Review of compliance

Countrywide Care Homes Limited Manor Park Care Home	
Region:	Yorkshire & Humberside
Location address:	Leeds Road Cutsyke Castleford West Yorkshire WF10 5HA
Type of service:	Care home service with nursing
Date of Publication:	June 2012
Overview of the service:	Manor Park is a care home that provides both residential and nursing care. There are three separate units within the home that are divided into nursing care residents, residential care residents and accommodation for people with dementia.

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

Our current overall judgement

Manor Park Care Home was not meeting one or more essential standards. Action is 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 because concerns were identified in relation to:

Outcome 04 - Care and welfare of people who use services
Outcome 08 - Cleanliness and infection control
Outcome 21 - Records

How we carried out this review

We reviewed all the information we hold about this provider.

What people told us

We spoke to people who use the service and relatives as part of this inspection. They told us that the staff are 'excellent' and that they feel the home is clean and that they like the food that is provided. People told us that staff did not always have time to stop and talk to people as they were very busy.

What we found about the standards we reviewed and how well Manor Park Care Home was meeting them

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

The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. This is because we found that people identified by staff during the visit as being in need of management in relation to their fluid intake were not being monitored or managed appropriately.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection

People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

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

Staff records and other records relevant to the management of the services were accurate and fit for purpose.

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. We will check to make sure that this action has been taken.

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.

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 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 non-compliant with Outcome 04: Care and welfare of people who use services. We have judged that this has a moderate impact on people who use the service.

Our findings

What people who use the service experienced and told us
We spoke to one person who uses the service and also to two relatives of service users.

We were told that the care staff are 'excellent' and that people who cannot 'speak for themselves or look after themselves' get 'extra help and attention' and that 'the staff are lovely to them.

We were told that in one instance a person developed a small pressure sore and that since that time (over 6 months ago) they have been turned every 4 hours and that this has been undertaken diligently every night ever since the sore healed. We were also told that people get their medication on time and that doses are never missed.

We were told that the food is 'very good' and that people are now offered additional drinks at 'mid- morning' and also in bed at 9pm.

People we spoke to said that the staff were rushed which meant that they didn't feel they had enough time to stop and talk to people. We were also told that there is only one type of each hoist which meant that sometimes people had to wait too long when they needed to be moved.

We reviewed 6 satisfaction survey questionnaires from March 2012. We found that all the responses were positive. 3 responses were from relatives and 3 from people who

use the service. One response commented that 'staff supervision of the lounge is now very good and is covered at all times'.

Other evidence
As part of this inspection we reviewed the care plans of two people who use the service on the nursing unit and also the bedside record of another person.

We found that handover records were thorough and detailed and that they detailed issues for staff to take note of such as 'TVN input' (tissue viability nurse). Bedside records we reviewed showed that care staff diligently recorded bed rail checks and nutrition records, although we found that fluid intake was not always noted. bedside hygiene charts also showed each day that a change of clothing had taken place and that washing had been undertaken by care staff.

Of the care plans we reviewed on person had a 'do not resuscitate' order in place and this was detailed as agreed with the individual concerned, signed and dated by a GP and reviewed in January 2012. In both of the peoples records we reviewed care plans for bed rails and pressure care were in place including consent forms and monthly waterlow scoring respectively. More generally care plans were found to be detailed and were reviewed monthly.

Daily care records were found to be well maintained, with an entry maintained on most occasions reviewed 3 times each day.

When we spoke to the nurse she explained that the person whose care record we were reviewing was being closely monitored as they were not taking on enough fluids. Despite this we found no record of there being an issue with fluid intake in any care plans, not was there any indication of what level of fluid intake should be expected. It was also the case that fluid intake was not being recorded regularly and on some days indicated that very little fluid was being taken at all. Despite this there is no record of any escalation or action to address the low levels of fluid intake. The service user had recently had a urinary tract infection which would suggest closer monitoring of fluid intake is important but is not being done. This was also found to be the case for the second person whose records we reviewed. The nurse we spoke to stated that fluid balance charts were being maintained for these people, however on further investigation these could not be located and we were told by a member of staff that these had been discontinued.

We found that one of the care plans for pressure care was very detailed and person centred. It included a body map and wound assessment when the pressure sore was first notices, referral to tissue viability service, turning regime and recording requirements. A review of care records showed that the 3 hourly turning regime recommended was being followed by care staff.

Our judgement
The provider was not meeting this standard. We judged that this had a moderate impact on people using the service and action was needed for this essential standard. This is because we found that people identified by staff during the visit as being in need of management in relation to their fluid intake were not being monitored or managed appropriately.

Outcome 08:
Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

What we found

Our judgement

The provider is compliant with Outcome 08: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
We spoke to one person who uses the service and also to two relatives of service users.

We were told that during the recent outbreak of diarrhoea and vomiting at the unit the residents were kept to their rooms and that cleaning was stepped up significantly. We were told that visiting times were restricted to 20 minutes and that letters were sent to relatives clearly explaining the reason for this. We were told be people we spoke to that they felt the service handled the outbreak well and that peoples clothes were always cleaned and that rooms were cleaned very regularly.

Other evidence
A review of the environment on the nursing unit found that the toilet and bathroom areas were clean and well maintained. All smelled fresh, toilets had all been flushed and hand washing soap and towels for drying hands were present.

The linen and other storage cupboards on the nursing floor are not being used in a way that enables them to be cleaned effectively. Although the main linen store had neatly stacked and stored linen that was all on shelves raised from the ground, there was a large pile of Christmas decorations and other items in one corner of the room which did not enable regular cleaning or the area. High levels of dust and debris were found behind the door of the main linen cupboard indicating that this room was not being cleaned effectively. In addition we examined the linen cupboard which was now being used as a general store room. It contained 8 mattresses and crash mats. We spoke to the nurse in charge who told us that these were clean storage ready for use, but when we examined the mattresses and crash mats we found them to be dirty and stained.

All of the corridor areas and carpets on the nursing unit were found to be clean, tidy and well maintained. All areas of the nursing unit were found to be free of unpleasant odours. The sluice room was found to be clean tidy and well maintained.

We interviewed a member of cleaning staff who explained that there was a clear rota which defined the responsibilities of each member of the cleaning team as they came on shift. Today she started at 8am and was scheduled to vacuum all rooms and corridors. Whilst inspecting we observed that all carpets on the nursing floor were being vacuumed.

We reviewed the cleaning equipment being used by staff and also inspected the main equipment store for cleaning materials. We found that the cleaning trolley being used to clean rooms was stocked with the correct equipment. We found that the cleaning store was clean, tidy and well maintained. Buckets and mops are colour coded and stored in a way which meant equipment for cleaning different areas were appropriately segregated.

A review of a recent review of hygiene standards by the local infection control team found the home 90% compliant with the audit. Infection control policies and a copy of the hygiene code are in place and available to staff for referen

Our judgement
People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

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 gather information about record keeping from people we spoke to about the service.

Other evidence
The paperwork for care plans was in the process of being transferred to the documentation used by the new provider responsible for the care home. As a result the records were difficult to navigate and some care plans took staff we asked to help us a long time to locate. Despite this we found that care plans and care records were in most cases detailed, person centred and completed to a high standard.

Records and care plans were found to be stored securely in locked filing cabinets.

Our judgement
Staff records and other records relevant to the management of the services were accurate and fit for purpose.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 04: Care and welfare of people who use services
	How the regulation is not being met: People identified by staff during the visit as being in need of management in relation to their fluid intake were not being monitored or managed appropriately.	

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.

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
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

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