Review of compliance

Sure Health Care Limited Derwent House Residential Home	
Region:	Yorkshire & Humberside
Location address:	Riverside Care Complex, Hull Road Kexby York North Yorkshire YO41 5LD
Type of service:	Care home service with nursing
Date of Publication:	October 2012
Overview of the service:	Derwent House Residential Home provides personal care and support for 32 older people, some of whom may be assessed as needing nursing care. There is currently no registered manager in post. Information about the service and how it operates can be obtained by contacting the home.

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

Our current overall judgement

Derwent House Residential Home was meeting all the essential standards of quality and safety inspected.

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 Derwent House Residential Home had taken action in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 16 - Assessing and monitoring the quality of service provision
Outcome 17 - Complaints
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 7 September 2012, looked at records of people who use services and talked to staff.

What people told us

We did not gain feedback from people living at the home during this visit as the inspection was a follow up visit which focused on record-keeping. When we visited the service in April 2012, all the people we spoke with, who lived there, told us they were happy at Derwent House. They told us their care needs were being well met.

What we found about the standards we reviewed and how well Derwent House Residential Home was meeting them

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

People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this 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

The provider had an effective system in place to identify, assess and manage the risks to the health, safety and welfare of people using the service and others.

The provider was meeting this standard.

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

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

The provider was meeting this standard.

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

Records were kept securely and could be located promptly when needed.

The provider was meeting this standard.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

A moderate impact means that people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

A major impact means that people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

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

What we found

Our judgement

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

Our findings

What people who use the service experienced and told us
We did not gain feedback from people living at the home during this visit as the inspection was a follow up visit which focused on record-keeping.

Other evidence
In April 2012 we carried out a review of the service. We judged, at that time, that improvements were needed to the way risk to people's health and welfare was being managed. We found risk assessments were not individualised. We also found the service was not routinely re-looking at people's care needs following incidents like an individual falling. This was needed so that the service could determine whether anything more needed to be done to minimise the risk of the person falling again. At this visit we looked at whether the provider had addressed the areas of non-compliance we had previously identified.

On this visit we found that people's care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. The service had reviewed the majority of people's care records, and associated risk assessments. We saw that they provided detailed information, describing what the service was doing to minimise the risk of people coming to harm. Most of these though were filed away, waiting to be 'typed up'. This meant they were not readily accessible for staff to refer to.

We saw however that the service had requested specialist advice for one individual, who had had several falls, and then changes had been carried out in line with the advice received.

We also noted that the service hadn't completed this piece of work according to risk. For example we saw one person had had a number of falls, but their care records and risk assessments had not been prioritised as needing to be more urgently available for care staff to refer to. The general manager contacted us shortly after our visit to say that all the care records and risk assessments had been completed and were now available for care staff to refer to, to check they were providing the right care and support.

The provider may find it useful to note that risk should be managed according to priority and should be reviewed in line with people's individual care needs. This would help to ensure the service was doing all it could to keep people safe from harm.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

The provider was meeting this standard.

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
We did not gain feedback from people living at the home during this visit as the inspection was a follow up visit which focused on record-keeping.

Other evidence
In April 2012 we carried out a review of the service. We judged, at that time, that improvements were needed to the way the quality of the service was being checked, month-on-month. This was because we found that all the records relating to how the service was being monitored were missing. At this visit we looked at whether the provider had addressed this area of non-compliance we had previously identified.

The provider took account of complaints and comments to improve the service. We found the manager had now developed some quality audit tools. These were to assess whether or not the service was working well, and in line with what people living at the home wanted. The general manager told us that when she started working for the organisation she found many policies and procedures at the home were missing. These were then re-written, to ensure staff worked in a consistent way.

We saw that although people's care records and risk assessments had mostly been completed, the service had not looked at which people were most at risk. The provider may find it useful to note that managing risk is an ever-changing process. Quality checking systems help to identify risk and maintaining these records would better demonstrate that a risk was well managed and was being reviewed appropriately.

We found that some checks on the way the service was operating were now being completed. For example we found that people had been asked for their views about recent menu changes at the service. The provider needed to let people know what changes were to be made as a result of these comments though, as this would help to show that people's comments had been listened to.

We found these quality checking processes needed to be further developed and then sustained. This would help to ensure that the service was running well, and changes were consistently being made in line with suggestions and comments made by the people living there.

Our judgement
The provider had an effective system in place to identify, assess and manage the risks to the health, safety and welfare of people using the service and others.

The provider was meeting this standard.

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

The provider is compliant with Outcome 17: Complaints

Our findings

What people who use the service experienced and told us
We did not gain feedback from people living at the home during this visit as the inspection was a follow up visit which focused on record-keeping.

Other evidence
In April 2012 we carried out a review of the service. We judged, at that time, that improvements were needed to the way complaints were being managed by the service. This was because we found that policies and records relating to complaints management were missing. At this visit we looked at whether the provider had addressed the area of non-compliance we had previously identified.

People were made aware of the complaints system. This was in a format that met their needs. We found that the provider had put a complaints policy in place. This was displayed for people to read, and was also referred to in the Service User guide, which was available for people to read. We also saw information about local advocacy services displayed in the home, as well as a reminder to people about what they should do if they had any concerns about the service.

We saw the service had received one complaint since our last visit, though this related to an incident earlier this year, before the current manager was in post. We saw that this had been well managed, though the documentation to evidence this could be improved, by being more detailed and recording that the complainant was happy with how their concern was managed.

Our judgement
There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

The provider was meeting this standard.

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

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not gain feedback from people living at the home during this visit as the inspection was a follow up visit which focused on record-keeping.

Other evidence
In April 2012 we carried out a review of the service. We judged, at that time, that improvements were needed to the way care records were being stored. Some people's confidential records were kept on the first floor landing, where they could easily be accessed both by people living there and by visitors to the home. At this visit we looked at whether the provider had addressed the area of non-compliance we had previously identified.

Records were kept securely and could be located promptly when needed. We found that people's records were now kept in an office, which could be locked when not occupied. This meant unauthorised people could not readily access these records. We saw that care staff were using the office when necessary, to read these records. This meant that although this was the manager's office, the care staff were not excluded from entering and checking the care records stored there.

The provider may find it useful to note whether confidential meetings were also held in that office, as these may prevent care staff from being able to look at people's care plans in a timely way.

Our judgement
Records were kept securely and could be located promptly when needed.

The provider was meeting this standard.

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. We ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
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