Inspection Report

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

Fewcott House Nursing Home

Fritwell Road, Fewcott, Bicester, OX27 7NZ

Tel: 01869345501

Date of Inspection: 14 August 2013

Date of Publication: September 2013

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

Care and welfare of people who use services	✖ Action needed
Staffing	✓ Met this standard
Supporting workers	✖ Action needed
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Fewcott Healthcare Limited
Overview of the service	Fewcott House is a care home with nursing, which can accommodate up to 40 people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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 14 August 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, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We reviewed information sent to us by commissioners of services and talked with other authorities.

What people told us and what we found

We conducted a visit in response to concerns we had received regarding Fewcott House. During our visit we spoke with eight people who used the service, 12 members of staff and two relatives. We looked at 11 people's care plans and staff training and supervision records.

We found that people's needs had been assessed, but that care and treatment had not always been planned and delivered on the basis of the assessments. For example, where people had been assessed as having a very high risk of developing pressure areas it was not always clear what actions staff should take and were taking to reduce and manage the risk.

We found that there were enough suitably qualified and experienced staff on duty to meet the needs of the people. However, we found that staff were not always appropriately supported to carry out their role. For example, nursing staff had not received regular supervision and appraisal.

The provider did not have suitable systems in place to assess and monitor the quality of the service that people received. People were sometimes exposed to care that was not always safe due to a lack of quality monitoring.

We found that notifications to CQC of deaths of people who used the service had not always been made.

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

What we have told the provider to do

We have asked the provider to send us a report by 02 October 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with eight people who used the service. We looked at 11 people's care plans and spoke with staff about people's needs. We found that people's needs were not consistently assessed and care and treatment was not always planned and delivered in line with their individual care plan. For example, we looked at one care plan where a 'behaviour assessment' had identified that no special assistance was required. However, within the daily notes, it was apparent the person commonly expressed abusive language and intimidating behaviour. We looked at the care plan and could not find documented strategies for staff to follow to manage this behaviour. We spoke with one care worker about how they managed this person's behaviour. The care worker told us they "just walk away". We spoke with some people who said there were "peculiar residents" who "wandered around and shouted".

Care and treatment was not always planned and delivered in a way that ensured peoples' welfare. We looked at risk assessments. Some had been undertaken using the 'Waterlow score' to identify the risk of people developing pressure damage. Six of the eight risk assessments we saw had identified a very high risk of pressure damage. It was not always clear in the care plans what preventative actions staff were taking.

For example, we spoke to one person, assessed as high risk of developing pressure damage. This person was in bed and said "my heels are aching terribly. Being in bed all the time the heels are on the bed and that's why they're painful" and "I feel I'd like to lift my feet up because they're so painful". The person told us they had spoken to staff; "they don't know what to do. They don't want to know". We looked at the person's care plan. The tissue viability plan, written by nurses working at the home, did not clearly identify how staff should prevent pressure damage. The Waterlow guidance and royal college of nursing guidelines recommend people assessed as being at 'high risk' should have an alternating pressure relieving mattress. This person did not have one. The 'pain' care plan

stated "staff to elevate legs whilst in bed". We looked at the daily notes for the previous week and saw only one entry to indicate that the person's legs had been elevated whilst in bed. We looked at other plans relating to people at high risk and found that some detailed regular repositioning, but they did not contain details on what pressure relieving equipment was being used.

Care and treatment was not always planned to ensure people's safety. For example, one file contained three care plans for immobility. Each plan had a different date and different instructions to staff. There was a risk the person would not be supported appropriately because instructions to staff were not clear. This person's file also contained a hoist and sling risk assessment, which had not been reviewed for 15 months. This placed the person at risk of being supported inappropriately with their moving and handling needs.

We looked at the care plans of five people who had been assessed as being at risk of becoming malnourished or dehydrated. Records of eating and drinking were being maintained for all five people. We saw that two people's care plans indicated that they should drink at least 1500mls of fluid in a 24 hours period. We looked at the records for these two people which frequently indicated that they were not drinking the recommended amount. We saw that the daily fluid records had not been regularly added up. Therefore staff could not easily identify if people were drinking enough fluid. We could not find records of action being taken when people were drinking insufficient fluids.

Care was not being planned to meet people's social needs. One person said "I get a bit bored, it's ok but not like home". We saw that one person was able to mobilise in a wheelchair. The person's 'communication' and 'social interests' care plans indicated that staff should encourage the person to get up, socialise and attend activities. The daily notes for the last week indicated that the person had stayed in bed for five out of seven days. On the day of our visit we spoke with this person, who was in bed. They told us "it gets a bit boring". Staff we spoke with said "sometimes [the person] doesn't want to get up".

Following our visit the provider sent us a copy of the activities log which indicated that activities had taken place for people on 14 days over a seven and a half week period. The listed activities consisted mostly of exercise, discussion, needle and craft work and quizzes. We saw that the person we had spoken to had participated in five of these activities. The person said "I'd love it if someone was taking me out in a chair, I'd be seeing different things". The limited number of activities meant that people were not always having their leisure and social needs met or receiving stimulation to ensure their positive wellbeing.

Fewcott House employed an occupational therapist (OT) for one hour, one day a week. We spoke with the OT who felt the home had a good philosophy; "It's nice here, they really do try and do their best for the residents". The OT told us they gave staff a weekly activity planner which had a theme. The OT felt staff found it hard to adhere to the planner, but said; "some do when they get a chance". The OT stated that the provider wanted to create "a philosophy where staff understand that activity is 24/7. Even getting dressed is an activity if it's meaningful". The OT showed us PALS (Pool Activity Level) assessments for each person and told us that they did these assessments alongside care workers to identify people's level of ability in a number of areas. These assessments were clear and up to date, but we did not observe them influencing the care plans. This was an example of where assessments had not always informed the planning and delivery of care.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. We were told that an assessment of staffing levels had been undertaken based on the needs of people using the service. The provider told us that they needed to have 2 nurses on each day shift supported by 1 senior carer, or 1 nurse supported by 2 senior carers with five care assistants in the morning and four care assistants in the afternoon. At night they needed to have 1 nurse supported by three care assistants.

We asked to see the staffing rota for the previous two weeks. We saw that the required number of nursing and senior staff had been present during 11 of the 14 days and that the required number of care assistants had been present on 13 of the 14 days. We saw that the required number of nursing and care staff had been present during every night shift.

Records indicated staff were delivering the care that had been planned. For example, where people were being nursed in bed and regular repositioning was required we could see that this was being done regularly the majority of time.

We observed there to be staff present in communal areas on the day of our visit. However, the provider may find it useful to note that the staff we observed were not always meaningfully engaged with people who used the service.

At the time of our visit Fewcott House had a vacancy for the position of activities coordinator. We were told that they were in the process of recruiting a person to fill the position.

Supporting workers ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not always cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

One person told us "the staff do their best, some nice ones have gone though". During our visit we paid particular attention to looking at support to nursing staff due to concerns that had been shared with us. We spoke with the two nurses on duty and looked at the training and supervision records for six nurses.

The provider did not have suitable arrangements in place to ensure that the nurses were appropriately supported in relation to their responsibilities. At the time of our visit the nursing staff told us that Fewcott House was understaffed in terms of nursing support and that there was "no clinical person" for the nurses "to turn to". We were told that it was Fewcott House's policy that all staff would receive supervision four times per year and an annual appraisal and that new staff would receive supervision more regularly. We looked at six nurses' files. Regular records of supervision were not present. Two files for longstanding employees did not contain any supervision records. We found that annual appraisals had not occurred regularly for the four nurses who had been in post for over a year; only two had received appraisals and these were in 2010 and 2011.

Where supervision had taken place we could see that training needs had been identified and addressed. For example, one supervision record from May 2013 identified that the staff member required training in medication. We saw from the training record that this member of staff had undertaken medication training in June 2013.

Fewcott House provided support to people with a range of needs including mental health, learning disability, physical disability and dementia. We looked at the training matrix for all staff employed at Fewcott House and could see that some staff had been provided with training in a range of topics. One nurse we spoke with said they still had some basic training outstanding and that specialist training was provided to depending on the needs of people who were moving to Fewcott House.

We looked at the training records which indicated that four out of six nurses had not undertaken infection control training and two had not undertaken safeguarding training.

This supported the comments of the nurses about basic training. We could see from the training matrix that 15 out of 28 care workers and nurses received training in relation to Parkinson's at the start of 2012; this also supported the comments of the nurse about specialist training. We were informed that a number of gaps in staff training had already been identified prior to our inspection, and that the provider was in the process of addressing these.

Assessing and monitoring the quality of service provision ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received. The provider did not have an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The provider did not have an effective system to fully assess and monitor the quality of the service that people received. The provider told us they had not requested any formal reporting from the manager of the home or clinical lead to inform their assessment of the quality of the service. The provider said "I'm here seven days a week. I can see. I speak to residents and family". We asked if there was an audit plan and we were told that the provider did not have oversight of the audit system that was in place.

There was a risk of people receiving poor care because of a lack of quality monitoring. For example, we could not find evidence that the food and fluid charts were being audited to ensure that people were drinking enough. We looked at do not attempt resuscitation (DNAR) forms held on people's files. We were told that a system of reviewing DNAR forms had not been in place previously. We saw that a number had not been correctly completed and often lacked information on the involvement of the person. There was a risk that treatment may not have been in line with the wishes of people or delivered in their best interests. We were told that the provider was currently undertaking a review of all DNAR forms held in people's files.

We found that the service lacked systems to ensure that decisions in relation to the provision of care were made appropriately. For example, we looked at the use of bed rails. This equipment can be used as a form of restraint and therefore comprehensive records about their use should be kept in accordance with the mental capacity act (MCA) good practice guidance. We could not find appropriate records in care files and also found that some staff lacked training in the MCA. We also found that monthly routine inspections of bed rails were not regularly recorded in line with Fewcott house policy. We were told that an audit of care plans had not been undertaken. Therefore the provider could not be assured that care plans and risk assessments were up to date and fit for purpose. We were told that a new care plan system was being introduced and that each person's care

plan would be reviewed and updated in the autumn.

There was no evidence that learning from incidents took place and appropriate changes had been implemented. For example, we looked at the accident and incident records. We found there had been lots of recorded falls. We asked if an audit of falls had been undertaken and what falls planning was in place. The provider told us that the clinical lead had undertaken a falls audit, but was not able to locate the audit or inform us of any action that had been taken as a result.

The provider did not have an appropriate system in place for monitoring the performance of staff in the home. We were told that the provider had been made aware of poor practice amongst staff by an external agency. This practice had not been identified by the internal monitoring system. The poor practice was being addressed by the provider at the time of our visit. We saw records of responses to complaints from the home manager. Responses acknowledged people's complaints and where appropriate provided an apology. However, it was not clear from the information supplied whether complaints had been taken account of to improve the service.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person had not taken proper steps to ensure that service users were protected against the risk of receiving care or treatment that was inappropriate or unsafe. The planning and delivery of care and treatment did not meet the service user's individual needs and did not ensure the welfare and safety of service users. Regulation 9 (1) (b) (i) and (ii)
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010** **Supporting workers**
	How the regulation was not being met: Staff were not always supported through appropriate training, supervision and appraisal to enable them to care for people using the service. Regulation 23 (1) (a)
Regulated activities	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
	How the regulation was not being met: The registered person had not protected people who used the service from inappropriate or unsafe care and treatment, by the means of an effective system to regularly assess and monitor the quality of the service. It was not evident that changes had been made to care as a result of analysis of incidents occurring at Fewcott House. Regulation 10 (1) (a) and (c) (i)

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 by 02 October 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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