they do not need to include them in any new report sent to us after this review of compliance.

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

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

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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