Inspection Report

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

Mill Green

Newbold Road, Rugby, CV21 1EL

Tel: 01926864242

Date of Inspection: 25 April 2013

Date of Publication: May 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	WCS Care Group Ltd
Registered Manager	Ms. Lynn Mary Randall
Overview of the service	The service is registered to provide accommodation and personal care for up to 15 younger adults with a physical disability.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 April 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with staff, reviewed information sent to us by commissioners of services and reviewed information sent to us by local groups of people in the community or voluntary sector.

What people told us and what we found

Many of the people who lived at the home were not able to talk about their care and support because of their complex needs. We observed that care staff talked to people reassuringly while they assisted them. Care staff explained that they monitored people's needs by watching their facial expressions and body language, if they were not able to communicate verbally.

In the three care plans we looked at, we found people or their relatives had agreed how people should be cared for and supported. The care plans considered people's dependencies, abilities and preferences for care. People were involved in discussions about their ongoing care and support. When people declined to be supported with particular aspects of their care, this was recorded.

The provider's system for managing medicines included individual medicine cabinets for each person, training for staff and regular checks of medicines and of staff's competence. Staff recorded when medicines were administered or declined.

The provider checked that staff were suitable to work with vulnerable people before they started working at the service. Care staff we spoke with told us that their induction process included reading care plans, shadowing experienced staff and being trained to care and support people safely.

We found that people's and staff records were kept securely and updated regularly. The provider's policy for record keeping specified how long records should be kept before they were destroyed.

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

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

In the three care plans we looked at, we saw that people or their relatives had signed their consent to the care and support described in their care plans. When people had not wanted support for particular elements of care, it was clearly recorded. For example, one care plan was marked, "Declined to be checked hourly at night. They will buzz if they want staff" and another was marked, "May need assistance and will ask for it."

We found that when people's care plans were reviewed and changed, people were asked to sign again to show they agreed with the changes. People's care plans listed the activities they did and did not want to take part in. For example, one care plan we looked at was marked, "Memory album not wanted." One care plan we looked at included photos of how the person liked their personal possessions to be arranged, so that staff would keep their room that way.

Care staff we spoke with explained how they asked people for their consent at the time of giving care. One member of care staff told us, "C can say 'no' and with D, I tell them what I am going to do and describe the routine as I do it. They will make noises if they don't want to do something." Another member of staff told us they understood another person's needs and preferences by observing their response. We found the person's care plan included detailed instructions for staff to support this person.

When the senior care staff showed us how they administered medicines, we heard them ask people whether they had any pain, and whether they wanted pain relief. The senior care staff only gave pain relief medicine to those people that wanted it. This meant that before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We found that people's abilities and dependencies had been assessed when they moved into the home. A risk assessment had been completed and their care plan was written, dependent on the level of risk identified. For example, for one person who was not able to mobilise independently, two staff were required to assist with all transfers. The plan included use of specialist equipment, such as a pressure relieving cushion and mattress. For a person who was not able to communicate verbally, their care plan included instructions for, "Staff to check the person every half hour at night" and for staff to "Recognise their body posture and facial expression." This meant care and support were planned and delivered in a way that ensured people's safety and welfare.

We looked at the care plans for three people who lived at the home. We found they were detailed and easy to read. Instructions for staff were clear and people's preferences for male or female carers were recorded. People's care plans took account of their needs and preferences for personal care, nutrition, activities and sleeping habits, for example.

Care staff we spoke with told us they understood people's needs well before they started working with them, because they were explained in the care plans. People we spoke with were happy with the care and support they received. They told us that staff supported them to manage their everyday needs. This meant that people's needs were assessed and care and support were planned and delivered in line with their individual care plan.

During the staff shift handover, we heard a detailed, verbal exchange of information about how each person had been during the morning. Staff coming onto the afternoon shift were given precise information about actions that needed to be taken. Staff kept daily, written records about people's moods, behaviour and appetite, and when other health professionals visited them, for example.

The care manager reviewed people's care plans every month. They reviewed the daily records, people's risk assessments, accidents and incidents, and discussed people's needs at regular team meetings. Care staff we spoke with told us they knew if a person's care plan was changed, because they would be told and the handover book was marked, 'See care plan for X." All staff had to sign in and out of the handover book, which meant they were kept informed of any changes.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

The provider had a medication policy and trained the staff to handle medicines safely. Training included information about the benefits and side effects of medicines, how to record and what staff should do if a person declined to take their medicines. Only staff who had been trained were allowed to administer medicines and the manager regularly audited the medication records. This meant that medicines were administered safely.

A senior are showed us how they managed people's prescribed medicines. Everyone who lived at the home had their own medicine cabinet in their room, which was kept locked. Staff recorded the temperature of the cabinets, by using a thermometer, which was left in the cabinet. The senior on duty kept the keys for the cabinets. Controlled drugs were kept in a separate locked cupboard, with a book that was signed by two staff, in accordance with the regulations. This meant that medicines were kept safely.

We saw that staff recorded each time they administered medicines and the records were kept in people's own rooms. Staff used a pre-agreed code so that the next staff on duty knew if anyone declined to take their medicine. The three records we looked at were up to date on the day of our visit. We saw staff kept records of creams they applied if people had sore skin. The medicine sheets included a picture of a body, which was marked to show exactly where creams should be applied. This meant that there were appropriate arrangements in place in relation to the recording of medicine.

Some people had medicines prescribed for pain, which were only given if people needed them. We heard the senior carer asked people whether they had any pain and if so, which pain relief they preferred. The senior counted the number of tablets in the packet and checked that the number matched the amount recorded by the previous staff, before administering pain relief. The senior recorded whether pain relief was administered or not required.

Care staff we spoke with told us that if a person was not able to communicate verbally they would check their facial expression and body language to assess whether they might be in pain. One member of care staff told us, "If A calls out, they may be in pain and I let the senior know." The senior care staff we spoke with told us the signs they would look for that a person might be pain, if they were unable to communicate verbally. They said, the

person might, be "Flushed, have a high temperature, or be vocal, or unsettled." This meant that medicines were given to people appropriately.

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

In the three staff files we looked at, we saw that the manger checked that staff were suitable to work with vulnerable people before they started working at the service. The manager said that they regularly observed staff in practice. If they had any concerns, through watching staff's behaviour, or hearing stories, for example, they would re-run the checks with external agencies. This meant that appropriate checks were undertaken before staff began work.

Care staff we spoke with told us they knew what their job entailed because they were given a job description with their application pack. One member of care staff said, "I had a job description for 'enablers'." We saw that the job descriptions were kept in a file in the manager's office. Tis meant staff could check their understanding of their role, and were aware of how they could progress their career.

Care staff we spoke with told us they had an induction period when they first started working at the home. One member of care staff told us, "I started by reading care plans and getting to know people and learnt about the level of their disability." Another member of care staff said, "I shadowed to begin with. Y talked me through it and she always checked to make sure I was ok."

One member of care staff told us, "My induction included training in manual handling, fire safety and health and safety." Another member of care staff said, "The trainer went in the hoist when we had the training. It would be useful if staff went in it so they see it from the person's point of view." We saw the manager kept copies of training certificates in staff's files and an electronic record of training delivered and planned.

Care staff told us they were continually assessed in their role. One member of care staff said, "X watches us work and does observations, especially for newer staff." The manager kept a record of their observations of staff's practice for discussion at their regular one to one meetings. One member of care staff said, "I had one to one with X. They are a fantastic manager. They asked if I was enjoying it. I am really enjoying it. Working with people is rewarding."

People we spoke with told us the staff were nice. Staff were observant and anticipated people's needs, while talking with them about their interests. We heard staff explained the

process to a person with limited mobility while they assisted them to move around the home. People were supported by suitably qualified, skilled and experienced staff.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

Reasons for our judgement

The three care plans we looked at were detailed and described how staff should support and care for people. Care staff we spoke with told us that they had time during their induction to read people's care plans before they started working with them. Care staff told us they knew who preferred male or female carers, for example, because it was written down. We saw that staff recorded information about people's physical and mental well being. Visits and advice given by other health professionals was recorded. This meant that people's personal records including medical records were accurate and fit for purpose.

People's records were kept in the care manager's office, where only staff could access them. Staff updated people's records at the end of their shift, so the information was kept up to date. This meant that people's personal records were kept securely and could be located promptly when needed.

Staff records were kept in locked filing cabinets in the manager's office. The three staff files we looked at included a record of staff's recruitment, suitability checks, training and supervision. We saw information in the files matched the information held on the central electronic records. The manager had printed out a matrix of staff's training dates so staff knew when they needed to undertake refresher training. This meant that staff records were accurate and fit for purpose.

We found that the provider had a record keeping policy that included how long records should be kept for. The list of records to be archived included confidential care records, employment and equipment maintenance records, for example. On the day of our visit, the manager was in the process of checking whether records in one filing cabinet should be kept or destroyed. This meant that records were kept for the appropriate period of time and then destroyed securely.

About CQC inspections

We are the regulator of health and social care in England.

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

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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