Review of compliance

Parkcare Homes Limited Cotswold Lodge	
Region:	South East
Location address:	Coast Road Littlestone New Romney Kent TN28 8QY
Type of service:	Care home service without nursing
Date of Publication:	October 2011
Overview of the service:	Cotswold Lodge is registered to provide a service for up to eight adults who have a learning disability.The home is about a mile from the town of New Romney and it situated very near to the sea front.

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

Our current overall judgement

Cotswold Lodge 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 as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

Due to the nature of the service we were not able to gain views directly from most of the people who were at home during our visit, although one person told us "It's cool, happy here" and that they liked the manager.

We saw that people were comfortable in the company of staff and they spent a lot of time during our visit in areas where they could see or communicate with staff.

We telephoned some relatives to gain their views on the home, they told us that they were very satisfied with the service overall. They said that staff communicated well, were helpful, and always told them if there were any medical appointments or problems. Their comments included, "Staff are always aware they are working in someone else's home" and "Everything they have done has been wonderful". One person said they would recommend the home to other families.
Due to the nature of the service we were not able to gain views directly from most of the people who were at home during our visit, although one person told us "It's cool, happy here" and that they liked the manager.

What we found about the standards we reviewed and how well Cotswold Lodge was meeting them

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

Staff respect people's privacy and promote independence. People or their representatives are involved in making choices about how their care and support is given.However; the way in which clothes and some of people's belongings were stored does not maintain their

dignity.

Overall, we found that Cotswold Lodge was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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

People receive the care and support they need in a way that is safe, meets their needs and takes into account their personal preferences.

Overall, we found that Cotswold Lodge was meeting this essential standard.

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

Systems are in place to protect people from abuse, or the risk of abuse, and staff are aware of how to keep people safe.

Overall, we found that Cotswold Lodge was meeting this essential standard.

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

The standard of cleanliness and infection control in the home was poor. People are not sufficiently protected from risk of infection due to the overall poor standard of cleanliness.

Overall, we found that improvements were needed for this essential standard

Outcome 10: People should be cared for in safe and accessible surroundings that support their health and welfare

The standard of the accommodation overall is poor and does not respect people's dignity or their need to live in a safe, suitable and well maintained home.

Overall, we found that improvements were needed for this essential standard.

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

Staff receive the training they need for their role. However, the provider is not employing sufficient numbers of appropriate staff to fully meet people's needs. Care staff are overstretched by having to undertake all the domestic tasks and this is impacting on the quality of the service provided.

Overall, we found that improvements were needed for this essential standard.

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 registered provider is not adequately monitoring the quality of the service provided. No action is being taken to improve the service provided even when internal audits and information gathering exercises identify problems.

Overall, we found that improvements were needed for this essential standard.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 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

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 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We did not speak directly to people about this outcome, but were able to see that they were consulted about their choices that these were respected, and that staff respected their privacy.

Other evidence
The home was fully occupied with eight people living there when we visited, four people were at home and others had gone out for the day to do shopping and to have lunch. During the visit we saw that people were treated respectfully. Staff understood people's daily routines, and as routine can be very important to people with autism they made sure that these were followed. Routines were clearly recorded in people's care plans.

People at home spent their time as they chose during the morning, one person chose to get up late, another person said they wanted to watch one of their favourite DVD's in their room so staff put it on for them, and others spent time with staff or in the lounge. The service catered for people with autism and learning disability, some people were not able to communicate verbally or had a little verbal communication. We saw that staff understood people's methods of communication and that they responded to non verbal communication such as noises or facial expressions. They made sure that people were settled and attended to if they seemed anxious or were saying they needed something.

Staff respected people's privacy, people living at the home had keys to their rooms and key holding agreements were in place signed by them or their representatives. The home was introducing new care plans that give clear details about each person's needs, we could see that people had been involved in the process as far as they were able.

Independence was promoted and people were consulted about the running of the service. People were supported to help with household tasks if as far as possible, such as preparing a drink or cleaning their rooms. Regular residents meetings were held, we read the notes of the last two meetings. People's comments were recorded exactly as they were said which showed that sometimes there were very lively discussions, the meetings appeared to have been fun and helpful comments had been made. For people who were not able to communicate fully verbally notes were made of their non verbal views. Examples of topics discussed were meals, this year's holiday, and staff had explained some new pictorial policies, such as about how to complain and keeping safe.

People we saw were acceptably dressed but many of their clothes had been put away in drawers and cupboards looking like they had been screwed up, clothes were unfolded and unironed.Staff told us some people do "rummage" with their clothes, but this did not apply to each person whose clothes were put away in this fashion.

There was a cupboard with named open sections for each person in the entrance hall with items such as shoes and towels in. One section contained incontinence sheets, this section was not named but having the sheets and other items on display was not respectful to people or their dignity.

Our judgement
Staff respect people's privacy and promote independence. People or their representatives are involved in making choices about how their care and support is given.However; the way in which clothes and some of people's belongings were stored does not maintain their dignity.

Overall, we found that Cotswold Lodge was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

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 could see from reading care plans and other recording that people were consulted about the care and support they received, and that their preferences and views were recorded. During our visit staff explained to people what they were doing and gave them options, such as for what to do or what to have for lunch.

Other evidence

We read four people's care plans in detail, the new care plans being introduced were person centred and people had been involved in writing them. People had been asked about how they liked to be supported in all areas of their daily lives and their responses were recorded. They had signed the information when possible, or it had been noted that the information had been discussed with them. Daily routines such going to bed were recorded stating what time people liked to go to bed and get up and their choice of bedtime drink. The entry about bedtime for one person who used signs and gestures to communicate included, "sometimes I hold my hand up for a high five" this would help staff to understand the gesture. People had meetings with their keyworkers, these included discussions about personal goals and how to achieve them, one recent goal set was for a person to be able to make tea and toast.

Where people were unable to make an informed choice about their care, or an aspect of it, Best Interests meetings had been held with people's representatives. One person had recently needed an operation; consent to the surgery had been gained from their representatives after consultation with health professionals.

Health needs were recorded and people were supported to attend health appointments and keep in touch with health professionals such as speech and language therapists, dentists and community nurses. The person who had needed surgery was using a wheelchair temporarily, they were able to move around the ground floor freely with it and staff were recording their daily progress. Records showed that staff spent time each day supporting the person's full recovery and were pleased with progress. A physiotherapist visited to help staff with the person's exercises after lunch.

Relatives told us that the home makes sure that health needs are met and that it has purchased equipment for people when items needed had not been promptly provided by health services. People who needed to make sure they maintained a healthy weight were encouraged to exercise, one person used an exercise bike in their room daily and the number of miles they rode was recorded.

Individual risk assessments were in place such as for accessing the community, risk of self harm and epilepsy. One person was recorded as needing one to one support in the community to keep them safe and the manager explained how staffing was arranged so that people went on outings of their choice with sufficient staff for their individual needs.

People were being supported with activities of their choice, each person had their own individual programme of activities. The home had its own transport and activities included swimming, shopping, music, aromatherapy and going out for meals and walks. One person had a regular visit to Manston airport as this is their preferred trip out. A caravan holiday had been provided for people this year; comments on resident's meetings notes stated that they said they had enjoyed it. One person chooses not to go on holiday preferring to stay at home.
Staff took people to visit their families if relatives were unable to visit the home, relatives we spoke with confirmed this, and one person visited their mother fortnightly. Special trips were arranged for people's particular interests, one person showed us tickets for a wrestling match at the O2 Arena in November, and others had been to the Dr Who exhibition and a London show.

Our judgement
People receive the care and support they need in a way that is safe, meets their needs and takes into account their personal preferences.

Overall, we found that Cotswold Lodge was meeting this essential standard.

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
We did not speak directly to most people about this outcome, although the notes from residents meetings held this year showed that staff had shown people that there was new accessible information for them about what to do if they felt unsafe or had experienced abuse.

One person told us they would go to the manager if they were worried about anything.

Other evidence
We saw that the home had safeguarding policies and procedures for staff to follow, an accessible policy for people who live there, and an up to date 2011 copy of the Kent and Medway multi Agency Safeguarding procedures. The care staff on duty were aware of the need to keep people safe and we saw from records that staff receive safeguarding training and other training such as in food hygiene and emergency first aid.

We saw staff using safe working practices whilst supporting a person who uses a wheelchair and whilst preparing lunch.

Relatives we spoke with had no concerns about the safety of the home.

Our judgement
Systems are in place to protect people from abuse, or the risk of abuse, and staff are aware of how to keep people safe.

Overall, we found that Cotswold Lodge 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

There are moderate concerns with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We did not speak directly to people about this outcome.

Other evidence
We have also addressed concerns about cleanliness and infection control in Outcome 10.

During the visit we did a tour of the home and found that it was not cleaned to an acceptable standard. We saw that communal facilities such as the showers and bathrooms were dirty. There were areas in these rooms that could harbour infection, such as where there were missing tiles, gaps in flooring around toilet pedestals and walls, rusting radiators and a mouldy soap dish. All of the bedrooms we saw had not been cleaned to a satisfactory standard, they had dirty skirting boards and some walls had evidence of spillages on them of unknown substances that staff appeared not to have noticed. One had a broken wash hand basin pedestal and wooden soap dish black with what looked like a mould.

Shared areas of the home were visibly dirty and grubby with some worn and broken furnishings and furniture. One bedroom had an unpleasant odour; staff explained that the room had not yet been cleaned. The home does not employ a cleaner so staff are responsible for all the laundry, cleaning and cooking. Staff told us it is hard to find time to do more than basic cleaning as the care of people comes first. There appeared to be no cleaning plan other than for the most basic cleaning tasks. The kitchen was the only area that was clean, hygienic and well presented.

Our judgement

The standard of cleanliness and infection control in the home was poor. People are not sufficiently protected from risk of infection due to the overall poor standard of cleanliness.

Overall, we found that improvements were needed for this essential standard

Outcome 10:
Safety and suitability of premises

What the outcome says

This is what people should expect.

People who use services and people who work in or visit the premises:
* Are in safe, accessible surroundings that promote their wellbeing.

What we found

Our judgement

There are moderate concerns with Outcome 10: Safety and suitability of premises

Our findings

What people who use the service experienced and told us
We did not speak directly to most people about this outcome. One person told us they liked their room.
We saw that people's rooms were personalised to their choice, some people's rooms were sparsely furnished as they preferred this and were not happy if there were more items in them than they liked. Relatives we spoke with confirmed that their relatives living at the home liked their rooms empty of anything other than basic items, and would remove anything they did not want.
One relative said "The home could be cleaner" and another "We think a lot of the home although it is not the poshest of places".

Other evidence
We visited most of the bedrooms and all the shared areas. The bedrooms were all upstairs although one person who was unable to go upstairs after surgery was temporarily accommodated downstairs.Some bedrooms were sparsely furnished but all contained personal items that showed what people's interests were, these included model airoplanes,trains,model cars and balloons and one person had grown tomatoes in the greenhouse that were ripening on their windowsill. Some bedrooms had attractive murals on the walls painted by an ex member of staff, one was of the planets and another of aeroplanes.

We saw from provider visit records written earlier this year that some redecoration had taken place. Although we saw that the whole of the premises, with the exception of the kitchen, which was clean and hygienic, looked tired and in need of redecoration and refurbishment. We looked at records of provider visits that had taken place from April

2011 to the most recent recorded in July 2011.Each visit had identified that the home needed redecoration and refurbishment, at the time we visited there was no evidence this had been actioned or work was planned.

Throughout the home we saw that much of the furniture and carpeting was old, dirty and damaged. A settee had torn covers and carpets throughout the home were worn and stained to the extent of being shiny in places. The downstairs shower room had a very rusty radiator, tiles were missing, there were gaps between the tiling, flooring and skirting boards and overall the room was dirty. The upstairs bathroom had a dirty soap dish and a stained bathmat.

Some bedroom furniture was dirty and nearly all was worn and of poor quality, there was a chest of drawers that had clearly had a lot of fluids spilt on it that had not been cleaned up, and cupboards and drawers were broken. Whilst we understood from reading records and from speaking with staff, relatives and the manager that some people can sometimes exhibit behaviours that can cause damage to the environment that they live in, the lack of attention to keeping the home well maintained did not respect their dignity and promote their safety.

We saw a stained undersheet on a bed, it had been washed but remained very stained and was not suitable for use. The bottom sheet on another bed had a tear in it and other bedding was thin and worn. One person's spare bedding was screwed up in a wooden chest in their bedroom.

Our judgement
The standard of the accommodation overall is poor and does not respect people's dignity or their need to live in a safe, suitable and well maintained home.

Overall, we found that improvements were needed for 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

There are moderate concerns with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
One person told us they liked staff and the manager, we saw them chatting with the manager for quite some time in a relaxed way.
Relatives we telephoned were complimentary about staff and the level of support they provided, one relative said that "Staff have been fantastic" and another that "Staff seem to stay and they get to know clients----they are very good at communicating".

Other evidence
We read some training records and staff files and saw that staff were provided with induction, mandatory and specialist training and nearly all have an NVQ (National Vocational Qualification) in care at level two or above. Staff received regular recorded supervision and staff meetings are held.
People had good relationships with the staff present and were comfortable with them. Staff chatted with people whilst preparing lunch, having offered lunch choices to each person.

When we visited there were three staff and the manager on duty. There were usually four staff on duty but one carer that day had needed to leave unexpectedly. Four people had been taken out shopping and for lunch by two staff in the morning, so the manager and acting team leader were at the home with the four other people. This appeared to be appropriate for the needs of the people at home although it left the team leader with all the morning's domestic tasks as well as needing to attend to people's needs. We have addressed that cleaning was of a poor standard in outcomes 8 and 10.The home used to employ a cleaner but we were told when they left some time ago

they were not replaced.

Our judgement
Staff receive the training they need for their role. However, the provider is not employing sufficient numbers of appropriate staff to fully meet people's needs. Care staff are overstretched by having to undertake all the domestic tasks and this is impacting on the quality of the service provided.

Overall, we found that improvements were needed for this essential standard.

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

There are moderate concerns with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
We did not speak directly to people about this outcome.

Other evidence
The manager told us they completed regular internal audits of the service. We read some examples such as care plan audits, audits of any events of note at the home and of medication. The need for minor repairs or redecoration is recorded and referred to the organisation, who then sub contracted the maintenance work, but response to requests was slow.

The views of people living at the home are sought at resident's meetings,keyworker meetings and at care plan reviews and are well recorded.

There have been changes in the senior management of the home over recent months. Although provider visits had been taking place, work that had been identified as needing to be done to improve the environment over a period of months had not been planned for or carried out and no full environmental audit had been carried out.

Our judgement
The registered provider is not adequately monitoring the quality of the service provided. No action is being taken to improve the service provided even when internal audits and information gathering exercises identify problems.

Overall, we found that improvements were needed for 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.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: Staff respect people's privacy and promote independence. People or their representatives are involved in making choices about how their care and support is given.However; the way in which clothes and some of people's belongings were stored does not maintain their dignity. Overall, we found that Cotswold Lodge was meeting this essential standard but, to maintain this, we suggested that 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 within 7 days of this report being received.

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

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 12 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 08: Cleanliness and infection control
	How the regulation is not being met: The standard of cleanliness and infection control in the home was poor. People are not sufficiently protected from risk of infection due to the overall poor standard of cleanliness. Overall, we found that improvements were needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 10: Safety and suitability of premises
	How the regulation is not being met: The standard of the accommodation overall is poor and does not respect people's dignity or their need to live in a safe, suitable and well maintained home. Overall, we found that improvements were needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 13: Staffing
	How the regulation is not being met: Staff receive the training they need for their role. However, the provider is not employing sufficient numbers of appropriate staff to fully meet people's needs. Care staff are	

	overstretched by having to undertake all the domestic tasks and this is impacting on the quality of the service provided. Overall, we found that improvements were needed for this essential standard.	
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 16: Assessing and monitoring the quality of service provision
	How the regulation is not being met: The registered provider is not adequately monitoring the quality of the service provided. No action is being taken to improve the service provided even when internal audits and information gathering exercises identify problems. Overall, we found that improvements were needed for 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 7 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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