Inspection Report

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

Regents Court Care Home

128 Stourbridge Road, Bromsgrove, B61 0AN Tel: 01527879119

Date of Inspection: 19 June 2013 Date of Publication: July 2013

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

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Manor Care Home Limited
Registered Manager	Mrs. Becky Dallimore
Overview of the service	Regents Court provides accommodation and personal care for people. Nursing care is not provided.
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 19 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

When we carried out this inspection 31 people were using the service.

We spoke with the registered manager and five members of staff. At the end of the inspection we spoke briefly with one of the providers. During our inspection we spoke with people who used the service and one visitor. One person commented: "We are pleased with what they (the staff) are doing". Another person described the staff as: "Helpful and kind".

We observed how staff interacted with people. We saw that staff spoke with people in a respectful manner.

From our observations we saw that people were provided care that met their individual care needs. We saw equipment was used to prevent people who used the service from getting sore.

We found that appropriate arrangements were not in place that ensured the safe use and management of medicines.

A recent reduction in staffing levels during the afternoon was re-instated at the time of our inspection in order that people's needs could be better met.

We found that accurate records in respect of people who had used the service were not always maintained to show how care needs were to be met. We saw occasions where these records had not provided appropriate information to guide staff on how they should have meet people's needs.

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 07 August 2013, 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

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

At our last inspection in October 2012 we found that the provider was not meeting this outcome. Following that inspection the provider sent us a plan of the action they would take to address this issue.

During this inspection we spent time speaking with people who used the service to gain their views about their experiences of the home. Everybody we spoke with told us they liked the home. We found that people were happy with the support they had received.

We spoke with staff involved in people's care. We found that they had an understanding of people's care needs. We saw that staff were respectful to people whilst they were in the lounge areas and whilst they were providing support. We saw that staff had regard for people's privacy and dignity. For example bedroom doors were closed whilst personal care took place.

During this inspection we asked the registered manager how many people needed to sit on special cushions to prevent soreness. The provider may wish to know that when we had a look around the home we found one of the three people sat on a chair without one in place. Staff we spoke with were not aware that the person was not on their pressure relieving cushion. Shortly afterwards a senior member of staff noticed that the cushion was missing and took action to resolve the matter.

We saw that three people had specialist mattresses on their beds. These mattresses were in place as a means of preventing people from becoming sore. This meant that the provider had taken measures to prevent people becoming sore or any soreness worsening.

We saw from daily records and records maintained by community nurses that health care professionals were involved in the care of people who were at risk of developing sore skin. We were informed by the registered manager that nobody had any soreness at the time of

our inspection. Staff we spoke with confirmed this. This meant that medical professionals were involved in people's care as appropriate and that staff were aware of people's skin condition.

We saw staff reassured people when they were anxious or if they showed signs of distress. However due to the number of people who needed assistance staff were unable to spend additional time with people to ensure their anxiety was fully overcome.

People we spoke with told us that they liked the staff on duty. One person said: "All the staff are brilliant". Other comments included "I like them all" and: "They look after these people well".

Care plans and other written records were maintained detailing the care people required and the care provided. These included charts for staff to record the amount of drink provided. We saw that these records were not always up dated. This meant that staff were not always provided with information and guidance about how to meet people's care needs. This could mean that there was a risk of people's needs not been met. However staff we spoke with were knowledgeable about people's individual needs and how to care and support them.

Safeguarding people who use services from abuse ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

At our last inspection in October 2012 we found that some incidents between people who used the service had been recorded in the daily records. We found that neither the manager nor the deputy manager had been made aware of these incidents until we had brought them to their attention. Appropriate action such as informing the local authority under safeguarding procedures had not taken place. Following that inspection the provider sent us a plan of the action they would take to address this issue.

We saw that the provider had introduced a new system. Staff had recorded in a separate log any incidents between people who used the service. The log was also used to record any other safeguarding incidents. This meant that the registered manager had been alerted to any incidents that had taken place in the home. We saw that the registered manager had recorded the actions they had taken such as making a notification to the Care Quality Commission and had contacted the local authority. This meant that systems were in place to ensure that appropriate action was taken in the event of abuse taking place.

We asked to see the policy and procedure on safeguarding people. The provider may wish to note that the document we were shown stated that staff needed to respond 'appropriately to any allegation of abuse'. No additional information had been provided to guide staff on how they should respond and who to inform. We were shown another document but this was a policy written by the previous provider and therefore contained incorrect information.

We asked members of staff what they thought abuse was. They showed a good understanding of how and to whom they should report any allegations so they would be investigated and people protected. One person who used the service told us: "I could not imagine anybody being cruel here". This meant that people felt safe with the service provided.

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.

People were not protected against the risks associated with medicines because the provider had not ensured that appropriate arrangements were in place to manage medicines.

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

During this inspection we assessed the management of medicines. Comments from people who used the service did not relate to this outcome area.

We found that suitable arrangements were not in place to ensure that people always received their medicines as prescribed. We looked at the Medication Administration Record (MAR) charts of 10 people and found discrepancies between the records and the quantities of medicines that were held in stock.

We saw medicines stocked within the monitored dosage system. When we checked the MAR charts we found that medicines had been signed as given. The registered manager was unable to explain why staff had signed for these items when they had not been given. We audited some medicines dispensed in their original containers that had not been included in the monitored dosage system. We found that the number of medicines that remained had not always balanced with the records held. For example we found an occasion where we counted three too many sachets of a medicine. This meant that people had not always received their medicines as prescribed by a medical professional.

We looked at the medicines of one person and were unable to balance the amount remaining as they had not all been booked into the home correctly. The registered manager started an investigation into what had taken place. They were unable to demonstrate that the person concerned had received their medicines as prescribed.

We saw that some people had creams which they kept in their bedrooms. These creams were prescribed to help prevent people getting sore skin or to prevent dry skin. In one bedroom we saw one tube of cream. On viewing the MAR charts we saw that staff had signed for two creams. We asked where the second cream was. Staff were not able to show us this second cream. It was later confirmed by a member of staff that this cream was not available. This meant that staff had signed for prescribed creams that they had not applied as the cream had not been available.

Storage arrangements for Controlled Drugs (C.D's) were available. CD's are medicines that require extra checks and special storage arrangements. There was a system in place to ensure that these drugs were recorded. We checked the CD's held and found that the amounts were correct.

We were given assurance by the registered manager and one of the providers that the matters we found would be addressed with urgency to protect people from the risk of harm.

Staffing ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were supported by skilled and experienced staff so that their needs could be met.

Reasons for our judgement

At our last inspection in October 2012 we found that the provider was not meeting this outcome. We were informed in October 2012 that following a review of staffing levels at Regents Court they had been reduced. During our inspection in October 2012 we saw that people using the service were not attended to in a timely way. We also saw periods of time when staff had not been available to attend to people in the communal areas of the home. Following that inspection the provider sent us a plan of the action they intended to take to address this issue.

At the start of this inspection we were informed that staffing levels had been increased during the afternoon following our inspection in October 2012. However we were told that staff numbers had recently been reduced as the number of people using the service had fallen to below 32.

During our observations we saw that staff had responded to people in a timely way or as soon as they could. We saw that staff were kind and reassuring to people especially when they became distressed as a result of their dementia type illness. For example we saw staff comforted and reassured people who were searching for their parents or small children. Although we saw that staff were meeting people's needs, they were unable to spend any significant time with people. This often led to people becoming agitated again.

We brought our observation to the attention of one of the providers. We were given an assurance that staffing levels would be returned to the higher level to ensure that people's needs were better met and that the staffing levels would not be assessed solely on the number of people but on the needs of people who used the service.

Records ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and support because accurate records had not always been maintained.

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

During our inspection we found inconsistences and inaccurate records in respect of people who used the service.

We asked the registered manager for the care records of one person who had used the service. This was to show us what action had been taken over a period of time regarding visits from professionals and actions that had been taken by staff. The records we were shown did not contain the information we sought. This meant that the registered manager was not able to provide an accurate record of the action that had taken place during a period of time.

We found that care plans had not been an accurate record that contained information about all identified areas of care needs. We saw that care plans had not always been evaluated. This meant that the information available was not accurate in respect of people who used the service. For example the care plan of one person showed that they were to have dry foods and no milk. We were informed that this was no longer the case.

We saw that records regarding fluid intake for 13 people on the ground floor had information missing from them. As these had not been completed they were inaccurate regarding the fluid people had taken. This meant that due the lack of maintained records they were accurate which could have resulted in poor fluid intake having not been recognised.

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 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 had not ensured that appropriate arrangements were in place to manage medicines. Regulation 13.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were not protected from the risks of unsafe or inappropriate care and support because accurate records had not always been maintained. Regulation 20 (1)(a).

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 07 August 2013.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

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

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