Review of compliance

Stoneleigh Care Homes Limited Copperdown Residential Care Home	
Region:	West Midlands
Location address:	30 Church Street Rugeley Staffordshire WS15 2AH
Type of service:	Care home service without nursing
Date of Publication:	December 2011
Overview of the service:	Copperdown provides accommodation with personal care to 29 older people.

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

Our current overall judgement

Copperdown Residential Care Home 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, carried out a visit on 8 November 2011, looked at records of people who use services and talked to staff.

What people told us

People told us they were happy living at the home. They said they got on with the staff. Comments included, "They are lovely and caring", and "They make it like home".

People said they had their health and personal care needs met. They saw the doctor when they were ill. The optician, dentist and chiropodist visited them at the home. Staff knew about people's needs and treated people in a respectful way.

The staff organised social activities for people to do in the home. These included gentle exercise, musical entertainment and board games. There were no arrangements for the home to take people out of the home for activities or social events.

Each person had a plan of care but these were very limited and did not include all areas of need and did not show how people liked their care providing. Records were not in place to show that people's needs and any risks were being assessed or monitored.

What we found about the standards we reviewed and how well Copperdown Residential Care Home was meeting them

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

People who live at the home are having their needs met.

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

People cannot be confident that any abuse will be be acted on appropriately and people may not always have their rights upheld.

Outcome 09: People should be given the medicines they need when they need them, and in a safe way

People were receiving their medication as prescribed.

Outcome 21: People's personal records, including medical records, should be accurate and kept safe and confidential

The absence of up to date and proper records is not protecting people from the risk of unsafe or inappropriate care.

Actions we have asked the service to take

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found
for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

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 spoke to ten people living at the home. People told us they were happy living at the home. They said that they had their health and personal care needs met. Comments about the care included, "jolly good" and "I am quite happy [with the care]". We observed that people were suitably dressed and had their hair and nails attended to. People were supported to make choices. People said they chose where they spent their time and some people said they chose to eat their breakfast in their bedrooms. A staff member explained to us how she helped people to choose what they wanted to wear. Staff also said that people could choose if they wanted to take part in activities. We observed that there was only one meal served at lunchtime and that people were only offered an alternative if they did not like the meal on offer. People told us they liked the meals and that there were several choices at breakfast and tea.

People were treated with respect. We observed staff speaking in a friendly and caring manner. We saw staff encouraging and supporting people appropriately. Staff told us that they always sought people's permission before undertaking tasks and made sure that personal care was done discreetly.

We looked in detail at the care three people received. Care plans and records were very limited and did not cover all areas of need and did not give staff information on how to provide care in the way people wanted. We also observed that there was a lack of recorded ongoing assessments. There was a generalised risk assessment but no written evidence of individual risks being assessed.

One person we looked at had needs relating to dementia. We observed that staff responded appropriately and when we spoke to staff they were aware of their previous lifestyle and history. A staff member told us how they communicated and supported them by speaking with their family and by using cards and pictures. We observed that this person appeared to be quite settled and we saw staff speaking with them. We also saw one staff member singing to them. The person recognised the song and joined in happily.

We saw that people received medical support. The GP visited regularly, district nurses were involved to support people and a community psychiatric nurse was visiting to provide advice and support. This was confirmed by people we spoke to. Records confirmed that people were weighed monthly and any significant changes addressed.

There was evidence that the home provided activities. These included movement to music, dominoes and skittles as well as a visiting entertainer approximately once a month. A church service occurred monthly. People told us that they took part in exercises and had their hair done. One person said they would like to go out but this was not possible. The manager told us that currently there was no provision for people to go out unless with their relatives.

Other evidence
We spoke to all of the care staff on duty. They were aware of people's needs and knew the people as individuals. For example we asked about one person's continence needs and although there was no recorded information staff knew the support they needed. Additionally although no manual handling plans were in place staff could describe how this was done and we observed it being done correctly. We discussed with staff about pressure care and the deputy described people's pressure relieving equipment and how staff monitored people's skin on a daily basis. Staff we spoke to were aware of people's previous lifestyle and about the important people in their lives.

We spoke to the local authority about the home and they had not received any concerns about the care provided. We also spoke to a mental health professional who said that the service was very proactive in referring issues they found difficult to manage and acted on advice they gave. They found the home good at meeting routine care issues but did need support in dealing with more complex issues. They felt that staff were caring and got to know the people they were supporting. Another health professional told us that they had a good working relationship with the home. The staff referred health issues appropriately and acted upon any recommendations they made. They also confirmed that the service monitored people's weight and their nutrition. They also said that if they every had any concerns they would discuss them with the manager and were confident that she would address them. They felt that the staff were caring.

Our judgement
People who live at the home are having their needs met.

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

There are moderate concerns with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People said they got on well with the staff and found them caring.

Other evidence
Training records showed that some staff had received safeguarding training in 2009 and staff employed since then had not received any training. We spoke to some staff and they were not clear over safeguarding issues although were clear of their responsibility to make sure people were kept safe. Not all staff were aware of the home's whistle blowing procedures although one staff we spoke to was clear that she would report any concerns she had to senior staff.

We spoke to the manager and she was not fully aware of the safeguarding referral process. The home had its own safeguarding procedures but did not have a copy of the interagency procedures.

We checked a sample of people's money to check that the home was safeguarding people's money. The records corresponded with the money held and the manager confirmed that receipts were always obtained when money was spent.

Staff told us that some restrictions were in place to keep people safe. The manager told us that the people were in agreement but there was no evidence to show they had agreed or that discussions had taken place. We have told the manager to look at these issues and to tell us the actions they have taken. We have since been informed that the service has taken action to address these issues.

Our judgement
People cannot be confident that any abuse will be be acted on appropriately and people may not always have their rights upheld.

Outcome 09:
Management of medicines

What the outcome says

This is what people who use services should expect.

People who use services:
* Will have their medicines at the times they need them, and in a safe way.
* Wherever possible will have information about the medicine being prescribed made available to them or others acting on their behalf.

What we found

Our judgement

The provider is compliant with Outcome 09: Management of medicines

Our findings

What people who use the service experienced and told us
We did not ask people about this outcome area.

We checked the medication of the three people we looked at in detail. Records confirmed that people were having their medication as prescribed. One person had recently been prescribed an antibiotic and we saw that this was recorded on the medication administration sheet and had been given. We saw that medication was stored correctly, including checking the temperature it was stored at. Medication was checked on receipt and each person's medication was kept separately. Medication administration sheets were fully recorded with explanations when medication was not given.

Other evidence
Training records confirmed staff were trained in medication. We saw that there was a monthly audit of medication arrangements.

Our judgement
People were receiving their medication as prescribed.

Outcome 21:
Records

What the outcome says

This is what people who use services should expect.

People who use services can be confident that:
* Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
* Other records required to be kept to protect their safety and well being are maintained and held securely where required.

What we found

Our judgement

There are major concerns with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not ask people about this outcome area.

Other evidence
We observed that records were kept securely in the office. People's records we looked at were not up to date and did not contain the information needed to make sure that people were protected against the risks of unsafe and appropriate care. One record we saw stated that the person had been referred to the district nurse for continence support but the plan of care had not been updated to show the outcome of this. We also saw that another person had been referred for a follow up eye test but the records did not evidence the outcome of this.

As identified in outcome four there were no records of the assessments and ongoing evaluations of such areas as nutrition, continence and moving people safely. There were also no written records of assessments and plans to manage the risks to people. For example some people were identified as being at a high risk of falls but there were no comprehensive fall assessments and no plans in place. Similarly some people were using bedrails but there were no written assessments to identify such a need and to identify that their use was appropriate to meet people's needs and to keep them safe.

We raised the absence of records with senior staff of the home and they told us that information about people's care needs was provided to care workers verbally.

We saw that there were monthly reviews of care but these did not contain information about the care people had received. There were limited daily records being completed and therefore they did not give a daily account of the care people received to help plan their future needs. There were no records to confirm that discussions had taken place with people over their care needs.

The home maintained a record of accidents including falls but was not completing the legally required accident forms appropriately. We also saw that the home was not completing notifications required by the commission.

Our judgement
The absence of up to date and proper records is not protecting people from the risk of unsafe or inappropriate care.

Action
we have asked the provider to take

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 11 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 07: Safeguarding people who use services from abuse
	How the regulation is not being met: People cannot be confident that any abuse will be be acted on appropriately and people may not always have their rights upheld.	
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 21: Records
	How the regulation is not being met: The absence of up to date and proper records was not protecting people from the risk of unsafe or inappropriate care.	

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 14 days of the date that the final review of compliance report is sent to them.

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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