Review of compliance

Mrs Sandra Smith The Owls Care Home	
Region:	North West
Location address:	168 St Annes Road Blackpool Lancashire FY4 2BL
Type of service:	Care home service without nursing
Date of Publication:	August 2012
Overview of the service:	The Owls care home is registered to provide personal care for a maximum of fifteen people living with dementia. The accommodation comprises of eleven single bedrooms and two double bedrooms, some with en-suite facilities, a lounge. There are additional lounge and dining areas as well as bathing and toilet facilities within easy access for people living at the home. A passenger lift enables access to the first floor.The

	home is located in a residential area of Blackpool.

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

Our current overall judgement

The Owls Care 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 The Owls Care Home had taken action 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 27 July 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 visited The Owls and we spoke to several people and observed their care. Due to the ageing process and level of memory impairment of people living at the home we observed the interactions between people living in the home with one another and staff. Some people were no longer able to use words but we were able to observe their care. We saw that staff took the time to use people's preferred names and ask them if they wanted anything. Staff asked people to do things rather than tell them when they required support with personal care.

Two family members of a person living at the home said that their relative had recently moved into the home and had settled in quickly. They said this was their preferred place of care for their family member to be cared in. One family member said, "Dad's had his name on the waiting list for months. The home was recommended by the mental health services. Mum's just relived he's settled and safe".

What we found about the standards we reviewed and how well The Owls Care Home was meeting them

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

and supports their rights

The provider was meeting this standard.

People who used the service experienced safe and appropriate care and support that met their identified needs.

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

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.

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 was meeting this standard.

The provider's quality monitoring system had improved with more assessment of the systems that contributed to the quality of service people received being completed.

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 visited the Owls to follow up on the moderate concern we identified at our inspection on 24th and 25th May 2012. When we arrived at the home we spoke to several people and two family members of a person living at the home. They said that their relative had recently moved into the home and had settled in quickly. They said this was their preferred place of care for their family member to be cared in. One family member said, "Dad's had his name on the waiting list for months. The home was recommended by the mental health services. Mum's just relived he's settled and safe".

We spoke to as many people as possible as well as staff working at the home. To make sure their views were represented fairly we made observations of their care and their care records. Where people did not use words we saw that they smiled and waved when we spoke to them.

Other evidence
The information we saw gathered about the health needs of people at this inspection was more consistent. We looked at three care and support plans of people living at the home. One of a person who had recently moved into the home at short notice. During the inspection the family members of a person living at the home provided information about their relative. The family members said they were confident that their relative would receive the right care as they had been asked to provide information about their relative's needs and choices. A family member said, "I'm relieved we've been able to give the staff the information as the move was very sudden. The senior asked us for a

lot of information and we're confident he'll be alright. They (staff member) also gave us the contact details for the mental health team so we can talk about dad's long term care".

The care plans we saw had improved. We saw the home continued to gather information about the nutritional, mobility and safety needs of people. This included information to identify if people were at risk of falling, malnutrition or developing pressure ulcers.

We saw more consistent information provided about prescribed medicines. This meant that the home had improved its medicine management procedures.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. We saw that care plans were completed and supported by detailed information that the staff at the home were monitoring people's physical and mental health. We saw that staff were liaising with people's doctors, community mental health and district nurses.

Care and support plans had been re written and provided staff with more guidance on providing care to these people. Care and support plans were completed for all the identified needs of people. For example there were care plans in place to monitor and manage people's mental health need but these guided staff on managing people's mental health needs. We saw that care and support plans were being reviewed and that outcomes for people were being monitored. The staff member responsible for writing and monitoring care plans said there were still improvements to be made in care and support planning. They identified that the home needed to improve in involving people who did not have any family in care and support planning. They also said reviews of care needed to be more outcome focused in their content. They said as a result of care plan monitoring key workers would be responsible for reviewing and updating care and support plans. Senior staff would audit the quality and content of care and support plans so improvements would continue through the audit process.

Our judgement
The provider was meeting this standard.

People who used the service experienced safe and appropriate care and support that met their identified needs.

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
Many people living at The Owls were unable to express their views about medicines handling due to a variety of complex needs.

Other evidence
We found major concerns with the arrangements for handling medicines at our previous review in May 2012 and issued a warning notice requiring compliance with this regulation by 29 June 2012. The manager sent us an improvement plan detailing the actions they were taking to improve medicines handling. We found this had been acted upon and the warning notice was met.

We found that appropriate arrangements were made in relation to checking people's medicines on first admission to the home and ensuring adequate stocks of medication were maintained, to allow continuity of treatment.

We found appropriate arrangements were in place in relation to recording medicines handling. Records of medicines administration were clearly presented to show the treatment people had received and medicines were safely administered from the original pharmacy labelled containers. Changes to people's medicines and advice from GP's was mostly clearly recorded but we saw one example where advice to stop a prescribed nutritional supplement was not recorded.

We found some written information about the use of medicines prescribed 'when

required' to help ensure consistency in their use. However, the provider may find it useful to note that there was a lack of clear supporting information within one of the care plans we looked at about when the medication may be needed, and what other interventions may be used first.

Regular medicines audits were completed to help ensure that medicines were handled in accordance with the homes policies.

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.

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 living at the home did not comment directly on assessing and monitoring the quality of service provision.

Other evidence
We saw evidence that improvements had been made in monitoring the quality of the service delivered to people living at the home. We saw the manager was monitoring the quality of care delivered in the home. We saw the monitoring of the quality assurance system was now delegated to key staff in the home. We saw that staff had been given responsibility for monitoring the management of medicines, care and support planning, accidents and incidents.

Since our visit in May 2012 the owner had held a series of meetings with senior staff and the staff team and identified improvements needed in quality assurance. We saw the minutes of meetings held. These identified the staff accountable for the monitoring of aspects of the quality assurance system. We saw the audit process had continued and that the health and safety audit of the home had been completed.

Our judgement
The provider was meeting this standard.

The provider's quality monitoring system had improved with more assessment of the systems that contributed to the quality of service people received being completed.

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
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA