Review of compliance

Four Seasons 2000 Ltd
Rosedale Manor Care Home

Region:	North West
Location address:	Sherbourne Road Crewe Cheshire CW1 4LB
Type of service:	Care home with nursing
Date the review was completed:	December 2010
Overview of the service:	Rosedale Manor is a two-storey purpose-built care home set in its own grounds.The home is in a residential area approximately one mile from Crewe town centre. It is close to local shops and other facilities and is convenient for public transport.The home is divided into three separate living units. On the ground floor, Willows unit provides accommodation for ten people with severe and enduring mental health needs, and Woodlands unit provides accommodation and nursing care for 24 people with dementia. The first floor of the home,

	provides nursing and personal care for 46 older people.

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

What we found overall

We found that Rosedale Manor was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out the 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:

- Care and welfare of people who use services
- Staffing

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 15 December 2010, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use services.

What people told us

People living at the home told us that the staff are caring and that they are well looked after and that their care needs are met. Throughout our visit we also saw staff responding to and meeting people's needs in a timely, caring and safe manner. For example, we saw staff support the people who live in the home to move about the home and to eat their breakfast. This support was offered in a respectful manner and ensured their privacy and dignity was being maintained.

What we found about the standards we reviewed and how well Rosedale Manor was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights

People who live in the home told us their care and welfare needs are being met and we observed this during our visit. However, some information to support how individual and specialist care needs are being met is not included or reflected in the care plans of people who live in the home. Also, the dementia unit has a strong smell of urine which is not pleasant or appropriate for the people who live there.

- Overall, we found that Rosedale Manor was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

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

On the day of our visit we saw staff responding to and meeting people's needs in a timely, caring and safe manner. We were also told by the home manager that the home employs enough staff to ensure the health, safety and well being of the people who live there is maintained. However, not all staff have received the training they need to support them carry out their roles effectively.

- Overall, we found that Rosedale Manor was meeting this essential standard but, to maintain this, we have suggested that some improvements are made.

Action we have asked the service to take

We have asked the provider to send us a report within 28 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.

Other information

Please see previous review reports for more information.

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 4:
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 4: Care and welfare of people who use services.

Our findings

What people who use the service experienced and told us
We received information that made us concerned about the care and welfare of people living in the home. Since August 2010 this has included information about three people living in the home who had falls, one resulting in a fracture, and information about four separate incidents residents of negative resident interaction. Additionally, we had information from the local authority about another person living in the home who had an unexplained fracture. The reason for the unexplained fracture was investigated by health and social care professionals and staff from the home. This identified that the person with the unexplained fracture had recieved some inadequate nursing and care planning. Actions for improvement were agreed between social services professionals and managers at the home.

During our visit on 15th December 2010 we spoke to six people who live at the home. Everyone told us that staff are caring and that they are well looked after and their care needs are being met. Throughout our visit we saw staff responding to and supporting people in a caring and safe manner. For example, the people we saw who needed help with moving were assisted, as they required, in a way that kept them and others safe. We also saw people being treated with respect and listened to. For example, we saw staff taking people to breakfast, addressing them by their preferred name and asking what they wanted to eat and where they would like to sit.

We saw comfortable visiting facilities and the people we spoke to who live in the home told us that they can have visitors anytime and that their families and friends are made welcome by staff and treated well.

The provider showed us the results of its November 2010 survey which included question to relatives about their relative's care. The results are positive and support what we observed during our visit. For example, 100% relatives said that staff listen and act on what they have to say and 100% of relatives said that residents received the care and support they needed.

Other evidence
During our visit we looked at the documented plans of care for three people living at the home. All three care plans were up-to-date and had been regularly reviewed in response to changes in the individual's care needs. We also saw evidence of co-ordination of care and treatment with other health and social care professionals. For example, district nurses and the local hospital.

Two of the people whose care plans we looked at have enduring and severe mental health needs. One of these care plans included a specialist mental health risk assessment designed to identify the specific care needs of people with mental health needs. We asked the home manager why this risk assessment had not been completed for both people and he told us that this is a new tool and that there are plans for it to be used for all people with severe mental health needs.

All of the three care plans we looked at showed how health care needs are planned and being met. However, none of them reflected how the person's wider needs are being met. For example, their cultural or religious needs. Also, none showed how the individual or their relative have been involved in planning their care.

One of the people whose care plans we looked at had been involved in two incidents involving negative interaction with other residents. We were aware of these incidents as the manager of the home had notified the Care Quality Commission of them through our statutory notification process in November 2010. We looked that this person's care plan to see if what had happened had been recorded and how the person's plan of care had changed as a result. We found that only one of the incidents was recorded in the care plan and that the plan of care did not reflect the changes in care that had been agreed for either incident. For example, that the individual required more frequent checking by staff. We asked to see evidence that the person had received more frequent checks and we were shown signed checklists showing increased observations had taken place following the incidents.

During our visit we noticed a very strong smell of urine in the dementia unit. This was also noticed and reported by the Cheshire East Local Involvement Network respresentatives who visited the home in May 2010. These are people who visit health and social care services to see what the services are like for the people who are using them. We questioned the home manager about action taken to remove the smell. He said that the action he had taken has not removed the smell, for example changing carpets.

Our judgement

People told us their care and welfare needs are being met and we observed this during our visit. However, some information to support how individual and specialist care needs are being met is not included or reflected in the care plans of people who live in the home. Also, the dementia unit has a strong smell of urine which is not pleasant or appropriate for the people who live there.

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 minor concerns with outcome 13: Staffing

Our findings

What people who use the service experienced and told us
We received information that made us concerned about the staffing of the home. Since August 2010, this has included information about three people living in the home who had falls, one resulting in a fracture, and information about four separate incidents of negative resident interaction. We were concerned whether these incidents had occurred due to insufficient staffing.

During our visit on 15th December 2010 we spoke to six people who live at the home. Everyone told us that staff are caring and that they are looked after well and their care needs are met. Throughout our visit we saw staff responding to and meeting people's needs in a timely, caring and safe manner.

Other evidence
The manager of the home was appointed in September 2010. Previously he had held the deputy manager position. At the end of November 2010 we were told by professionals from the the local authority that the deputy manager post was still vacant. They were concerned about the capacity of the new manager to undertake both his new and old roles at the same time. Additionally, we were informed that several new residents with enduring mental health needs were coming to the home due to the closure of another local home. We were concerned about the further burden this would place on the new manager.

During our visit the home manager told us that interviews for a deputy manager are taking place and that he expects this post to be filled at the beginning of 2011. He told us that how he had been managing his workload so that residents care, welfare and safety needs were prioritised.

We asked the home manager whether he was able to maintain adequate staffing levels. He told us that staffing numbers are based on a staffing model which is used to indicate the numbers and skills of staff required to staff the home appropriately. He said that the home has sufficient staff to meet these identified needs. When there are staff shortages at short notice, for example due to sickness, he said he is still able to meets these needs. For example, by moving staff around or calling extra staff in on their days off. We looked at the staffing rota for the week previous to our visit and the week of our visit. This showed that the number of staff on duty did meet the staffing numbers required by the home's staffing model.

During our visit we asked staff about the training they had received. Two members of staff said they had not had training in moving and handling. One said they had not had specific training in dementia care despite having worked on the dementia care unit for a year. We asked the home manager how he monitored the training of staff. He said that due to the recent pressures on his capacity he had not had time to monitor whether staff had undertaken mandatory training.

Our judgement
On the day of our visit we saw staff responding to and meeting people's needs in a timely, caring and safe manner. We were also told by the home manager that the home employs enough staff to ensure the health, safety and well being of the people who live there is maintained. However, not all staff have received the training they need to support them carry out their roles effectively.

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
Treatment of disease, disorder or injury Diagnostic or screening proceedures	9	4
	Why we have concerns: Some information to support how individual and specialist care needs are being met is not included or reflected in the care plans of people who live in the home.	
Accommodation for persons who require nursing or personal care.	9	4
	Why we have concerns: The dementia unit has a strong smell of urine which is not pleasant or appropriate for the people who live there.	
Treatment of disease, disorder or injury Diagnostic or screening proceedures	22	13
	Why we have concerns: We were not assured that all staff have had all the training they need to support them carry out their roles effectively.	

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 28 days of this report being received.

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 Adult 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
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Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA