Review of compliance

Fewcott Healthcare Limited Fewcott House Nursing Home	
Region:	South East
Location address:	Fritwell Road Fewcott Bicester Oxfordshire OX27 7NZ
Type of service:	Care home service with nursing
Date of Publication:	November 2011
Overview of the service:	Fewcott House Nursing Home is a care home with nursing which offers care for up to 35 people. The home offers a service to older people, people with learning difficulties and people with physical disabilities.

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

Our current overall judgement

Fewcott House Nursing Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 07 - Safeguarding people who use services from abuse
Outcome 08 - Cleanliness and infection control
Outcome 13 - Staffing
Outcome 14 - Supporting staff

How we carried out this review

We reviewed all the information we hold about this provider, 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 who lived in the home told us that it was a 'magnificent home', they felt safe and happy. They were happy to talk to staff if they had any concerns and were confident that they would be dealt with. We were told that people were treated with 'great respect'.

What we found about the standards we reviewed and how well Fewcott House Nursing Home was meeting them

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

The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced except in relation to behaviour plans. People living in the home, and their relatives, where appropriate, were involved in planning and reviewing the care and support given. Care plans for people under 60 did not have specific guidance for staff to ensure their care was age appropriate.

Overall Fewcott House Nursing Home was meeting this essential standard, but to maintain

this we suggested some improvements were made.

Outcome 07: People should be protected from abuse and staff should respect their human rights

The home responded appropriately to safeguarding issues. Staff had been trained and knew how to protect the people in their care. People felt safe living in the home.

Overall we found that Fewcott House Nursing Home was meeting this essential standard.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

The home had an infection control policy based on the 'Code of Practice.' Staff had received training in infection control. The home made sure that staff understood and followed all relevant infection control procedures.

Overall we found that Fewcott House Nursing Home was meeting this essential standard

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs

The home regularly reviewed staffing numbers and adjusted them to make sure that peoples' needs were met.

Overall we found that Fewcott House Nursing Home was meeting this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Care was provided by appropriately trained staff. Supervision supported staff to develop the necessary skills needed to meet the needs of people living in the home.

Overall we found that Fewcott House Nursing Home was 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. 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

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 minor concerns with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People told us that they liked living in the home. They said that their families always felt welcome and one person described it as a 'magnificent' home.
People told us that they were involved in the development of their plans of care and any changes made to them.

Other evidence
There were 25 people resident in the home on the day of the inspection visit. Fewcott House Nursing Home was registered for 35 people but there were ongoing building and refurbishment works in progress. Building work is to include re-instating all en-suites that had been condemned as not adequate. People were using commodes and sharing bathrooms.

We arrived at 11.30 am, five people remained in bed. Three people were nursed in bed because they were very frail and two chose to stay in bed. One of those who had chosen to stay in bed wanted to get up at 12:00 and was assisted to do so. This person did not have fluids available or access to their call bell. However, staff told us that they were checked regularly to see when they wanted to get up and were offered drinks. Others who were nursed in bed had fluid and nutrition charts, and call bells were available for those who were able to use them. Plans of care included how frequently people needed to be checked. We were told that only one person in the home had a pressure wound, they had only been resident in the home for a few days. The home was developing a nursing plan for them that included wound care.

We observed care during a meal time and throughout the visit. We watched part of a music session. Staff treated people with respect and were seen to be interacting positively and sensitively with the people in their care. There were some instances of staff treating people with learning disabilities in a 'child like' way. For example, staff called two people 'good girls' and said 'aren't they sweet' within their hearing, However, the two people reacted positively to the staff. Staff were observed to be kind and attentive and were responding to peoples' needs quickly and efficiently. Staff were seen to be interpreting behaviours to enable them to meet needs that people were not always able to verbalise. People had meals on time and prepared as noted in their care plans. The cook was observed talking to people about the meals for the day and asking if there was anything they wanted that was not on the menu. One person told us that they were asked everyday about their food requirements. Nurses and care staff had a good knowledge of peoples' needs and gave them care accordingly.

The plans of care seen included all the relevant information to enable staff to appropriately care for people, with the exception of age appropriateness. For example, pre-admission assessments, life history charts which included phobias, habits and unpleasant life events, likes, dislikes and preferences, a mental capacity screening check list, a personal emergency evacuation plan, a nutritional screening tool, weight charts and personal support plans which included what time people chose to retire and rise and how people made choices. People or their representatives signed the plans of care. Several of the people who lived in the home were under 60 and had physical or learning disabilities. There was no detail in their care plans about how to ensure care was age appropriate.

Health appointments and visits by other professionals were recorded and showed that the doctor or specialists were consulted regularly and as appropriate. For example, one person had a behavioural assessment completed by a psychiatrist and another had contact with a specialist Parkinson's nurse.

Plans of care included any relevant risk assessments for individuals. These included risk assessments for falls, personal safety, nutrition assessments and monthly or weekly weight monitoring as the assessment required, moving and handling, skin integrity and fire. Some of the risk assessments were detailed, for example lifting and handling. Some assessments did not include the detail of how to minimise the risk. For example, the behaviour assessments noted peoples' behaviours, the risk these posed but there was little detail of how to minimise the assessed risks. Some people had bed rails, they told us they felt safer with them in place. The bed rails assessments and consent were sometimes signed by the nurses rather than the individuals or their representatives.

The care observed was given as noted in individual's plans of care. For example, one person's plan of care for personal care noted their preference in jewellery and clothing, they were wearing matching jewellery and smart clothing.
Daily notes were detailed and up-to-date.

Our judgement
The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced except in relation to behaviour plans. People living in the home, and their relatives, where appropriate, were involved in planning and reviewing the care and support given. Care plans for people

under 60 did not have specific guidance for staff to ensure their care was age appropriate.

Overall Fewcott House Nursing Home was meeting this essential standard, but to maintain this we suggested some improvements were made.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us that they felt safe in the home and trusted the staff. They said that if they had a problem they knew who to talk to and were confident 'it would be put right'.

Other evidence
The home had notified the relevant authorities about any safeguarding concerns. They dealt with them appropriately and worked with the Local Authority and health and safety executive to ensure peoples' future safety.

Deprivation of Liberty referrals were made to the local authority, as appropriate. The home completed mental capacity assessments to help them provide care to people who had difficulties in making decisions.

Peoples' choices and how they communicated what they wanted was noted on plans of care for individuals. The Mental Capacity Code of Practice was available in the office for staff to refer to.

Training records showed that all staff were trained in the safeguarding of vulnerable adults. Staff demonstrated that they understood the need to protect people in their care. They described what action they would take if they had a safeguarding concern, including reporting concerns outside of the organisation if they felt it was necessary.

Our judgement
The home responded appropriately to safeguarding issues. Staff had been trained and

knew how to protect the people in their care. People felt safe living in the home.

Overall we found that Fewcott House Nursing Home was meeting this essential standard.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We received no specific comments from people we spoke with about this outcome.

Other evidence
The home had a copy of the Code of Practice on the prevention and control of infections and related guidance and had developed a policy and procedure based on this. The Code of Practice was available to all staff with an infection control training DVD.

The home was clean and tidy throughout, with the exception of two clean, but stained commodes. The laundry used a coloured bag system. The red bags, used for infected laundry, were put straight into the washing machine. The home had an infected waste contractor who collected and replaced the yellow waste bins. The kitchen had received a five star (excellent) grading following an environmental health inspection in January 2011.

Hand washing facilities, gloves and aprons were available throughout the home, staff were observed using them. There were detailed instructions available to staff to enable them to safely care for people with infections. Staff were able to describe how they dealt with infection control issues. Most staff had completed infection control training and food hygiene training. The remainder had been booked onto a course in October 2011.

Our judgement
The home had an infection control policy based on the 'Code of Practice.' Staff had received training in infection control. The home made sure that staff understood and

followed all relevant infection control procedures.

Overall we found that Fewcott House Nursing Home was meeting this essential standard

Outcome 13:
Staffing

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by sufficient numbers of appropriate staff.

What we found

Our judgement

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
People told us that the staff 'were great, they listen to you and treat you with great respect'. One person told us that the home could do with more staff as they seemed under pressure on occasions and they had to wait longer than they liked to. However, they said that staff did a good job. People told us that staff always came quickly if they rang the bell. One person said that they would like to go out more but felt that staff didn't have the time to take them out.

Other evidence
On the day of the inspection visit there were four care staff, two nurses, a cook, a cook's assistant, a cleaner and a gardener on duty. We were told that the minimum staffing for 25 people was four care staff and two nurses (plus ancillary staff) in the morning, four care staff and one nurse in the afternoon and two care staff and one nurse at night. The managerial team were additional to the staffing hours. These numbers were reviewed on a daily basis by the manager and were dependent on the needs of the people resident in the home. Shortfalls were generally covered with bank staff although agency staff were used occasionally. The rota for September was viewed and this showed that appropriate staffing levels had been achieved on all occasions.

Staff were observed attending to people as necessary and giving appropriate levels of care. Staff told us that they thought they had enough staff, although at times they were very busy.

Our judgement

The home regularly reviewed staffing numbers and adjusted them to make sure that peoples' needs were met.

Overall we found that Fewcott House Nursing Home was meeting this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
We received no specific comments from people we spoke with about this outcome.

Other evidence
The training matrix showed that staff had received mandatory training and additional training to help them meet the specific needs of people in their care. For example, understanding of dementia, Parkinson's and learning disabilities.

Two of the 20 staff had completed a National Vocational Qualification (NVQ) level 2 and eight staff were in the process of completing their NVQ training. Staff told us that they had good training opportunities. They said they did not lift people until they had completed their lifting and handling training. They said they completed a five day induction before they started working alone. Mental capacity act and deprivation of liberty safeguards training had been completed by senior staff who were 'rolling out' the training to other staff.

Staff told us it was a good working environment where everybody worked as a team. They told us they had regular supervision, weekly when they were new and then monthly to two monthly when they were more experienced. Staff told us that the management team listened to them and would take action on any 'good ideas' or suggestions. For example, one staff member said that they had suggested more and varied activities, a programme of increased and more varied activities was in the process of development.

Our judgement

Care was provided by appropriately trained staff. Supervision supported staff to develop the necessary skills needed to meet the needs of people living in the home.

Overall we found that Fewcott House Nursing Home was meeting this essential standard

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

<table>
<tr><th>Regulated activity</th><th>Regulation</th><th>Outcome</th></tr>
<tr><td rowspan="2">Accommodation for persons who require nursing or personal care</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:
The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced except in relation to behaviour plans. People living in the home, and their relatives, where appropriate, were involved in planning and reviewing the care and support given. Care plans for people under 60 did not have specific guidance for staff to ensure their care was age appropriate.

Overall Fewcott House Nursing Home was meeting this essential standard, but to maintain this we suggested some improvements were made.</td></tr>
<tr><td rowspan="2">Treatment of disease, disorder or injury</td><td>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010</td><td>Outcome 04: Care and welfare of people who use services</td></tr>
<tr><td colspan="2">Why we have concerns:
The service had assessed the needs of people who lived in the home. This included any risks to their health and how those risks could be reduced except in relation to behaviour plans. People living in the home, and their relatives, where appropriate, were involved in planning and reviewing the care and support given. Care plans for people under 60 did not have specific guidance for staff to ensure their care was age appropriate.

Overall Fewcott House Nursing Home was meeting this</td></tr>
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	essential standard, but to maintain this we suggested some improvements were made.

The provider must send CQC a report about how they are going to maintain 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.

CQC should be informed in writing when these improvement 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
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
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