Inspection Report

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

Heatherdale Residential Home

South Broomhill, Morpeth, NE65 9RT

Tel: 01670760796

Date of Inspection: 12 July 2013

Date of Publication: August 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Wellburn Care Homes Limited
Registered Manager	Mrs. Allison Moore
Overview of the service	Heatherdale Residential Home is a detached property situated in South Broomhill, Morpeth which provides accommodation for persons who require personal care. The home can accomodate up to 36 older people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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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 12 July 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 talked with commissioners of services.

What people told us and what we found

We spoke with nine people, four members of staff and one visiting relative. People told us they were happy with the care and support they received. One person said, "I can't complain about anything. I can't fault them in any way." Another person said, "It is definitely their business to look after people." One visiting relative commented, "X is really happy here."

People told us their consent was gained prior to care being delivered and we found that staff acted in accordance with their wishes. We found that where necessary, the provider acted in people's best interests if they did not have the capacity to consent themselves.

We found that people's care and support needs were appropriately assessed and their care and support was planned. Where people required input into their care from external healthcare professionals this had been arranged.

People were cared for in a clean and hygienic environment and we found the provider had appropriate measures in place to monitor and manage infection control.

We found the provider had a structured staff selection and recruitment policy in place which aimed to ensure staff were suitably skilled, experienced and qualified to deliver care safely.

The provider had adequate systems in place to monitor the quality of the service provided.

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

Reasons for our judgement

People told us that their consent was always sought by staff prior to the delivery of care. One person said, "They (staff) always say are you happy, before doing things." Another person said, "I am not forced to do anything, they always ask me."

We made several observations of care delivery on the day of our inspection which demonstrated what people had told us. For example, we saw a staff member asked one person if they would like a wheelchair when they were struggling with their mobility, before obtaining one for them. In another instance, a staff member asked a person if they wanted any more of their food, before removing their plate.

Staff told us they always asked people's permission before delivering care. One staff member said, "We explain to people about their care needs and ask people to do things. If people didn't want a bath for example, we would leave it and ask them later." Another member of staff said, "I explain what I am going to do first and give people a choice." We found that staff were respectful of people's right to make their own choices and decisions. They understood the necessity to gain consent from people, so the choice was their own, before care and treatment was delivered.

We looked at four people's care records and we saw that, where relevant, people had been involved in decisions made about their end of life care. If people did not have the capacity to consent, procedures had been followed in line with legal requirements. For instance, best interest decisions had been made that involved the person's general practitioner, staff and in some cases their relatives. We saw these decisions, which had been regularly reviewed, were recorded on the correct legal paperwork and had been signed by all parties involved.

The provider operated consent policies related to medication and outings away from the home. People's care records showed that where they were able to, they had consented to

staff administering their medication. Relatives had signed consent forms on behalf of people who did not have the ability to sign these themselves. Similarly, this applied to excursions away from the home.

We concluded that people were aware of their choices in relation to their care needs and staff obtained their consent before delivering care. Where people did not have the capacity to consent, we found that decisions had been made in the person's best interests in line with guidance set out in the Mental Capacity Act 2005.

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

Reasons for our judgement

We spoke with nine people and they all told us they were happy with the service they received. One person said, "It's first class here and the staff are good, very obliging." Another person told us, "I love it here I do, I wouldn't go anywhere else." We spoke with one visiting relative and they told us they were happy with the care they observed. They said, "X can't praise the home enough. They look much better since coming here. They were frail but look much better now and they are really happy."

We observed pleasant, positive and polite interactions between staff and people. Staff encouraged people to be as independent as they could be, but where they needed assistance this was given in a prompt manner. For example, we saw staff assisted people with mobility issues by walking next to them or offering a support for their arm if required. One person who was not using their mobility aids appropriately was prompted by a staff member to stop and make adjustments to prevent an accident. At lunchtime we saw that people were given the assistance they required to enjoy their meal. Staff were aware of people's care needs and they cut up people's food for example, to help them eat as safely and independently as possible. We found that care was delivered in a way that was intended to ensure people's safety and welfare.

We looked at four people's care records. We saw that care plans and risk assessments had been developed following an initial assessment and these were regularly reviewed. Care plans were personalised to the individual and also incorporated any social and emotional needs. People's dependency levels and needs related to moving and handling had been assessed and reviewed, and where appropriate their dietary and nutritional needs. Some people had their weight and fluid intake monitored. This showed that people's care needs were continually assessed and their care and treatment was planned.

Staff demonstrated they fully understood the information held within people's care records and we observed that people received care in line with these records.

Regular and up to date healthcare professionals' involvement in people's care was evident in their care records. This demonstrated that the service ensured people's healthcare needs were met.

Cleanliness and infection control ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

We spoke with people and staff to assess their views of cleanliness within the home. One person said, "It is always clean here. If we go to the toilet or anything it is always clean." A second person told us, "It is always spotless here." Another comment made was, "It's really clean. The lady cleans every day." One member of staff told us, "It is always cleaned well here."

We saw the communal areas such as the lounge, dining area and corridors were all clean. We entered a large proportion of the bedrooms within the home and saw they were in good decorative order, clean and tidy.

There was a colour coded cleaning system in operation, where specific areas of the home were cleaned with different coloured cloths and equipment, such as mops and mop buckets, in order to reduce the risk of cross- contamination. For example, equipment and cloths for cleaning toilets and bathrooms were all coloured red. We saw there was a supply of Personal Protective Equipment (PPE), such as gloves and aprons, available in various parts of the home. Staff confirmed, and we observed they used PPE when necessary. One staff member said, "PPE is always available, there is plenty of it." We found that the provider disposed of clinical waste and segregated and cleaned soiled laundry appropriately. For example, dissolvable red laundry bags were used to separate and transport soiled linen to the laundry. Staff confirmed this linen was cleaned on a designated high temperature sluice cycle in the washing machine. These measures helped to limit the risk of people or staff being exposed to an infection.

We looked at how the provider decontaminated commode basins in use within the home. We found that these were washed and sprayed with disinfectant after each use and once a week steeped in a disinfectant solution. The provider may find it useful to note that the process in place for the cleaning of commode basins within the home did not fully reflect current national best practice guidelines, and should be revisited. These guidelines recommend that after being cleaned and disinfected, commode basins should be steeped in a sodium hydrochlorite solution for a specified length of time (after each use), to ensure effective decontamination.

The provider had infection control policies in place with specific guidelines for staff to

follow. For example, we saw guidelines related to, the use of protective equipment, handling of infectious persons, effective hand-washing and the disposal of clinical waste and 'sharps' such as needles. We found that staff were aware of the provider's infection control policy and procedures. When asked, staff explained processes they followed which reflected guidance set out in the provider's infection control policies and reduced the risk of people's exposure to potential infection.

Certificates confirmed that staff had received infection control training during the year 2012 and the manager told us that one member of staff had taken on the role of infection control champion. This person monitored infection control within the home and attended meetings held locally by healthcare professionals, where updates related to infection control best practice were shared. Staff told us that the housekeeper undertook spot checks on cleanliness regularly and provided feedback to staff where improvements were needed. We saw documentary evidence that cleanliness audits took place.

We concluded that the service had effective systems in place to reduce the risk and spread of infection.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

We looked at how the provider ensured that staff employed by the service were suitably skilled and qualified. We reviewed the recruitment and selection processes in place. Documentary evidence showed that staff had completed a job application form, they had been interviewed prior to their appointment, and the provider had explored their experience, qualifications and skill sets to ensure they were appropriate. We saw staff had been given a contract of employment.

Appropriate checks had been undertaken before staff began work. For instance, we looked at three staff files and found that references had been sought from previous employers in all cases and several pieces of identification supplied by the applicant. For each staff member the provider had also carried out a Criminal Records Bureau (CRB) check (now known as Disclosure and Barring Service checks (DBS)), and the staff member had not commenced employment before the results of these checks were received. The Disclosure and Barring Service replaces the Criminal Records Bureau and the Independent Safeguarding Authority. DBS checks are designed to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. The fact the provider carried out these checks demonstrated they sought to ensure people's safety by appropriately vetting the staff they employed.

We asked staff about their experiences of the provider's employment process. They told us the recruitment and selection process was very thorough and this supported our findings. We viewed staff training files to establish whether staff were suitably skilled and qualified and we found that they were. Certificates showed that staff had received training that was specific to the role they performed, such as National Vocational Qualifications in Health and Social Care.

Recruitment records showed the provider explored that staff were both physically and mentally fit for work by asking them to complete a 'Health Assessment Questionnaire' to ensure there was no impact on their ability to deliver care to people appropriately and safely.

We concluded there were effective recruitment and selection processes in place to ensure people were cared for by staff appropriately.

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 received.

Reasons for our judgement

The provider had effective systems in place that assessed and monitored the quality of care and support provided. There were policies and procedures in place related to, for example health and safety and the handling of accidents and injuries which supported care delivery and gave direction to staff. Staff said that management were very approachable and dealt with any issues raised effectively. One staff member said, "Management are approachable. We tell them and they listen." Another member of staff commented, "I get asked if I am happy and if everything is ok." This demonstrated that the management of this service listened to concerns raised by staff, and sought to resolve them.

The manager told us and documentary evidence confirmed that resident and families questionnaires, which asked for people's opinions of the service, were conducted annually. In addition, staff questionnaires were also distributed annually for those staff who wished to complete them. We saw the provider had analysed the results of these questionnaires and drafted a plan of actions to be undertaken to drive improvements. This showed that people who used the service, their representatives and staff were asked for their views about the service they received, and they were acted on.

We saw the provider had a yearly plan in place which, for example, identified meetings that were due to take place throughout the year, how often care plans would be evaluated and when medication audits would be done. In addition, there was a refurbishment programme in place. We saw that this yearly plan was followed in practice. Care plans had been reviewed in line with this plan, medication audits done as specified and necessary redecoration completed to date. This demonstrated the provider monitored the service they delivered, by planning ahead and striving to make improvements where necessary.

Documentary evidence showed that staff and residents meetings took place regularly, and staff and people confirmed they could express their views through these forums. In addition, we saw the provider had an effective complaints, compliments and suggestions policy in place.

The provider had introduced a quality audit tool that related to CQC essential standards of

care, which the manager had completed and sent to head office. This asked the manager to check and confirm, for example, that needs were regularly assessed and evaluated in care plans. In addition, records showed that the regional manager conducted their own audits and had highlighted errors and where improvements were needed. In addition to these audits, staff practice in respect of medication administration was measured regularly through medication competency assessments.

Evidence showed that the provider sought to protect the health and safety of people who used the service, staff and visitors by conducting maintenance checks on the building and equipment throughout the home to ensure it remained safe.

We concluded that the provider monitored the service they delivered appropriately and took account of issues raised in order to improve the service.

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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