Inspection Report

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

Borrage House

8 Borrage Lane, Ripon, HG4 2PZ

Tel: 01765690919

Date of Inspection: 25 September 2014

Date of Publication: January 2015

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

Details about this location

Registered Provider	Anchor Trust
Registered Manager	Ms Jane Bentley
Overview of the service	Borrage House is close to the centre of Ripon. It is owned by Anchor Trust and provides accommodation for up to 40 older people who require support and personal care.
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 25 September 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 our inspection 36 people were using the service. Below is a summary of what we found.

We spent time speaking with people who lived at Borrage House as well as speaking with relatives and staff. We spoke with the provider/manager and we reviewed records and spent time observing people in the home. If you want to see the evidence that supports our summary please read the full report.

We considered all the evidence we had gathered under the regulations we inspected. We used the evidence to answer the five questions we always ask:

Is the service safe?
Is the service effective?
Is the service caring?
Is the service responsive?
Is the service well led?

Is the service safe?

People were cared for in an environment that was safe, clean and hygienic. Equipment at the home had been well maintained and serviced regularly. There were enough staff on duty to meet the needs of the people who lived there. We spent time observing people and noticed that they were cared for safely. Every member of staff we spoke with said that they were happy with staffing levels and said that these helped to provide safe and appropriate care.

Staff records demonstrated that mandatory training was up to date and that staff were trained to meet the needs of people. Staff were trained in the care of people with dementia, moving and handling and safeguarding.

CQC monitors the operation of the Deprivation of Liberty Safeguards which applies to care

homes. While no applications had needed to be submitted, proper policies and procedures were in place. Relevant staff had been trained to understand when an application should be made, and how to submit one.

Is the service effective?

During our visit we spent time observing people and staff. It was clear from our observations and from speaking with staff that they had a good understanding of people's care and support needs and that they knew them well. For example, we noted that staff were able to tailor the way they spoke to each person, particularly their sense of humour and speech, to be able to make each person feel listened to and important.

People were cared for by staff who were supported to deliver care safely and to an appropriate standard. Staff had received training to meet the needs of the people living at the home and told us that they were able to put their training into practice.

Is the service caring?

People were supported by kind and attentive staff. We saw that staff showed patience and gave encouragement when supporting people, especially when they needed help moving around and to eat. Staff took into account the needs of people when planning activities so that they could take part in these safely. Staff told us that they worked hard to make sure their training was applied to the individual needs of people so that they could be supported to take part in activities important to them.

Staff said that they were very happy with the level of professional and emotional support they received from the management team.

Is the service responsive?

People's needs had been assessed before they moved into the home and these were checked by regular reviews, in which they were involved. People's needs assessments included an assessment of their capacity to make decisions as well as consideration of their dietary and nutrition requirements.

People's preferences and interests were acted on by staff who used monthly meetings to support people to meet their needs and goals. People had access to activities that were designed to stimulate them and they were able to influence the running of the home.

Is the service well led?

There was a manager in place who was registered with the Commission as the manager of this location, in line with the requirements of the registration of the service.

Staff had a good understanding of the ethos of the home and quality assurance processes were in place. Staff told us that they were clear about their roles and responsibilities and that management support helped them to do their job effectively. One person spent time talking with us and told us how supported they had felt by staff. The person said, "[Staff] talk to me nicely and I always feel like I'm important to them."

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 who used the service understood the care choices available to them. We spent time observing people, speaking with staff and reviewing records. We found that care and treatment choices had been explained to people who had the capacity to understand. Where people had been found by mental health professionals to lack the capacity to understand, appropriate professionals and the person's representative had been involved in planning their care. This meant people and their representatives were encouraged and supported to make decisions about the care that was provided.

People had been provided with a resident's guide which explained to them the facilities and care options available to them. This had been given to people when they came to live in the home and was freely available for people, their relatives and visitors.

We spoke at length with staff about consent and the Mental Capacity Act 2005. We found that staff had knowledge of this and that they had applied this appropriately to their assessments of people. This ensured that people were supported to make their own decisions where they could and that, where this was difficult, they had the appropriate support from well-trained and knowledgeable staff. For example, people's bedrooms had doorbells on them and people were able to keep their own keys. This meant that people were supported to live independently and were able to maintain their privacy and dignity.

We found that when a person came to live in the home, staff had spent time with them and their relatives discussing consent to care. This included areas such as their consent to have their photographs used around the home from activities as well as their consent for staff to contact medical professionals on their behalf. This had been recorded in each person's care plan and was reviewed regularly by a multi-disciplinary team. We found that people had signed consent forms themselves where they had the capacity to do so. Where this had not been possible, there was documented evidence of how staff had gained

consent.

We spent time observing people and staff around the home. We found that staff asked people for their consent whenever they were assisted to move or offered food and drinks. We noted that staff did this in a way that was discreet and maintained people's dignity. For instance, staff asked people where they would like to eat and then asked them if they would like help to get there. We found that staff communicated clearly and in a way that meant each person was able to understand. We spoke with people and their relatives about this. One person said, "Staff always ask me how I feel and what I want before we do anything. I sometimes enjoy a lie-in on a Saturday morning and sometimes I prefer to eat breakfast in my room. [Staff] understand what my needs are and they treat me with respect." A relative said, "In 18 months I've never had a concern about the way staff treat or speak to people. [My relative] is encouraged to make their own decisions and when they find this difficult, we have a good process in place."

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We reviewed assessment records and found that each person had a personalised care plan in place with input from relevant specialists such as mental health doctors and dieticians. Care plans included evidence that people's wishes and aspirations were listened to and used to plan their care. For example, people's care plans included sections titled 'What is important to me', 'How to support me' and 'My Living Story'. These documents helped staff to understand people and to provide care that promoted people's involvement and reduced the risk of social isolation. We found that this was achieved because staff used care plans that focused in-depth on areas of need such as physical needs, psychological needs and medical needs.

We found that care plans were reviewed every month by staff and that staff discussed the care plan with the person it applied to regularly. For example, people were asked if they wanted staff to check on them in the night or if they preferred to be left alone. We looked at nutritional reviews, one to one meeting records and multi-disciplinary health records and found that assessment of needs was on going and that care was provided flexibly and in the best interests of the person.

Care was planned and delivered in a way that was intended to ensure people's safety and welfare. We reviewed risk assessments and found them to be thorough, up to date and fit for purpose. These documents had a focus on supporting people to maintain the lifestyle that they wanted. We found that staff had made sure people could take part in activities safely and that they had spoken to people about how to keep themselves safe. People's welfare was supported by their ability to contribute to the home. For instance, the lounge area displayed artwork created by people and there was a quiet jigsaw area, which had been provided as a result of people's own requests. This supported people to maintain their independence.

Where people did not have the capacity to understand the choices available to them we saw the provider acted in accordance with legal requirements. legal safeguards exist to ensure people are only deprived of their rights if it is within their best interests. The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes.

People's care plans included communication sheets that were used by staff to record when they had spoken with people's relatives and medical professionals. This system was used to make sure that all staff were aware of any changes to a person's care. We found that care plans included detailed personal information such as people's sleeping habits, their likes and dislikes and how they wished to be talked with by staff. This enabled staff to provide appropriate and individual care and support.

We spent time speaking with staff about catering and found that people were provided with food that was important to them that also matched their nutritional needs. This had been achieved by talking to people about their likes and dislikes and then discussing these with medical professionals and the homes own catering staff. We found that people were always offered a choice of meals and that their feedback was acted on. People were supported to make their own choices and staff were able to suggest extra items to support people to eat healthily. We spoke with people about this. One person said, "The food here is great. I really look forward to the Sunday roast and anytime we have meat the cooks do an excellent job."

We found evidence that care and treatment was delivered safely by reviewing multi-disciplinary care records. There was a consistent approach to involving appropriate medical professionals. There was evidence that the manager was responsive in changing care or treatment delivery when needed to ensure a person's welfare. We spoke with staff who told us that they had a positive relationship with local GPs. Staff said that this helped people to receive timely attention to any problems.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. We reviewed care plans and medical records and spoke with people and staff. We found a good awareness of people's individual needs and found no evidence of unlawful discrimination. We spent time observing people in their living environment with staff. We found that staff spoke to each person with respect and that they had a good understanding of each person's personality and needs. We spoke with staff and found that care was delivered depending on the wishes and personality of each person which enabled a culture of equality to exist.

There were arrangements in place to deal with foreseeable emergencies. We spoke with staff about emergency provision and looked at records. We found that a robust emergency plan was in place which included weekly fire drills and annual simulated evacuations. We spoke with staff who were aware of the needs of each individual in an evacuation, which included knowledge of personal evacuation plans. Staff told us that they were confident in fire and evacuation procedures. We found that some people who lived in the home would not be able to evacuate without help from staff. We spoke with staff about this and found that each person had a personal evacuation plan, which staff would use to support them to leave the building quickly and safely, including the use of evacuation sheets.

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

Appropriate arrangements were in place in relation to obtaining and recording medicines. We found evidence of this by inspecting the medicine storage areas, reviewing documentation and speaking with staff and the registered manager. We found that each person had an individual medicine file which was labelled with a recent photograph. This enabled staff to quickly identify records. The provider had a policy in place which ensured that only staff with appropriate training were able to administer medicines. This was evident by reviewing the medicine administration records (MARS) which also demonstrated a consistently accurate approach to recording the time and dosage of medicines for each person.

The temperature of the medicine storage room was monitored on a daily basis and we found that the temperature was kept at a safe level, which maintained the integrity of medicines. We found that a safe temperature of a fridge used to store chilled medicine was consistently maintained.

We found that medicine was documented and stock checked on receipt. Medication quantities were updated after each dosage was administered. The home had a system in place to ensure accuracy in the distribution of medicine. We also found that the home had an appropriate protocol in place to monitor the administration of 'when-required' (PRN) medicine, including topical creams and paracetamol. We found that people's care plans included reference to PRNs and that staff had followed procedures correctly. This ensured that people had access to medicines when they needed them and that these were administered safely.

We inspected the medicine storage area and found that controlled drugs were securely stored in a locked cabinet. The home had a monitoring system in place that ensured that controlled drugs were stock-checked and monitored for correct administration.

Medicines were prescribed and given to people appropriately. We found evidence of this by reviewing the medical records of people. People's prescribed medicine was monitored by staff in the home. We spoke with staff who told us that if a person refused their medicine this was recorded appropriately and medical advice was sought. We spent time observing people in the home and noted that staff administered medicine in a manner that

maintained the dignity of people who lived there.

We reviewed recent medication audits and found that these were completed regularly to ensure that medicine was stored and administered safely. There was evidence in people's medication records that people understood what their medicine was called and what it was for. We spoke with people and relatives who all told us that they felt that staff were clear in their explanations of medicine and that they knew what their, or their relatives, medicine was for. Where a person did not have capacity to understand this, their representative was informed of the need for and purpose of medicines.

We spoke with staff about the administration of medicines. They told us that their training about medicines had been comprehensive and had included communication techniques to help them to talk to people about their medicines as well as how to avoid errors in administration.

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.

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

Reasons for our judgement

We spent time observing people around the home and found that there were enough qualified, skilled and experienced staff to meet people's needs. We found that if people wanted to spend time with staff they were able to do so and that where a person wanted to be alone, they were able to find space to do this. We observed that when a person needed assistance or attention that staff were able to offer this promptly.

At the time of our inspection 36 people lived at the home. We looked at the staff rota and found that staffing levels were organised around the times that people needed the most support. On a morning, the home had a manager, two team leaders and five carers. During the afternoon, there was a manager, a team leader and three carers. The manager had implemented a new shift to cover the period between late afternoon and the evening so that people who wanted to eat late or wanted company were able to be supported with this. The manager told us that they had seen a, "tangible improvement" in people as a result and that many people had become, "much more involved and stimulated and they really look forward to evenings now."

We spoke with people and staff about activities and found that people were supported to take part in activities important to them with appropriate staff supervision. The home had a dedicated activities coordinator. We found that past activities that people had enjoyed had included visits from a local historian, weekly quizzes and a performance by Appalachian dancers. One member of staff said, "We all really enjoy spending time with [people]. They can always choose their own schedule and our job is to make sure we support them with that." This showed that staff were able to provide individual care in the best interests of each person.

We spoke with six staff and were told that they felt current staffing levels meant that they could provide effective care. The provider may wish to note that staff raised concerns about staffing levels at weekends, which had reduced due to on-going sickness levels. Staff told us that although this had not reduced the level of effective care that they could provide, it sometimes meant that they could not spend as much time with people as they would like. We spent time with staff and observed that they were able to work effectively together. This ensured that people's care and treatment was monitored continuously and that staff felt confident in delivering responsive levels of support.

In speaking with staff we found consistently positive responses when we asked about the quality and standard of training and management. Staff told us that whenever they had requested additional training this had been provided. One member of staff said, "Our manager is brilliant and most of the team leaders are helpful on shifts. We also have a brilliant relationships with people's relatives and they're welcome to stay to have lunch or dinner."

We spoke with people and relatives about staffing. One person spent time telling us how much they enjoyed the staff team and that they felt very welcome and relaxed in the home. Another person told us that sometimes the provider used agency staff and that they were difficult to communicate with because they did not know people as well as permanent staff. We spoke with the registered manager about this. We found that agency staff had been used to cover staff shortages and that a new recruitment drive was planned to reduce the need for temporary staff. A relative said, "I'm always made to feel very welcome here. The food is outstanding and I'm so grateful that I'm able to sit and have meals with [my relative]. The place has a great atmosphere and I'm sure you've noticed from walking around that there are always staff around to talk to when you need them."

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

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We found evidence of this by reviewing the assessments conducted when a person first came to live in the home. We found that each person had sections in their care plan focused on promoting emotional and psychological wellbeing and involvement in social activities. The sections were used by staff to talk to people about their care and to make changes when a person requested this. These arrangements helped staff to understand how people felt about their care and to recognise when someone was unhappy.

We reviewed multi-disciplinary medical records and found that changes to care were clearly and appropriately documented. These records always included a consultation with the person involved, or their representative where they did not have capacity. The appropriate professionals had been involved in instances where care or treatment had changed and we found evidence that people were involved in this process. These records showed us that there were monitoring arrangements in place to help protect the health and welfare of people.

We reviewed the incident log and found that incidents were responded to quickly and appropriately with the use of a risk assessment action plan. We also found evidence of this by reviewing daily record sheets. We found that a robust procedure was in place that enabled the manager to investigate incidents effectively.

The provider used monthly customer feedback questionnaires to ensure that the voice of each person was heard by the staff and management teams. We found that these were given to people to complete without staff influence and that they had been used to understand feedback about the food and standard of care in the home. The questionnaires were also available in a form that was accessible to people with communication needs, such as the use of faces with expressions on them to reduce the need for writing.

As part of the provider's internal quality system, each care plan was reviewed on a monthly basis to ensure that it was being implemented, was up to date and fit for purpose. Care plan reviews were also completed on an as-needed basis if a person requested a change

in their care or if staff had concerns about them.

We found that as part of the provider's regular internal quality audits, an annual questionnaire had been distributed to people and their relatives. We reviewed responses to this and found them to be very positive, with a focus on complimenting the standard of care offered by staff. The questionnaire had been used alongside internal audits by the provider's own quality team to make sure that the level of care people received was of a high standard. We found that the provider conducted regular quality audits on the infection control, cleanliness and health and safety procedures in the home. Quality audits also had a robust focus on medicines and this included checks on the staff administering medicines. This helped to ensure that the service provided by the home was safe and effective and enabled managers to share evidence of good practice with other staff.

The complaints policy was freely available to people who used the service, their family and visitors. We reviewed the complaints log and found an effective relationship between the manager and the provider that helped in resolving complaints quickly.

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.

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