Review of compliance

TAS CareLimited Rose Cottage Nursing Home	
Region:	South West
Location address:	47 High Street Haydon Wick Swindon Wiltshire SN25 1HU
Type of service:	Care home service with nursing
Date of Publication:	August 2012
Overview of the service:	Rose Cottage Nursing Home provides care and accommodation to up to 18 older people. There are 16 single rooms and one shared room.

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

Our current overall judgement

Rose Cottage Nursing Home was meeting all the essential standards of quality and safety inspected.

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 23 July 2012, observed how people were being cared for, talked to staff and talked to people who use services.

What people told us

We spoke with three people who gave us detailed information about the care they received. They all were very complimentary about the care and the staff in the home. They told us that they trusted the staff and were treated respectfully. One person said "I can't praise the staff highly enough and they provide me with exactly what care I need".

What we found about the standards we reviewed and how well Rose Cottage Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Overall people who lived at Rose Cottage had their dignity and independence respected and had opportunities to give their views about the care they received.

Rose Cottage was meeting this essential standard.

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

People experienced care, treatment and support that met their needs and protected their rights.

Rose Cottage was meeting this essential standard.

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

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Rose cottage was meeting this essential standard.

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

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

Rose Cottage was meeting this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The provider had an effective system regularly to assess and monitor the quality of service that people received.

Rose Cottage was meeting this essential standard.

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

Records were well-kept so that people were protected from the risks of unsafe or inappropriate care and treatment.

Rose Cottage was meeting this essential standard.

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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People told us they felt that they had as much information as they needed about the service. One resident was very appreciative of the staff supporting them on their regular visits to hospital for treatment. They said the staff took time explaining what was said by the Doctor and what it would mean for them. Another person enjoyed being taken out regularly to places they chose to visit. All the people we spoke with said that they trusted the staff and they were treated respectfully

Each person had their own room and had brought small personal items when they moved in. We saw that the rooms were clean and tidy. Two people told us that they chose to spend time alone in their rooms. We saw that other people liked to spend time with others in the lounge.

Two relatives commented that they thought the home was very good at maintaining people's dignity and independence. They said that the staff were very courteous, good at listening and then acting upon their comments about the care.

We saw several occasions when the manager and staff enhanced people's self-esteem by greeting them and complimenting them, for example, on their appearance.

Other evidence
People who lived at Rose cottage understood the care and treatment choices available to them. The manager told us that they gave people a brochure and Statement of Purpose when they were interested in moving into the home. We saw a copy of the brochure which gave people information about the service so that they knew what to expect.

People expressed their views and were involved in making decisions about their care and treatment. We observed staff asking people whether they wanted assistance or wanted a drink. We saw staff explaining what was going to happen to someone who needed assistance with a hoist. The manager told us that there was a residents' and relatives' meeting about every three months and we saw minutes of these meetings. We saw that the manager had been sharing developments in the home with people and relatives and information about changes to activities. People had opportunities to ask questions and make suggestions and comments. There was also an annual survey so that people and their relatives could give their views.

We were concerned at the last inspection because there was limited information about people's individual circumstances. This made it difficult to provide support in a person centred way. The manager told us that they were changing the care planning records to a new more person centred system. We saw several new style care plans which contained detailed information about people's individual circumstances so that their needs would be met. We saw information in these care plans about how to maintain people's dignity and promote their independence.

Our judgement
Overall people who lived at Rose Cottage had their dignity and independence respected and had opportunities to give their views about the care they received.

Rose Cottage was meeting this essential standard.

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
People had new detailed care plans. These provided information to show how people had been involved in developing the plans and included quotations from each person.

Other evidence
We looked at four new style care plans. We saw that peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. The plans were very detailed and were written in a person centred way with the life history of each person. Each person had a person centred assessment which focused on their physical, social, emotional and healthcare needs.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. People also had a series of risk assessments including the risk of developing pressure areas, falls, fractures and staying safe. There were also risk assessments for the use of bed rails, moving around and nutrition. Records were also kept of weight to make sure people maintained a healthy weight. Where a risk or need was identified a care plan was developed to manage that risk or need.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. People's individual and diverse needs were recorded in their care plans for example in relation to religion and disability so that their needs would be met. One person had a visual impairment and their care plan recorded the action needed to support them to be independent.

The Deprivation of Liberty Safeguards would only be used when it was considered to be in the person's best interest. No one had been subject to a Deprivation of Liberty Safeguard. The staff we spoke with knew the procedure to follow should this become necessary.

Our judgement
People experienced care, treatment and support that met their needs and protected their rights.

Rose Cottage was meeting this essential standard.

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

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
The people we spoke with said that they trusted the staff and felt they were treated respectfully. Staff showed respect for people by responding to them in a calm, friendly but polite way.

Other evidence
People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. We saw that there was information about "No Secrets" and the Swindon Borough Council safeguarding adults procedure. We also saw a training plan that showed that there had been safeguarding training for staff in April 2012 and more training was planned in September 2012.

We spoke with staff about their understanding of their safeguarding responsibilities. They described how they would recognise signs of neglect, unintended harm or abuse. They told us that they were alert to any signs of distress because they got to know the people, they cared for, well. They said that they would not hesitate to report any concerns about people's safety. They also told us that they had received training in safeguarding but not all staff had received recent refresher training. However, more training was planned.

People who use the service were protected against the risk of unlawful or excessive control or restraint because the provider had made suitable arrangements. There were risk assessments about the use of bed rails and people had consented to these.

People were not subject to any other forms of restraint.

Our judgement
People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Rose cottage was meeting this essential standard.

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

The provider is compliant with Outcome 13: Staffing

Our findings

What people who use the service experienced and told us
The people we spoke with were very complimentary about the care and the staff in the home. They said that they thought there were always enough staff on duty to meet their needs. We saw staff responding to people's needs, encouraging them to do things for themselves and assisting people when they needed more support.

Other evidence
We spoke with four staff, one registered nurse, 2 care workers and, 1 bank care worker. All said that they felt very supported by the home owner, with good training opportunities provided, regular supervision and enough staff on duty at all times to provide good care to people. They also commented that changes to people's care or condition were communicated well at handover, and in person by the home owner.

Staff had opportunities to develop the skills they needed to support people. All the permanent staff we spoke with said that they had undertaken a comprehensive induction with mandatory training in all relevant areas. They showed a good knowledge of the residents and the type of care they required. The bank care worker had training scheduled for later in the week of the inspection. The nurse was about to attend a 3 month distance learning course about dementia care that included protected study time each week. We saw a computer based training matrix that showed the range of training the staff had completed.

We were concerned at our last inspection because the way staff were deployed was affecting the quality of support people were receiving. We looked at the staff rota. This

showed that there was a qualified nurse working at all times of the day. During the morning there was a nurse and three care staff and in the afternoons and evenings there was a nurse and two care staff. At night there was one nurse and one member of care staff. There was one extra member of staff between 7 am and 8 am.

The owner, who was also the manager, told us that he had made changes to the way the staff were deployed. He had replaced the previous registered manager. He had also allocated the care staff to particular tasks and areas of the home so that their work was more focused. For example, at lunchtime he had allocated staff to help people eat their meals in the dining room. One member of staff was helping people to eat their meals in their rooms upstairs and another member of staff was helping people to eat their meals in their rooms downstairs.

We observed care over the lunchtime period. We saw three members of staff assisting three people in the dining room. The staff were sitting next to the people, encouraging them and assisting them to eat their meals at their own pace.

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

Rose Cottage was meeting this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
Two relatives told us that they had attended a residents' and carers' meeting. They thought that the level of information received from the home was appropriate and they felt fully informed about changes to care and treatment. They commented that the home owner was good at listening and responding to people's queries.

Other evidence
People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. There had been a survey in March 2012 of residents' and relatives' views. There were also residents' and relatives' meetings. The manager told us that he planned to share the findings from the survey at the next meeting. The survey had identified some improvements needed to the environment such as changing three carpets.

There was a log of complaints but there had been no recent complaints to indicate improvements needed. However the provider took account of people's comments to improve the service.

The registered person had systems to assess and monitor the quality of the services provided. There were regular audits of medication, the environment, risk assessments, the kitchen, care plans, maintenance, nutrition, pressure sores and cash and property. We saw records of these. There had also been an audit of medication by the pharmacist. People had individual risk assessments and the audits of people's rooms included environmental risk assessments. Portable appliances were tested. There was

a fire risk assessment and we saw records of fire safety checks.

We were concerned at the last inspection that there were aspects of the environment that were not being well monitored. Some improvements had been made to the environment and further improvements had been identified from the annual survey. The environmental audits made sure that the quality of the environment was being monitored.

The manager told us that he discussed accidents and incidents and any learning points with the staff. However there was nothing formally recorded about this. When we spoke with staff they talked about learning from individual incidents that occurred.

Our judgement
The provider had an effective system regularly to assess and monitor the quality of service that people received.

Rose Cottage was meeting this essential standard.

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

The provider is compliant with Outcome 21: Records

Our findings

What people who use the service experienced and told us
We did not speak with people about their records. However, we saw a new system of care planning. The plans included people's views and showed how people had been involved in developing them.

Other evidence
We made a compliance action at the last inspection because the right information was not being recorded to make sure that people's rights and interests were protected.

On this occasion we found that people's personal records were accurate and fit for purpose. There was a new system of care planning and most people had a new style care plan. These included people's needs, likes and dislikes and personal histories. They reflected people's views about how they liked to be supported. Each person has an assessment of capacity by the GP. People with capacity signed their own records and people without capacity had identified a person to make decisions on their behalf. One person had a copy of their enduring power of attorney.

There had also been concerns about poor record-keeping in relation to people who needed their fluid intake monitoring or who had pressure sores. There was only one person who had a pressure ulcer and they had a record of changes of position and fluid intake.

At our previous inspection we found shortcomings in the recording of staff recruitment checks. During this inspection we found staff records and other records relevant to the management of services were accurate and fit for purpose. We checked three staff recruitment files. These showed that each member of staff had had two written references, a Criminal Records Bureau (CRB) check and Independent Safeguarding Authority (ISA) check before they started work. Nurses had a check of their personal identification number (PIN). Each member of staff had a copy of their passport or driving licence as proof of identity. There were also copies of certificates of training and qualifications.

We saw that each member of staff had a copy of their supervision records. There was a training matrix which recorded the training that staff had planned and received. We saw records of audits and fire safety checks. Records were kept securely in the office and could be found promptly when needed.

Our judgement
Records were well-kept so that people were protected from the risks of unsafe or inappropriate care and treatment.

Rose Cottage was meeting this essential standard.

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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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

Document purpose	Review of compliance report
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