Inspection Report

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

Somerville House

Somerville Road, Willand, Cullompton, EX15 2PP

Tel: 01884820811

Date of Inspection: 02 January 2014

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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	✓ Met this standard
Management of medicines	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Graysar Associates Limited
Registered Managers	Mrs. Sarah Kingdon Mrs. Samantha Jane Martin
Overview of the service	This 29 bedded home provides residential care and support for older people.
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 2 January 2014, 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.

What people told us and what we found

At the time of the inspection there were 29 people living at the home. We spoke with eight people who lived at the home, two relatives, a visiting GP and district nurse. We spoke with six members of staff, the registered manager and the providers.

People said the food was 'excellent' and 'always plentiful'. We saw that lunch consisted of plenty of fresh meats and vegetables with an appetising freshly made desert.

Staff worked closely as a team and we saw how staff supported each other throughout the day. People we spoke with felt the home provided a good level of care. People said 'the staff are all first class' and 'I speak my mind and I say that the staff are very helpful'. Staff said 'we listen and learn from people here and make sure care is centred on their well-being'.

We examined nine care plans and found they were person centred, and holistic in their content with evidence of monthly reviews.

We spoke with two relatives who confirmed they had no hesitation in recommending the care provided. One relative said they had not realised until their relative came to the home 'how much they needed a place like this'. They felt confident their relative 'was safe'.

We found there was a comprehensive quality assurance system in place with monthly monitoring, to cover all essential standards of care. The provider told us they sought to make improvement wherever possible and said 'we can always find something which we could do better or differently'.

You can see our judgements on the front page of this report.

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.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

We spoke with three people about arrangements made prior to their admission about the care needed. They told us 'everything was explained' and that they were asked for their agreement to proposed care and support, both before and after arriving at the home. They said that staff respected their decisions if they did not want to do something. One person said 'the girls are so lovely, I can say anything'. We observed that staff encouraged and gently supported people where needed.

Care files examined showed that people had consented to the care and support offered, through signatures on forms, although some of the people we spoke with could not remember anything about their file or papers. The memory of many of the people living at the home had deteriorated over the years and while some were aware of 'paperwork' they were unable or uninterested in confirming their involvement.

Staff we spoke with had an understanding of the procedure followed where they felt a person lacked capacity to make an informed decision. Staff were observed to ask people if they wanted help and were sensitive and gentle in their communication and interaction with individuals.

All staff had received training in the Mental Capacity Act 2005 and we were told that best interest meetings were held, but lately they had not been required.

Senior staff told us that people were involved in all decisions about their lives and said that they identified individual likes/dislikes and preferences often by observation. They said staff 'did their best to accommodate everyone's wishes'. They said 'we all listen and learn from the people here and make sure care is centred on their well-being'.

Any issues concerning care treatment or consent issues were discussed confidentially at handover between the staff.

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.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We examined nine care plans and found they were well organised, tidy, clear to read and up to date with evidence of regular monthly reviews.

Care plans and files were person centred and holistic in their content. Initial assessments were undertaken by the manager and the provider prior to the person's arrival at the home. Thereafter the care plan was developed with the involvement of the person concerned and their keyworker. The manager explained that staff aimed to ensure that any intervention offered met the expressed need. Wherever change occurred, new assessments were undertaken which helped to make sure the information in care plans was relevant and up to date.

We saw that care files included a falls assessment which clearly stated specific risks to individuals. We looked in detail at five files with a falls assessment and noted that it was not clear whether or not the initial assessment had been reviewed. In one case there was no date on the assessment and in others no note had been made of any change to the risk initially presented. We discussed this with the provider and manager who acknowledged the need to revisit, the review, recording and dating procedure.

We spoke with two relatives who both confirmed they had no hesitation in recommending the care provided at the home. One person told us they had not realised until their relative came to the home 'how much they needed a place like this'. They said they felt confident their relative 'was safe'.

Almost half of the people at the home suffered from some degree of memory loss which meant that the home had put in place measures which ensured people's safety. One of the relatives we spoke with said the routine use of pressure mats meant that people with failing memory were able to access all parts of the home freely with the confidence that staff would know they were moving around.

All of the staff received training in dementia. We observed the fitting reassurance given by staff to a person who was distressed on the day of the inspection due to a problem in their room. Staff listened carefully and gently assured the person that the issue would be

addressed and resolved as quickly as possible.

We met and spoke with a visiting GP and a district nurse. Both said they visited the home several times a week and told us communication between the surgery and the home was 'excellent'. They said the staff team were 'well informed, and everyone knows everyone which meant a quicker response can be made'.

We were shown how the 'interventional round system' linked into the call bell which ensured that people who were ill were checked thoroughly every three hours. The check which included, comfort and pain management, nutritional and fluid intake, tissue viability and continence and personal hygiene meant that effective mechanisms were in place to meet the care needs of individuals.

We spoke with six members of care staff and two domestic staff over their break. They told us they enjoyed their work, 'loved working with older people' and felt the quality of their care was good. They said they worked 'very closely as a team' and this was observed in the way in which they conducted their duties. Staff said there was always 'back up' and always someone to help if needed. One said 'I would be happy for my Nan to live here – you have to think if you would be happy for your relatives to be cared for in the way we do, and I would'. Another staff member told us they paid particular attention to getting 'the little details right'.

There was a keyworker system in place, named on the front page of a person's care file. A keyworker, to two people at the home explained the process which started on the person's arrival. Roles of a keyworker involved regular reviews of people's care files, making note where any change had been noticed either by themselves or another staff member, taking action as needed or referring to the manager if additional support was needed. Staff said they had developed their skills as a keyworker over time, and demonstrated their careful attention to the detail of keyworker responsibilities. Examples were given of a person's increased weight noted by the keyworker and the steps taken which addressed the issue and meant that the person maintained a balanced diet to remain active and healthy.

Emergencies and gaps in the staffing rota were covered by existing staff or by a team of trained bank workers employed by the home.

We did not observe any activities on the day of the inspection but were told by people and evidenced on notice board that activities were planned both on a group and an individual basis. We saw a file which showed who had participated in activities, which helped staff to monitor participation and interest in what was arranged. Two of the people and a relative we spoke with said they would like to see more activities they could join in and use their minds with 'like-minded people'.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We observed the medicine procedures followed at the home and found there were appropriate arrangements in place for the safe administration of medicines.

We noted that medication held in the locked trolley was checked alongside the record before being offered to a person. We were told that no one administered their own medication and were told that people preferred responsibility for their medicine to be taken by the staff. People we spoke with were comfortable with the arrangements in place.

We spoke with the staff member responsible for medication on the day of our visit who were competent, knowledgeable and confident of the medication policies and procedures followed. They were aware of potential risks that might occur and understood the importance of monitoring side effects. Where there was a refusal to take medication this was noted in the records.

We observed how staff explained and reminded individuals about the medicines they were taking and ensured they had been swallowed or taken.

We saw that where checks were needed before, for example taking insulin, that staff wore appropriate protective clothing. When administering medication, staff wore a distinct red tabard to help others be aware they should not be distracted as they were undertaking medication responsibilities. The manager explained this had been introduced to reduce the risk of error and to make clear the particular duties being carried out.

All staff who administered medication had received appropriate training in the safe handling of medicines.

We examined the medication and administration records and found they were clearly signed and were up to date with no gaps in the entries. The controlled drugs record was seen and noted. This had been signed by two members of staff and in line with legislation.

We were shown how medicines were received into the home and had been checked with

the amount of stock documented. Medications were safely stored in a locked drugs trolley which, when not in use was firmly attached to the wall. Controlled drugs were held within a further locked cabinet.

We noted that on each occasion medicines were removed from the trolley it was immediately locked, which meant that people could be assured that potential risk of error was reduced. Some medications were held in people's rooms. These were stored in locked cabinets fixed to the wall.

We examined the medication files and noted some inconsistency in the specimen signature sheets, either where a staff member had not provided a sample of their signature or that the staff member had left. Dates were not routinely provided on signature forms. Irregularity in completing forms could potentially mean people were not always fully protected from risk.

As part of the home's quality assurance system an annual appraisal of medication in use at the home was conducted by the pharmacist.

Assessing and monitoring the quality of service provision ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We found there was a comprehensive and detailed quality assurance system in operation at the home. The providers explained the system which included an ongoing annual programme. Monthly monitoring and audits were conducted and recorded to cover all essential standards of care. The monthly audits seen were detailed and made clear where an improvement could be made. Audits were backed up by improvement plans to ensure appropriate action had been taken which addressed any issue or area raised.

There were a full range of policies and procedures in place, which were seen. Policies were reviewed and revised alongside the quality audit process which meant that policies were updated on a regular basis. Two recent examples included: the suitability of equipment and dementia. Staff were advised of changes in policy through staff meetings, supervision and their pay packets! Staff were aware of the policies and where they could be accessed. We asked one member of staff to explain a particular policy, which they were able to do.

The provider told us they always sought to make improvement wherever possible and said 'we can always find something which we could do better or differently'.

Annual questionnaires were circulated to people living at the home, family members and visiting professionals. Any items noted were backed up by comment for action and review.

Although we did not see any recently returned questionnaires from people, we were told that people, new to the home, were asked after three months for feedback to take account of any issues or improvement the individual would like to see.

An accident book was in place which was read and showed details of two recent accidents which had been fully recorded.

The manager held meetings with people living at the home regularly. Minutes which were

recorded and displayed on the notice board in the lounge were seen. The manager told us they encouraged people to speak freely at meetings, to express their views and to learn from people's experiences of the home. There had been discussion at the last meeting, about making a complaint, to help support people who may be hesitant to raise issues of concern. No formal complaints had been received in the last year. The complaints policy was seen to be displayed on notice boards throughout the home. We were told that any minor worries or concerns were dealt with immediately and not always recorded.

The providers were actively involved with the home and participated in meetings with both staff and people where possible. We were told that the providers had links and cooperative relationships with other care providers and sought professional advice where necessary, to ensure a safe service, continually reviewed and monitored, was provided at the home.

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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