Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Romney Cottage Residential Care Home

Madeira Road, Littlestone, New Romney, TN28 8QX

Tel: 01797363336

Date of Inspection: 28 October 2013

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We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard

Details about this location

Registered Provider	Romney Cottage Residential Care Home
Registered Manager	Ms. Maureen Gosbee
Overview of the service	Romney Cottage is registered to provide care and accommodation for up to 22 people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

We used a number of different methods to help us understand the experiences of people using the service, because some of the people who lived there had complex needs which meant they were not able to tell us about their experiences. We observed how people spent their time during the day, how staff met their needs and how people interacted with staff. We spoke individually with two people and with two members of staff.

We observed that people were encouraged to make choices about their daily lives. Their choices and preferences were recorded on their care records and respected by staff.

People's needs were assessed before they moved to the service to make sure that it could meet them. We saw that people's care records were mostly kept up to date. Any changes in needs were recorded and the service made sure that people's health needs were met and they saw health care professionals when they needed to. We telephoned a social care professional who told us that the service made sure they were contacted if there were any concerns or queries about the health or welfare of the person they supported, and that staff followed the advice they gave.

We observed that staff were respectful towards people and treated them in a dignified way. A person told us "If I ask them (staff) something they always answer it if they can".

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases

we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

People's privacy dignity and independence were respected.

Reasons for our judgement

People were supported to express their views and make decisions about their care and support. We saw that people's care plans contained details about the choices and decisions they had made in relation to their care and support.

Records, observation and discussion with people and staff showed that people made choices about their daily lives and if there was a concern that a choice may have a risk attached other professionals were consulted. For example, a person who had been assessed as needing to use a pressure cushion to sit on in order to help prevent soreness to their skin was not happy to use their cushion and had removed or destroyed cushions. This had been clearly documented, as had discussions the service had had with health professionals for advice. Whilst the person's choice not to use a cushion was respected, other action was being taken, for example to explore the reason why their skin had become vulnerable to soreness.

People's choices and preferences had been recorded on their care records. For example how they liked to be supported with their personal care, things they liked to do for themselves, what they like to eat and their personal interests. We observed that people were supported to make choices. For example, a person who needed some assistance to eat their food but who liked to be partially independent with eating had been eating their lunch by themselves but needed support to finish their meal. Another person's records showed that they preferred to manage their own personal care, they confirmed this was the case and the service respected that they like to be independent.

People living at the service had a range of needs. Some people had a history of mental illness or alcohol dependency in their earlier lives. For some people his had had an impact on their overall health and contributed to them developing conditions such as diabetes or dementia. The service recognised that some people's past life experiences had shaped how they liked to spend their time. It provided a sensitive approach to people's individual

needs and routines, and gave them time to adapt to a change of routines and accommodation. For example, the service respected that a person sometimes chose to sleep on the floor as this had been their routine before they moved there. The manager told us that when this happened staff made sure the person was safe and warm enough, and that the person had now started to choose sleep in a bed sometimes.

The service had a written daily menu, whilst there was no set daily choice of meal people could have an alternative meal if they wished to. The main meal of the day was served at lunchtime, the manager told us that a person who preferred to have their main meal in the evening did so and had a light meal at lunchtime. A person told us that if they or others did not like a set meal choices were available.

Where people did not have the capacity to make an informed choice about a significant aspect of their care or support staff acted in accordance with the legal requirements of the Mental Capacity Act. They consulted people's representatives and relevant other professionals before a decision was made. Staff received Mental Capacity Act training so that they knew how to support people with decision making if necessary.

People's privacy dignity and independence were respected. We saw that staff knocked on people's doors before entering, spoke with them respectfully and allowed them time to speak or to make decisions without rushing them. The provider had purchased new clothes protectors for people who needed them to wear at mealtimes to protect their clothes from food spillages, which meant that people's dignity was maintained at mealtimes.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed and care and support was planned and delivered in line with their individual care plan. Records showed that the manager undertook an assessment of people's needs to make sure that it could meet them before people were offered a place at the service. A person who had moved to the service recently told us "the manager and another member of staff came to see me at home and asked what I wanted".

The same assessment process took place for people who were assessed as suitable for short term rehabilitation by their local authority and referred to the service by them. People who were at the service for short term rehabilitative care were usually there for approximately six weeks. The service then focused on improving people's health and nutrition, promoting their independence and working with their sponsoring authorities to return them to the community. A person at the service for rehabilitation said they hoped to be able to return home. They said they preferred to live independently but recognised they had needed time, appropriate healthcare, rest and support to be able to be in a position to consider this.

We looked at four people's care records and saw that they contained information about the care and support that people needed in all areas of their daily lives. Most of the care plans had been regularly reviewed throughout the year and updated when they needed to be. For example, to show that a person's medicines had changed or there was a change to their personal care needs. However, the provider might like to note that we found there were some gaps in the records. The manager said that each person was usually weighed regularly. This was to make sure they were maintaining an appropriate weight. However, some people were not recorded as having been weighed since April 2013 and one care plan we looked at had not been reviewed since then. Records did show that where there was concern about a person's weight, action was being taken about this The manager told us that a new system for reviewing care plans was to be introduced shortly and then they all would be fully reviewed on a more planned basis.

The service offered people some activities including board games and quizzes, art, reminiscence and going out locally for walks. The service did not employ an activities coordinator but staff told us they had time to provide activities in the afternoons and to

speak with people on an individual basis.

Staff told us they kept up to date with any changes in people's needs through daily handover meetings and records, written information provided by the manager and they got to know new residents by spending time with them. The manager had increased the number of handover meetings held daily to make sure each shift was up to date with information.

People's health needs were recorded, the service made sure that people saw health care professionals such as their GP, dietician, chiropodist and dentists when they need to for routine and other health appointments. We saw that appointments and their outcomes were recorded and that if there were concerns about a person's health appropriate health professionals were contacted promptly. A person who was at the service for rehabilitation had needed dental treatment, this had been quickly arranged and the person told us they appreciated that it had taken place.

The service worked with health and other professionals to make sure people had the treatment and equipment they needed to keep them healthy and to promote their independence as far as possible. For example, five people had been assessed as being at risk of developing pressure areas. The service took action to prevent pressure areas developing or to treat them if they did. People had been provided with air flow mattresses and pressure relieving air flow cushions by the District Nursing service if they needed them. District nurses visited people who needed their pressure areas treating regularly and the manager told us the service had good relationships with the GP and District Nurses. Records showed that as well as the District Nurses making a record of their visits, staff kept a separate record for each person of the visits and of any treatment or advice given. Records showed that the service followed through advice given. Further advice was sought if necessary, for example one person at risk of developing pressure areas had been referred to a dermatologist to explore the reason why. The GP visited another person during the inspection as the service had been concerned about the person losing weight. The GP prescribed food supplements to increase the person's nutritional intake in order to promote healthy skin and good skin repair. Staff we spoke with knew which people could be at risk of skin breakdown and what action to take if it did, or to try to prevent it happening

Individual risk assessments had been completed that identified any potential risks to people's safety and gave guidance for staff about how to prevent them. For example, risk assessments in respect of going out independently, mobilising and smoking.

The service had arrangements in place to deal with foreseeable emergencies. Due the very strong winds during the night and early morning prior to the inspection, the service had been without power for a while. Therefore staff had not wished to open freezers to take out food for the day's meals in case other food items started to defrost. Instead staff rearranged the menu so that people still had a hot lunch, but the main meal would be in the evening rather than at lunchtime.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social 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 essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - 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.

Moderate impact - 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.

Major impact - 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

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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