Review of compliance

S Singh Adkar Tatchbury Manor Care Home	
Region:	South East
Location address:	Tatchbury Lane Winsor Southampton Hampshire SO40 2HA
Type of service:	Care home service with nursing
Date of Publication:	November 2011
Overview of the service:	Tatchbury Manor Nursing Home is registered with the Care Quality Commission to provide care and accommodation to 38 people in the older person category with dementia. The service is situated close to the village of Netley Marsh in the New Forest. The service is registered to provide the

	regulated activity of accommodation for persons who require nursing or personal care. The service does not currently have a registered manager.

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

Our current overall judgement

Tatchbury Manor Care Home was not meeting one or more essential standards. We have taken enforcement action against the provider to protect the safety and welfare of people who use services.

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 Tatchbury Manor Care Home 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 4 October 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

People told us that they liked living at Tatchbury Manor. They had been able to bring in personal things to furnish their rooms. One person told us that they liked to eat in the dining room and that their favourite breakfast included a bacon sandwich which they had every day. They also told us they liked it when their relative visited and that they would have their hair done in preparation. We were told that activities took place sometimes and that they could choose whether or not to join in.

One relative told us that they were very happy with the care their mum was receiving. They said that their relative was always clean and well presented. They also told us that their relative was now having less falls and was generally more alert and able to have a conversation without them falling asleep. They told us that hey had been involved in review meetings.

What we found about the standards we reviewed and how well Tatchbury Manor Care Home was meeting them

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

Some assessment of peoples care needs have been undertaken. Though this information has been used to develop care plans, care practices do not always ensure that people receive appropriate care to meet their needs.

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

Though the home has a medicines management system in place. Medicines are not always managed safely. The management of as required medicines is inconsistent and it is not always clear when these should be used.

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

In a previous review, we found that improvements were needed for the following essential standards:

- 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
- Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
- Outcome 05: Food and drink should meet people's individual dietary needs
- Outcome 06: People should get safe and coordinated care when they move between different services
- Outcome 07: People should be protected from abuse and staff should respect their human rights
- 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
- Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

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

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

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
One person told us that they liked to eat in the dining room and that their favourite breakfast included a bacon sandwich which they had every day. They also told it they liked it when their son visited and that they would have their hair done in preparation. We were told that activities took place sometimes and that they could choose whether or not to join in.

One person told us that they sometimes went out with their friends and 'it was good to get out.'

Other evidence
We issued a warning notice on the provider on 12 September 2011. We carried out this visit to check on the improvement implemented.

We reviewed five sets of records. They contained information about the person including their likes and dislikes. We saw that some of the records contained information that mirrored what the individual had told us. Senior staff told us that they were in the process of reviewing and up dating all the records. We saw some evidence of this process.

Records included risk assessments and behaviour management plans where these were required. Where medication was prescribed for the management of challenging behaviour it was not always clear when this was to be used. We also saw that for some people, who were known to be prone to constipation that it was not always clear when

aperients were to be used, though bowel habits were monitored.

From review of the daily records it was noted that peoples continence pads were not checked until the late afternoon. The staff confirmed that the pads were not checked until around 16:00-17:00 hrs. This was a long period of time, as some of these residents were up and dressed for their breakfasts. During the night more frequent checks were recorded.

We observed people were treated with dignity and respect. Staff talked to them and explained what they were doing. Everyone went to the dining room for lunch. We saw that one to one assistance was given to all those who required help with their meal. People were offered a choice as to what they wanted to drink and help was given to those who required it.

Although the fluids records had improved, there were gaps on some of these which may put people at risk of not receiving adequate fluids.

People were given support to move around and those that were unable to walk were moved using hoists. We saw that each person had their own named sling for use with the hoists. Everyone was up and dressed and sitting in the lounges. During the afternoon activities were provided that some of the residents took part in.

We observed that one of the residents was pulled backwards in their wheelchair. Staff told us that this was because his feet would slip off the footrest. The care plans did not contain this information and there was no evidence that an assessment had been considered for a more suitable wheelchair.

One person had been receiving a thickener in their fluids at our last visit. We observed that they did not have a dietary care plan in place to show how their dietary needs would be met. A staff member told us that they were no longer receiving thickened fluid as this had been discontinued by their GP. Staff confirmed that a dietary care plan was needed and this had been missed.

Our judgement
Some assessment of peoples care needs have been undertaken. Though this information has been used to develop care plans, care practices do not always ensure that people receive appropriate care to meet their 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

There are moderate concerns with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
Most of the people were not able to tell us about their medicines management. One person said that the staff gave them their medications and this 'was all right.'

Another person said that they had asked the staff for something for their headache last week.

Other evidence
We issued a warning notice on the provider on 12 September 2011. We carried out this visit to check on the improvement implemented.

During this visit we found that the home had introduced a new system for managing the residents' medicines. Medicines were now ordered on a 28 day cycle and came in blister packs.

There was a record of medicines received and those that were discarded. A random check of the stock showed that staff were monitoring the stock balance. There were some discrepancies in the amount of medicines that were ordered/ received and the remaining stock.

The record for one person indicated that four disposable enemas had been received. The medication administration record (MAR) showed that one had been administered. Three of these could not be accounted for, as there was none remaining in stock.

Another record indicated that four enemas had been requested. However there was none in stock. Staff said that they thought that none had been received. Staff were failing to follow the home's procedure for ordering and receiving medicines. We were told that the staff should have followed up when none were received.

There was a homely remedy list that the staff said was current. The list was available in the residents care plans, but the form had not been completed in its entirety by the GP signing the form. The staff were not clear about the in house process for homely remedies. When reviewing the care plans we saw that the use of care plans for as required medication was inconsistent. The lack of a clear plan of care for as required medicines put people at risk of not receiving their medicines in a consistent way to meet their needs.

For one person we saw that they had received two doses of an as required medicine. Only was recorded in the correct place on the MAR chart. The second dose had been recorded but it the wrong place.

During our visit we found that the staff had left a resident's monitored dose medication unattended on top of the medicine trolley. This was removed and brought to the attention of the senior nurse. This was unsafe as others could have taken the medicines.

Our judgement
Though the home has a medicines management system in place. Medicines are not always managed safely. The management of as required medicines is inconsistent and it is not always clear when these should be used.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: Some assessment of people's care needs have been undertaken. Though this information has been used to develop care plans, care practices do not always ensure that people receive appropriate care to meet their needs.	
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: Though the home has a medicines management system in place medicines are not always managed safely. The management of as required medicines is inconsistent and it is not always clear when these should be used.	

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

Document purpose	Review of compliance report
Author	Care Quality Commission
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