Inspection Report

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

Rotherlea

Dawtry Road, Petworth, GU28 0EA

Tel: 01798345940

Date of Inspection: 14 November 2013

Date of Publication: December 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✗ Action needed
Management of medicines	✗ Action needed
Staffing	✗ Action needed
Complaints	✓ Met this standard

Details about this location

Registered Provider	Shaw Healthcare Limited
Registered Manager	Mrs. Deborah Embleton
Overview of the service	Rotherlea provides accommodation and personal care for up to 70 older people. At the time of our visit, there were 61 people in residence.
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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 November 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

We spoke with 13 people during our visit. Most people told us that they were very satisfied with the service. One said, "You can't beat this place". Another told us, "The carers we have are really lovely".

We spoke with five relatives. They had mixed experiences of the service. One said, "The whole place is just very nice. The atmosphere is good, the carers are very helpful, caring and approachable". Another told us, "They're lovely but I don't think they've got time to care".

We spoke with eight carers, three team leaders and the manager. Staff told us that they enjoyed working in the home. One said, "I love it, it's the best job ever". Many told us, however, that they were finding it increasingly difficult to meet people's needs with the number of staff they had on shift.

We found that people were happy in the home. People's rights with regard to consent were being promoted by the service and staff understood how people's capacity should be considered. People told us that they could approach the staff and manager if they were unhappy or had ideas to discuss.

We found, however, that there were not enough staff in all parts of the home to ensure people's safety and welfare at all times. Where risks had been identified support plans were not always in place or followed. We observed some dangerous moving and handling practice and found that prescribed creams were not properly managed.

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 11 January 2014, 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

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We observed that staff involved people in making decisions and offered support rather than simply delivering the necessary care. For example, we heard a member of staff asking one person if they felt that they needed an 'as required' (PRN) medicine. Another person told us that they preferred to be supported by male care staff. They told us that this was respected.

People that we spoke with told us that they felt involved in their care. One said, "It's good because you can do as you like, they don't force you to do anything. I get up when I like and you can have what you fancy when you want it". Another told us, "I can always have a bath; they ask you what you want". Staff that we spoke with said that they took time to speak with people and to check that they were in agreement. One told us, "If they decline then they decline, you can't make them. I'd try again a bit later or see if they'd like help from someone else". We found that people's wishes were respected.

We noted that the home had involved people and, where they wanted, their relatives in advanced care planning discussions. This is where people state their preferences regarding the type of care they would wish to receive, and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future. Some people had expressed their wishes with regard to hospitalisation and 'Do not attempt cardiopulmonary resuscitation (DNACPR)' decisions. This information was clearly recorded and accessible.

The provider might like to note that some relatives told us that they were not always kept up to date with respect to GP or hospital appointments. They also told us that their relatives were not always consulted. One said, "They don't seem to tell X about appointments and she is razor sharp".

Where people did not have the capacity to consent, the provider acted in accordance with

legal requirements. Where people had a legal representative, for example a Lasting Power of Attorney, this was clearly recorded. We noted that mental capacity assessments had been carried out regarding specific areas of responsibility, such as people's ability to manage their own finances. We also saw the records of a best interest meeting that the home had called earlier in the year.

Staff training records confirmed that staff had attended training on the Mental Capacity Act 2005. Most staff that we spoke with had a good understanding of this legislation and how it applied in their day-to-day work. The manager demonstrated a clear understanding of her obligations with respect to people's rights and choices when they appeared to lack the capacity to make a particular decision.

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 always planned and delivered in a way that ensured 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

People's needs were assessed but care and treatment was not always delivered in line with their individual care plan. We examined the care plans of four people. We found that detailed assessments had been completed and that individual support plans were in place. These were in areas such as communication, breathing, and pain management. They provided clear details for staff to follow in order to meet people's needs. Staff that we spoke with told us that the care plans were helpful. One said, "The care plans are very easy to read and to understand what people need".

We noted examples of people who had been referred to and treated by external health professionals, such as a GP, District Nurse or Dietician. We saw that the advice from these professionals had been incorporated into the care plan. This demonstrated that the home worked in partnership with other professionals to ensure that people's needs were met.

We saw that monthly monitoring was in place, for example most people were weighed on a regular basis and the home used the Malnutrition Universal Screening Tool (MUST) to identify those who might be at risk from weight loss. We found, however, that where specific risks had been identified the support plan was not always followed. For example, one person had been identified as at risk from weight loss and dehydration. They had been put on a daily food and fluid chart. The charts had not been completed in full. Furthermore, the fluid charts had not been totalled to show the overall intake and output. The charts were not being used effectively which meant that the person was at risk of not having received sufficient food or fluids.

We found that, where people had been assessed as at high risk of falling, there were not always appropriate arrangements in place to keep them safe. In the downstairs part of the home 11 of the 28 people had been assessed as at high risk of falling. Prior to our visit we had received notifications from the home of a number of falls resulting in serious injury. Whilst the risk of people falling had been identified there was a lack of individual care planning in place to monitor and keep them safe.

Care and treatment was not always delivered in a way that ensured people's safety and welfare. During our visit we observed four occasions were people were moved in wheelchairs without the footplates in situ. On one occasion the wheelchair did not have any footplates available to use. A member of staff that we asked about this said, "Usually I wouldn't use it without the footplates because it is so unsafe". The manager told us that there was no reason for this practice and that it was unacceptable.

We saw that assessments had been carried out where people required the aid of a hoist to transfer. This included information on the size of sling that was required. We found, however, that some people had to share slings. This was because the home did not have a sufficient quantity of the necessary sizes. For one of the full body hoists, used by two people, there were three slings of different sizes but both people required the medium. The minutes of the October residents' and relatives' meeting stated, 'Slings that are used for residents, should be for each individual but they are too expensive to purchase in one go'. The provider had not ensured that they could meet people's assessed needs and ensure the safe delivery of care in this area.

The downstairs part of the home specialised in looking after people with dementia care needs. We observed sensitive interactions between staff and the people they were supporting. One person was worried as they didn't know where to go. We saw that the member of staff recognised the person's needs. They spoke with the person in a way that would have made them feel valued and listened to. We saw that the person became less anxious and was happy to sit down.

The environment reflected attention to detail in respect for the needs of people with dementia. It was interactive and visually stimulating with memorabilia and good signage. We noted that where possible this signage was personalised. For example there were story boxes on people's bedroom doors and on the en-suite bathrooms was written, 'X's toilet'. The doors on the floor were open so people could move around freely.

During our visit, people were engaged in activities. One person told us that they helped the staff with some tasks. They told us, "It makes you feel good". The home had two members of staff dedicated to providing activities. We noted that there was a weekly activities programme that included preparation for monthly themed meals, dedicated to a particular country. Outside there were raised beds where organic vegetables were grown and a pet rabbit. Most people told us that they had plenty to do in the home. One said, "It's very nice here, I always get involved in things like needlework and cooking". One person who did not have any friends of relatives living locally told us that they would like to go out more.

People that we spoke with were generally very satisfied with the care and support that they received. One said, "They just know to give me the things that I like". Another told us, "I can ask for help if I need it and they're all helpful and good workers".

Management of medicines ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Current practices did not ensure that prescribed creams were appropriately administered or recorded.

We have judged that this has a minor 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

Medicines were handled appropriately. Medicines were administered by the team leaders on duty. Where controlled drugs had been prescribed these were checked and administered by two members of staff.

Medicines were kept safely. Medicines were stored in locked trolleys, one for each of the seven units. These were then stored in a locked medicines room on each floor. The team leaders on duty held the keys to these rooms. This ensured that access to medication was managed appropriately. Some medicines were stored in dedicated fridges. The room temperature and the temperature of the fridge were checked daily to ensure that medicines were stored at the right temperature. Controlled drugs were stored separately and securely. Checks of the stock levels found these were correct and matched the records.

Medicines were prescribed and given to people appropriately. People that we spoke with were satisfied with the way that they received their medication. We observed part of the medication round during the morning. We saw that the member of staff provided information to people about their medication. We saw that people were offered a choice of drink and that the member of staff made sure that the person was comfortable before they left.

We saw that records identified when medication should be given on an 'as required' basis (PRN). For each medication a PRN protocol was in place. This provided information on what the medication was for and the circumstances in which it should be given. In most cases, staff had completed the notes section with an explanation. For example we read, 'One paracetamol given as requested' and, 'Unable to give paracetamol as too close to dose'.

We found an example of where medication was covertly administered. This had been authorised by the GP. The instruction was kept with the Medication Administration Record (MAR) on file.

We looked at the MAR charts for two units, one from each floor. They were up to date and provided evidence that people had been given medication as prescribed. Any gaps were clearly noted using an appropriate code. Where medication was given on a PRN basis, for example for pain relief, we saw that this was recorded, along with the dose given. Where a person had refused medication this was clearly marked.

There were not appropriate arrangements in place for the administration or recording of prescribed creams. We noted on the MAR charts that prescribed creams, such as steroid creams, were noted as, 'Applied by support staff'. In people's bedrooms we saw that there was usually a body map on the bathroom door. This showed where on the body each cream should be administered. We found that this did not always include all the creams that a person was prescribed. We also found one prescribed cream that had expired in May 2013. The team leader removed this immediately. On the tubes of a further two creams, the name of the person it had been prescribed for was no longer visible.

We were shown the separate MAR charts that were kept in each unit. These had not been routinely completed. There were a large number of gaps without any supporting explanation. Furthermore, for one person we found that there was no chart for the month of November. A member of staff told us that they used the daily notes to record when creams were administered. We found some instances where, 'Applied all creams' had been noted but no regular record. When we looked at the provider's policy it stated that, 'A photocopy of the relevant MAR sheet is to be attached to the treatment chart in the service user's room'. This was not in place.

Staffing ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

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 two floors of the home had their own staffing requirements. These had been determined by the provider on the basis of dependency studies. During the day the upstairs 40-bed residential floor was staffed by six carers and a team leader. This had been reviewed in February 2013 and was deemed to be sufficient to meet people's needs. The downstairs floor which looked after up to 30 people with dementia care needs was staffed by five carers and a team leader. This staffing level was last reviewed in September 2011. At night the home was staffed by four carers upstairs, three downstairs and a team leader covering the home.

We asked the manager how the dependency study was reviewed and whether the staffing level was ever amended in response to changes in people's needs. She told us that the staffing level was fixed.

People that we spoke with told us that that the staff worked very hard but that there were sometimes not enough of them. One said, "They work at lot, they don't stop! They're terribly short of staff". One person living upstairs told us, "You can't get down to the garden as you have to wait for a carer". Another said, "There's nobody here at times, and if you need the toilet you have to wait."

We noted that staffing levels had been raised at a recent residents' and relatives' meeting. Relatives told us that they found it hard to catch staff if they wanted to speak with them. One said, "They're very good and they do their best but they haven't got time to deal with any care issues. They are rushed off their feet". Another told us, "I wanted to check but the team leader was doing the drugs round and I couldn't see any other staff".

Staff that we spoke with told us that they had a good team. They told us that they were particularly stretched downstairs. One said, "We've got too many high dependencies down here". The team leader told us that there were currently 28 people living in downstairs part of the home. Of these 28 people, 16 required the support of two members of staff for all transfers and 11 had been assessed as at high risk of falling. We found that the six staff on duty were unable to attend to people's personal care needs and ensure the safety of

people living in that part of the home.

We noted that the home was recruiting. The manager told us that they had 500 carer hours and 58 team leader hours to fill. We saw that steps had been taken to recruit new staff. This included advertisements in local papers, two forthcoming recruitment open days and promoting the provider's 'Refer a friend' scheme to staff.

We looked at the staff rotas for the previous two weeks. We noted that temporary staff had been employed in order to meet the shortfall. Over this period, temporary staff had been used on all but two days. We saw that there were particularly high numbers of temporary staff at evenings and weekends. For example, on one Saturday in November more than half of the carers on duty were temporary. On one night shift, five of the seven carers had been temporary members of staff.

Staff that we spoke with told us that this presented a challenge. They told us that where possible the home used the same members of temporary staff. This ensured some continuity but they told us it was still difficult to meet people's needs. One said, "It's really hard work when we have agency staff, they can really only stand there and let you get on with it. We just carry them to be honest". Another said, "If we don't have enough of our own staff on shift it can get very hard".

From our observations on the day of the inspection and from talking with staff, people who used the service and relatives, we found that there were not enough staff to safeguard the health, safety and welfare of people in all parts of the home at all times. This was exacerbated by the fact that the home had a number of vacancies to fill meaning that a significant proportion of shifts were covered by temporary staff who were not always familiar with people's needs.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available.

Reasons for our judgement

People were made aware of the complaints system. We saw that the complaints procedure was displayed in various places throughout the home. People told us that they felt safe and that they could express concerns to any of the staff they knew. One said, "I've not had any problems, we can talk to them you see". Another said, "If I wasn't happy I'd speak to the staff before I complain". Staff that we spoke with were able to explain how they would respond to a complaint.

People were given support by the provider to make a comment or complain where they needed assistance. The home invited feedback in a number of ways, including via a suggestions box. They also held residents' and relatives' meetings. The minutes were readily available on noticeboards in the home. Relatives told us that they also received copies.

People's complaints were fully investigated and resolved where possible to their satisfaction. We looked at the home's complaints log. We found that the few formal complaints received had been investigated and resolved.

The provider might like to note that some relatives expressed that they were not fully satisfied with the way that informal complaints were handled. One said, "You never get an answer". The concerns of the relatives that we spoke with during and after our visit, centred on staffing levels and issues with laundry going missing or being damaged in the wash.

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 activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The provider had not protected people against the risks of unsafe care and treatment by identifying, assessing and managing risks relating to their health, welfare and safety. Regulation 9 (1) (b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage all medicines. Current practices did not ensure that all medication had been recorded or safely administered. Regulation 13

This section is primarily information for the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not sufficient numbers of suitably qualified, skilled and experienced persons employed to safeguard the health, safety and welfare of people at all times. Regulation 22

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 11 January 2014.

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.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk