Review of compliance

Mr T & Mrs S Kandiah Remyck House	
Region:	South East
Location address:	5 Eggars Hill Aldershot Hampshire GU11 3NQ
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Remyck House is a privately owned care home registered to provide residential care for up to 29 older persons, many of whom may have dementia. The home is located in the North Hampshire town of Aldershot with easy access to town centre shops and other communal facilities. The towns of Farnborough and Fleet are within 10

	minutes drive, Guildford 20 minutes drive, as is the M3 motorway giving easy access to London.

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

Our current overall judgement

Remyck House 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 to check whether Remyck House had made improvements in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 09 - Management of medicines

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 5 September 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

Not all the people that used the service at Remyck House were able to tell us about their experiences. To help us to understand the experiences people had, during our visit, we used our SOFI (Short Observational Framework for Inspection) tool. We made use of this several times during the visit.

We talked to two people about their medicines and both expressed that they were happy with the home handling their medicines for them and that this worked well for them.

What we found about the standards we reviewed and how well Remyck House was meeting them

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

Remyck House has addressed the concerns we had identified previously. People who use this service are given safe and appropriate care. Their care needs have been identified, but the provider must ensure that they are reviewed regularly and maintained to reflect the actual care needs of the individual. Activities are planned for residents but more enphasis is needed to ensure each resident is able to participate if they want to.

On the basis of the evidence provided and the views of the people using the service we found the service to be compliant with this outcome.

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

Whilst there are some improvements in the management of medicines at Remyck House, the home still does not fully protect people against the risks associated with the unsafe use and management of medication as it does not have detailed care plans for medicines prescribed to be taken 'as required'.

Overall, Remyck House was not meeting this essential standard.

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 05: Food and drink should meet people's individual dietary needs
- Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
- Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

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
Not all the people that used the service at Remyck House were able to tell us about their
experiences. To help us to understand the experiences people had, we made use of our Short Observational Framework for Inspection (SOFI) tool during the visit.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome after we issued a warning notice for this outcome. The action plan stated that all care staff were more involved with residents' activities. They advised that care plans were developed with the resident and their family involved and that care plans included residents' wishes regarding times to get up and go to bed and likes and dislikes regarding foods.

The Hampshire Multi-Agency Safeguarding team had held review meetings before our latest visit. As a result, the home had received input from the
Hampshire County Council's Partnership in Care Training (PaCT) regarding training in care planning.

When we visited, staff told us they had received training in writing care plans and had enjoyed developing them.

During our visit, we looked at several care plans. All had been developed recently and included the involvement of the resident and/or their family as appropriate. This showed

that the individual agreed the content. Each care plan had been written in the first person tense and were centred on the person's needs. Staff told us that the care plans were more detailed and included specific information of how each resident wanted their care to be provided, such as routines, likes and dislikes and interests.

Staff told us the home operated a key-worker system. This is where a resident has a member of staff who has extra responsibilities for ensuring the overall welfare of specific residents, such as updating care plans and ensuring they have enough toiletries.

During our visit, we made use of our Short Observational Framework for Inspection (SOFI) tool. The SOFI tool allowed us to spend time watching what was going on at the home and helped us to record how people spent their time, the type of support they got and whether they had positive experiences. We observed that staff spoke with residents in a calm, friendly and encouraging way.

During our visit, we saw that residents were moving freely around the home. Staff provided support to residents that wanted to move to a different area of the home to have their lunch or join in the activities.

The manager told us that one activity co-ordinator was in post. They devised and organised a range of activities. A weekly activity timetable was produced and was available for people to read.

During our visit, we observed staff interacting with one resident in particular, who was able to participate in activities that the staff suggested, for example, drawing a picture and laying the tables in the dining room for lunch. However, we did not see staff interact with residents who were sat quietly in the lounge area and nor did we see them offer similar activities to any of the other residents in the lounge. One member of staff was sat next to a resident as they looked through the pages of a book. The resident mentioned a few times that they liked drawing but the member of staff did not respond, or talk to the resident about what they were looking at.

Our judgement
Remyck House has addressed the concerns we had identified previously. People who use this service are given safe and appropriate care. Their care needs have been identified, but the provider must ensure that they are reviewed regularly and maintained to reflect the actual care needs of the individual. Activities are planned for residents but more enphasis is needed to ensure each resident is able to participate if they want to.

On the basis of the evidence provided and the views of the people using the service we found the service to be compliant with this outcome.

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

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We talked to two people about their medicines and both expressed that they were happy with the home handling their medicines for them and that this worked well for them.

Other evidence
Following our last visit, the home provided us with an action plan to improve their compliance with this outcome after we issued a warning notice for this outcome. The action plan included that
a full medication audit had been completed 30 and 31 July 2011 and would be completed weekly thereafter. The deputy manager and two designated senior care workers checked all medication records daily. The deputy manager checked stocks of medication and ordered medication in time to ensure that all residents received their medication when required.

We visited the home to check the improvements had been implemented.

During our visit, we found that the home was keeping records of all medicine received. Checks had been made on a weekly basis of the quantity of medicines held in the home, and of medicine quantities and the administartion recorded on medication administration record (MAR). These checks had identified a shortfall in stock for one person in time to order supplies to make sure there was continuity of prescribed treatment. However, checks made of the MAR sheets had not identified gaps that we

found.

All medicines in the home were accounted for. However, the home did not know the quantity of medicines that were ordered because they did not see the prescription as it went directly from the doctor to the pharmacy.

At this visit, we identified some minor improvements necessary to allow for better records and management of medicines. For example one person was having a medicine with breakfast but the instruction on the medicine was that it should be taken on an empty stomach for best effect.

There were no care plans for medicines prescribed that were to be taken only when needed. This is important for person centred care and consistency and is particularly important for pain management of medicines.

When a resident went out for the day, their medicines were given to the family to manage. This worked well but records around this practice were lacking to show exactly what was not administered by the home.

One person had been refusing their medicines for a while and we did not see any evidence of a follow up with this information. The doctor had not been contacted. This was a concern and the severity of this was pointed out to the provider during our visit.

Our judgement
Whilst there are some improvements in the management of medicines at Remyck House, the home still does not fully protect people against the risks associated with the unsafe use and management of medication as it does not have detailed care plans for medicines prescribed to be taken 'as required'.

Overall, Remyck House was not meeting this essential standard.

Action
we have asked the provider to take

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 13 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 09: Management of medicines
	How the regulation is not being met: Whilst there are some improvements in the management of medicines at Remyck House, the home still does not fully protect people against the risks associated with the unsafe use and management of medication as it does not have detailed care plans for medicines prescribed to be taken 'as required'. Overall, Remyck House was not meeting this essential standard.	

The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards.

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

The provider's report should be sent to us within 14 days of this report being received.

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

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

What is a review of compliance?

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

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

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

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

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

Information for the reader

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