Commission for Social Care Inspection

Making Social Care Better for People

Inspecting for better lives

Key inspection report

Care homes for older people

Name:	Knappe Cross Care Centre
Address:	Knappe Cross Care Centre Brixington Lane Exmouth Devon EX8 5DL

The quality rating for this care home is:	two star good service

A quality rating is our assessment of how well a care home, agency or scheme is meeting the needs of the people who use it. We give a quality rating following a full assessment of the service. We call this a 'key' inspection.

Lead inspector:	**Date:**							
Rachel Fleet	2	6	0	6	2	0	0	9

This is a report of an inspection where we looked at how well this care home is meeting the needs of people who use it. There is a summary of what we think this service does well, what they have improved on and, where it applies, what they need to do better. We use the national minimum standards to describe the outcomes that people should experience. National minimum standards are written by the Department of Health for each type of care service.

After the summary there is more detail about our findings. The following table explains what you will see under each outcome area.

Outcome area (for example Choice of home)

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

This box tells you the outcomes that we will always inspect against when we do a key inspection.

This box tells you any additional outcomes that we may inspect against when we do a key inspection.

This is what people staying in this care home experience:

Judgement:

This box tells you our opinion of what we have looked at in this outcome area. We will say whether it is excellent, good, adequate or poor.

Evidence:

This box describes the information we used to come to our judgement.

Copies of the National Minimum Standards – Care Homes for Older People can be found at www.dh.gov.uk or bought from The Stationery Office (TSO) PO Box 29, St Crispins, Duke Street, Norwich, NR3 1GN. Tel: 0870 600 5522. Online ordering from the Stationery Office is also available: www.tso.co.uk/bookshop

The Commission for Social Care Inspection aims to:

- Put the people who use social care first
- Improve services and stamp out bad practice
- Be an expert voice on social care
- Practise what we preach in our own organisation

Our duty to regulate social care services is set out in the Care Standards Act 2000.

Reader Information

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Information about the care home

Name of care home:	Knappe Cross Care Centre
Address:	Brixington Lane Knappe Cross Care Centre Exmouth Devon EX8 5DL
Telephone number:	01395263643
Fax number:	01395223648
Email address:	knappcross@onetel.com
Provider web address:	

Name of registered provider(s):	Ashdown Care Limited
Type of registration:	care home
Number of places registered:	42

Conditions of registration:		
Category(ies) :	Number of places (if applicable): Under 65	Over 65
old age, not falling within any other category	0	42

Additional conditions:

The maximum number of service users who can be accommodated is 42.

The registered person may provide the following category of service only: Care home only with Nursing - Code N to service users of either gender whose primary care needs on admission to the home are within the following category: Old age, not falling within any other category (Code OP)

Date of last inspection								

Brief description of the care home

Knappe Cross is a 42-bed care home for older people with nursing needs. Thus Registered Nurses are part of the care team, throughout the day and night. In a semi-rural area of Exmouth, the house is a 3-storey Grade 2 listed building, which has been extended to include a large 2-storey annexe. It is situated in its own grounds, with gardens, patio areas, ample parking and some views to the sea. The home has several lounges and sitting areas, a dining room and a 'function room'. Two small passenger lifts link the floors, one in the main building and one in the extension. The home is also currently considering the installation of a stairlift. There are 34 single bedrooms and 4 double bedrooms. All but two of the rooms have ensuite facilities. Information about

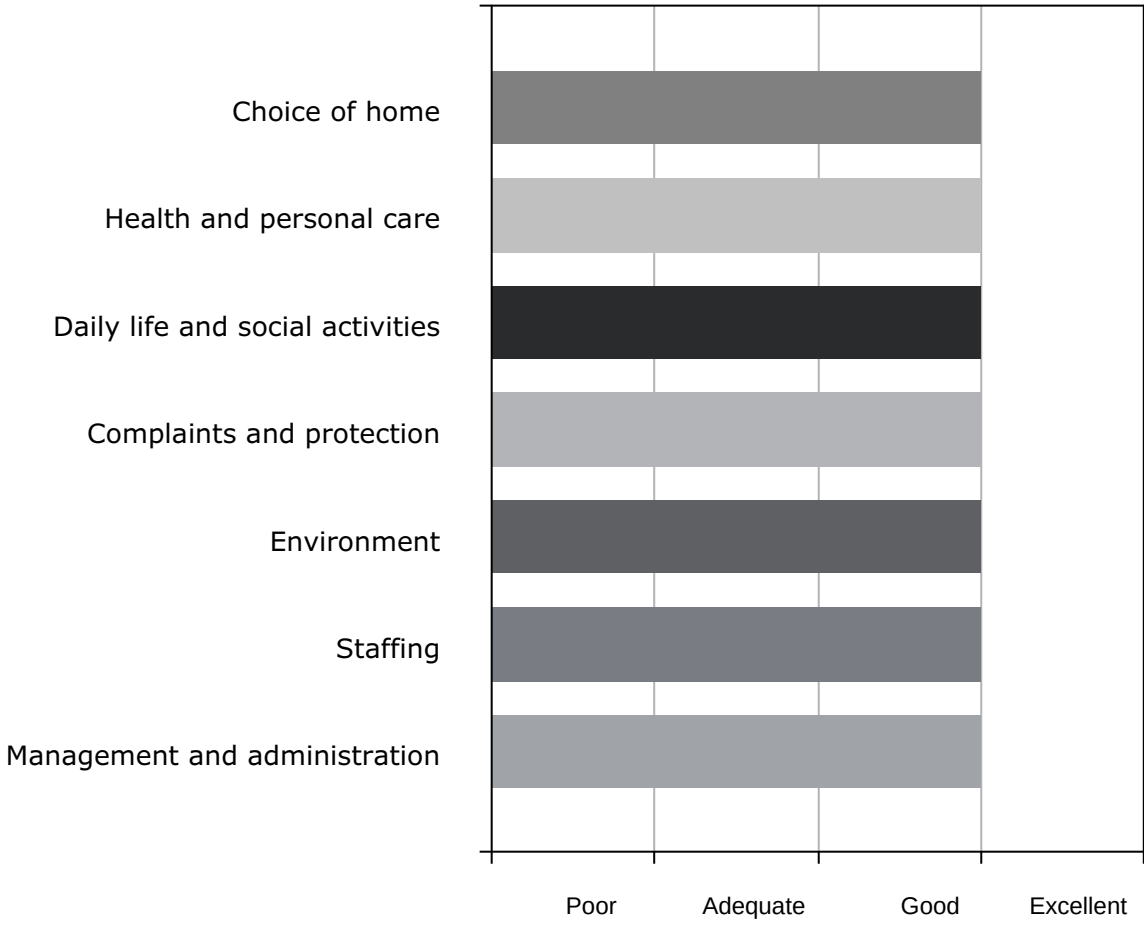
Brief description of the care home
this service, including our previous reports, is available from the home by contacting them directly. The fees range from 330-750 pounds per week, depending on the individual's needs, whether they are privately funded or funded through Social Services, and the room size. There are additional charges for transport, some social activities, a staff escort if required for health appointments away from the home (20 pounds), and for personal items such as toiletries and newspapers.

Summary

This is an overview of what we found during the inspection.

The quality rating for this care home is:	two star good service

Our judgement for each outcome:



How we did our inspection:

Our last key inspection of the home was on 2 July 2007, and we carried out an Annual Service Review on 17 July 2008.

This key inspection took place as part of our normal programme of inspection. Our unannounced visit to the home was carried out in thirteen hours over two week days.

Prior to our visit we sent surveys out, asking people about the home. Of 22 surveys sent to people who lived at the home, 14 were returned - most were completed by the individual or with help from their family;1 asked to speak to us. Of 22 surveys sent to staff, 11 were returned. Of 10 surveys sent to health and social care professionals who support people living at the home, 1 was returned. Feedback from these surveys is

included in this report. Other information given to us throughout the year has also been taken into account.

Paula Burtoft, the home's registered manager, had completed a questionnaire (the Annual Quality Assurance Assessment, or 'AQAA') before we visited, including the home's assessment of what they do well and how they plan to improve further, as well as general information about the people living there, the staff and the facilities.

During our time at the home, we looked closely at the care and services offered to 4 people as a way of judging the standard of care and services generally. They included people new to the home, people cared for in bed because of physical frailty, people without support from family or friends, and people with mental health needs. Where possible we spoke with these people in depth. We looked at their care assessments and care plans, and spoke with staff about their knowledge and understanding of the plans. We looked at their bedrooms and we looked at the overall environment from their perspective.

We met at least 10 people who lived at the home and a visitor, all but one being able to give us their views. We also spoke with 5 care or ancillary staff, and the manager. We looked around the building, and read other records including medication, staffing, accident and incident reports, training, fire safety and recruitment.

We ended our visit by discussing our findings with Paula Burtoft, who assisted us fully during our time at the home.

What the care home does well:

Asked what the service does well, comments from people who live at the home ranged from 'Meals and cleaning' to 'Entertainments and activities'.

We found prospective residents can get good information about the home, to help them make an informed decision when choosing where to live. Their needs are assessed well, to ensure that the home can support and care for them appropriately if they move in.

People's healthcare and personal care needs are met through increasingly person-centred care planning and management, by sufficient numbers of suitable and caring staff, who respect peoples' privacy and dignity.

Most people living at the home benefit from varied and interesting daily lives, which are enhanced by continued links with the community around the home, including their friends and families.

The accommodation is homely, and being improved to make it safer and easier to access for those people who are disabled.

The home is well managed, and working hard to make sure it is run in the best interests of those who live there. People's complaints are heard and acted upon. Those living at the home are generally kept safe and protected from harm.

What has improved since the last inspection?

Care plans written for each person at the home increasingly show how their health and welfare needs are to be met in an individualised way, including those for people with mental health needs and communication needs. Staff are receiving training that helps them to care for people with certain conditions, and there are enough staff on duty to ensure that the people who live here can have their needs met.

Medications that are no longer used are not kept in the home for any longer than necessary.

People are now supported to continue with the faith of their choice and to attend religious services of their choice.

People with mobility problems have appropriate seating, in the areas of the home that they use. Certain environmental hazards have been addressed so that people can move safely around the home.

Areas of the kitchen have been cleaned or repaired, ensuring that it is a safe environment for food preparation. Fridges work properly, so food is stored at appropriate, safe temperatures.

What they could do better:

Greater attention to aspects of personal care will ensure people's dignity is upheld at all times, with regard for nail-care, cleanliness of people's spectacles, etc.

People enjoy an appealing and nutritious diet, although the variety of meals offered to people with certain dietary needs should be improved so that they do not get the same meal twice in one day.

Through more effective arrangements for the administration and safe storage of medication, people would receive all medicines they are prescribed, without risks to their wellbeing. Our previous timescale, of 31/08/07, for addressing such matters has not been fully met.

Continued development of opportunities for leisure and recreational activities, especially where people are not able to initiate or control their social lives as much as others, would improve the quality of these individuals' lives.

When asked what the service could do better, one person said, 'Answer call bells.' We found that various procedures for ensuring people get timely attention should be strengthened, whether they have a callbell or not.

Much has been done to improve the environment, but more needs to be done to ensure the home is kept hygienic and pleasant throughout, and so that more people (with a range of disabilities) can have a bath if they wish. Servicing of all gas appliances should also be done in a more timely manner.

Staff training needs to be further developed, evaluated, and accredited in some cases, so as to ensure people's individual needs are met and they are in safe hands at all times, as well as to ensure the health and safety of everyone at the home.

The home's policies should be regularly reviewed, with additional policies produced that ensure the requirements of the Mental Capacity Act 2005 will be fully met.

If you want to know what action the person responsible for this care home is taking following this report, you can contact them using the details set out on page 4.

The report of this inspection is available from our website www.cqc.org.uk. You can get printed copies from enquiries@cqc.org.uk or by telephoning our order line –0870 240 7535.

Details of our findings

Contents

Choice of home

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People are confident that the care home can support them. This is because there is an accurate assessment of their needs that they, or people close to them, have been involved in. This tells the home all about them and the support they need. People who stay at the home only for intermediate care, have a clear assessment that includes a plan on what they hope for and want to achieve when they return home.

People can decide whether the care home can meet their support and accommodation needs. This is because they, or people close to them, have been able to visit the home and have got full, clear, accurate and up to date information about the home. If they decide to stay in the home they know about their rights and responsibilities because there is an easy to understand contract or statement of terms and conditions between them and the care home that includes how much they will pay and what the home provides for the money.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

Prospective residents can be assured that their needs will be assessed, to ensure that the home can support and care for them appropriately if they move in. People have good information about the home to help them make an informed decision about where to live.

The home does not provide intermediate care.

Evidence:

In surveys from people who lived at the home, most confirmed they had enough information about the home before they moved in. We were shown an information pack taken by the manager when she meets prospective residents to tell them about the home and assess their needs. It included the home's Service User Guide, a sample weekly menu and the current activity programme. A company website has also been set up to provide people with information about the home.

Evidence:

We saw the home provided a breakdown of individuals' care fees, in their 'Terms and conditions' or contract, to clarify nursing care fees as opposed to fees for accommodation, etc.

Someone new to the home confirmed their advocate had been shown around the home and had discussed the individual's care needs with senior staff, before the manager went to meet the person and assessed their needs.

We noted that the Service User Guide said people would not be excluded on the grounds of their religion, ethnicity or culture, but did not include other aspects of diversity such as people's sexuality. The manager said this was an unintended omission, which she would rectify, and that the home did not discriminate on such matters.

The home's assessments that we read were comprehensive. Information had also been obtained from Social services care managers or hospital staff where they were involved with supporting or caring for the person.

A health professional who completed our survey thought the home's assessment processes usually ensured the right service was planned for people. We saw action plans had been drawn up subsequent to the home's initial assessment - further follow-up that was needed, such as getting equipment, noting furniture that people wished to bring so their room was prepared accordingly, etc.

Information gained pre-admission included clubs people were attending and current friendships, with action planned to enable these to be continued. Where people's faith was recorded, it was also noted if they still practised this faith, etc.

The AQAA indicated that the home's pre-admission assessment form had been revised with consideration for the Mental Capacity Act 2005, so as to gather information regarding people's Power of Attorney, Advanced Decisions, etc. One pre-admission assessment we saw had little reference to the person's capacity to make decisions for themselves, their 'last wishes', etc., although it was recorded that this was still to be discussed. This meant there was no current guidance on how staff should respond if the person - who was now living at the home - were taken seriously ill, for example.

Information from assessments had been used as the basis for plans of care for each person. Staff told us they were given good information about people's needs before and when they moved in, which helped them to care for people safely and in an individual way.

Evidence:

Some additional detail would have been helpful, to further ensure people received person-centred care. For example, no risk assessment was recorded in relation to a prospective resident with impaired sight, and their subsequent care plan said they had 'visual problems' but without stating what these were or how they affected the person and their daily life.

Health and personal care

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People's health, personal and social care needs are met. The home has a plan of care that the person, or someone close to them, has been involved in making. If they take medicine, they manage it themselves if they can. If they cannot manage their medicine, the care home supports them with it, in a safe way. People's right to privacy is respected and the support they get from staff is given in a way that maintains their dignity.

If people are approaching the end of their life, the care home will respect their choices and help them feel comfortable and secure. They, and people close to them, are reassured that their death will be handled with sensitivity, dignity and respect, and take account of their spiritual and cultural wishes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People's healthcare and personal care needs are met through good care planning and management. Their privacy and dignity is respected.

Evidence:

All but one of the surveys from people who lived at the home said they always or usually received the care or support they needed, including medical attention. Asked what the home did well, their comments included, 'Excellent care on a one to one basis - from carers and nurses', 'Give you personal treatment', and 'Everything possible has been done to make me comfortable since I came out of hospital, and I appreciate this.' One person added, 'I am more than happy with my spouse's care.'

Each person at the home had a care plan, which they or their representative had been involved in developing. Key needs, such as maintaining nutrition and hydration, safe moving or handling, and skin care needs, had been considered and identified. Plans detailed how people's needs were to be met. We saw detailed information on what support people needed with their personal care, the nature of any pain they

Evidence:

experienced, their preferred bedtime, etc. One included arranging hairdressers' visits in the mornings, when the person would be more settled and receptive to such attention. One person was to be offered a hot meal in the evenings, staff having noted they did not appear to 'enjoy' sandwiches.

People's care records included their 'Social profiles', which described their personal histories, their likes, dislikes or preferences, events important to them, etc. Staff we spoke with knew about people's individual preferences. However, actions to meet related social needs were either not then stated for two of the four people we case-tracked, or not followed up.

In some cases, we observed that people were not given care included in their care plans, and asked staff about this. They were able to give satisfactory explanations, but this information should then also be included in the care plans, to promote consistent care and ensure care plans are up-to-date. Where care plan reviews had been carried out to ensure the care planned was appropriate to meet all the person's needs, we noted the evaluations reflected people's physical needs more than how how people spent their time or had their social needs met.

Some of the people we case-tracked had mental health needs. Advice had been sought from a Community Psychiatric nurse in one case, and this advice had been incorporated into the person's care plan, as a specific aspect of care and where the advice was relevant to other aspects of care needed by the person. Their care plans did not yet include assessments of their capacity to make decisions, etc.

Where the use of bed-rails was considered for individuals, risk assessments had been completed. They, or their representative, had signed to show they had been involved in the matter, although we noted the section for recording their opinion was often blank.

Staff meeting minutes indicated that fluid intake targets for individuals should be part of their care plan. This was not the case for someone we case-tracked, who had a fluid intake chart in their room. Although the person looked hydrated and was being given fluids regularly, staff could not tell us what the target was, and no totals were included in the person's daily care notes made by staff. We discussed this with the manager.

Care plans included the check ups, by community-based professionals, that people would need for certain medical conditions they had. The health professional who completed our survey thought the home usually monitored and met people's needs properly, and said they were particularly good at pro-actively seeking and acting on advice effectively, so as to improve people's well-being.

Evidence:

People we spoke with also felt staff attended to their health needs well. One person told us staff had given them prompt attention when the individual themselves had not realised they had a health problem. Care notes showed that staff had observed that someone with communication difficulties due to mental health needs was in pain; they arranged for a dentist to see the person, and the problem was successfully addressed. Advice from a Speech and Language therapist had been transferred to one person's care plan; the therapist noted an improvement in the person's state over time. A care plan for someone with diabetes included the usual range of their blood glucose and what staff should do if it was not within this range. Information leaflets were available, in the entrance corridor, on 'Staying steady', 'Healthy bones', and 'Better hearing', among other topics.

However, we noted a risk assessment had been carried out which resulted in the footrests being removed from someone's wheelchair. There was no evidence that other relevant professionals, such as a physiotherapist or occupational therapist, had been consulted, which we discussed with the manager since a lack of footrests also carries risks.

Several people had profiling beds to help make them comfortable and safely positioned when in bed.

Two staff - a nurse and a care assistant - represent the home as Link Staff for palliative care meetings held by the local Primary Care Trust. Some staff are currently undertaking a course on this area of care.

We saw the home included in their admission procedures a system for checking that the medicines people brought in with them were their current medication and that nothing was missing. This is very good practise. Medicines received by the home, and disposed of, were recorded. Medication administration records were mostly up to date, although applications of skin creams were still not recorded - something raised at our last inspection. Staff gave different explanations of practises for recording the administration of such creams. The manager confirmed that some action had been taken to try to improve such recording, but agreed this needed to be properly addressed. She also agreed audits of medication not taken by mouth, including insulin, needed improving.

When we checked stocks of controlled drugs, we found that there was no way of confirming when one item, with a limited shelf-life once opened, had in fact been opened. Systems in place showed medicines requiring cool storage had been kept at appropriate temperatures

Evidence:

Two people we case-tracked were on medication that could be used to sedate people, which is not always in an individual's best interests. We found little had been given, with, in one case, evidence that staff had tried alternative, more positive strategies, as guided in the person's care plan.

The health professional who completed our survey said the care service always respected people's privacy and dignity, as people confirmed and we observed during our visit. One person told us they would appreciate having a lock fitted on their bedroom door, and we passed this information to the manager.

Asked what the home could do better, a relative said 'All the nursing, care and attention is beyond what I expected, although aspects of personal care sometimes need attention.' On our visit, we noted some people had nails or spectacles that needed cleaning. A hairdresser visited the home regularly, and we could see the positive results of this.

Daily life and social activities

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

Each person is treated as an individual and the care home is responsive to his or her race, culture, religion, age, disability, gender and sexual orientation. They are part of their local community. The care home supports people to follow personal interests and activities. People are able to keep in touch with family, friends and representatives. They are as independent as they can be, lead their chosen lifestyle and have the opportunity to make the most of their abilities. People have nutritious and attractive meals and snacks, at a time and place to suit them.

There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

The majority of people living at the home benefit from varied and interesting daily lives, which are enhanced by continued links with the community around the home, including their friends and families. They enjoy an appealing and nutritious diet, although the variety of meals offered could be improved in some cases.

Evidence:

Comments in surveys from people who lived at the home, about what the home did well, included, 'Care & support with a very good family atmosphere, good social activities' and 'Relaxed & homely atmosphere. Freedom of choice at all times.'

The home's 3-monthly newsletter dated March 2009, displayed in the entrance hall, covered Easter celebrations at the home, the Queen's birthday, watching of a video on a local village that some residents used to live in, and dates for future planned events. We saw the current activities programme in some people's bedrooms, which showed activities were planned Monday-Friday. When we asked people how they found the week-ends, when no activities were planned, some told us they enjoyed using the garden, others said they had visitors.

Evidence:

Of 14 surveys from people at the home, 10 said there were always or usually activities organised that they could take part in. The home had libraries of large print books. People told us they enjoyed the Bingo games, and regular musical entertainment led by a pianist in the Ballroom/function room. One said they watched the exercise class that was held, choosing not to join in. Another was going on the outing (a 2-hour trip) taking place during our visit. People would not be getting off the bus because of their mobility needs, but the Organiser took along homemade cakes and flasks of tea, which people told us they enjoyed greatly on these trips. A visitor praised the Activities Organiser, saying she was 'excellent'.

One person said they were staying in to see visitors, but would go on the next outing which was in a fortnight's time. They said winter outings had included trips to watch fireworks and to see the Christmas lights.

People told us Communion was offered monthly, with a church service also held regularly. This was as a result of discussions at a residents' meeting, according to the AQAA.

The Service User Guide encouraged people to say if they had a particular interest and the home would try to accommodate this in the home's activity programme. The AQAA stated 'Activities are organised on a group basis and one-one basis', and we saw some evidence of one-to-one time spent by the Activities Organiser with individuals. However, records indicated such time was limited - for example, if someone was asleep when she visited them, records showed it could be a little while before they were visited again, especially when the Activities Organiser was away. Asked what the home could do better, the health professional who completed our survey suggested 'Consider an inclusive environment, encouraging further a community spirit for those less able to control their social contact independently.'

Of 14 surveys from people at the home, 10 said staff always or usually listened to them and did as asked; 4 said this happened sometimes. The health professional who completed our survey said the home usually supported people to live the life they chose, where possible. People we spoke with felt they were generally given sufficient choice in their daily lives. They confirmed people went to bed at a variety of times from early to late evening, at times of their choosing. One person was particularly pleased that they were now offered a choice of meal at lunchtime, a day ahead of the meal. One person commented that they would like baths to be available; we have discussed this further in the section on 'Environment'. We found bedrooms were personalised with people's possessions.

Two people living at the home told us they were given minutes of the residents'

Evidence:

meetings which they then shared with their visitors. The AQAA said visitors were offered refreshments and could stay for a meal should they wish to do so, which people confirmed during our visit. We met someone who had recently had a birthday. They said the cook had made them a lovely cake, and they had been able to entertain family members for tea. One care plan said staff should first check if an individual wanted to receive any visitors who arrived to see them, because the person was particularly prone to tiredness.

Of 14 surveys from people at the home, 13 said they always or usually liked the meals provided. Asked what the home did well, responses included, 'Meals' and 'Excellent food - quality, quantity, choice & service.'

People living at the home said breakfast was served by about 8.30am. A visitor told us the meals were 'out of this world'. Lunchtime choices during the week we visited included fish pie or lamb chops, sweet and sour chicken or egg and chips. Evening meal choices included scrambled eggs or ham salad, cheese and biscuits or cauliflower cheese. Sunday lunch was a roast dinner, with a buffet for the evening meal.

Lunchtimes we observed during our visit were calm occasions, with staff making themselves available discretely to assist people throughout the meal. Plated meals looked appetising, with vegetable nicely cooked. Eating aids were provided, and a hot trolley taken to upper floors for serving of meals to people not eating in the dining room. Most people seemed to be enjoying the food and confirmed this when we asked; where someone was not eating their meal, staff offered an alternative.

We noted people were given plastic disposable aprons to protect their clothing, which looked inappropriate. The manager told us she was awaiting delivery of less institutional clothing protectors, although we discussed whether good quality cloth napkins might be suitable also.

There were fresh fruit and vegetable in the kitchen stores, including salad items, and fruit juice, a variety of fruit squashes, and yogurts. Pureed meals were served attractively, with individual components served separately on the plate. However, we found through our observations and conversations with staff that people needing such a diet were given the same for lunch and tea, with the evening meal plated up at lunchtime. The manager said she would look into this.

Complaints and protection

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

If people have concerns with their care, they or people close to them know how to complain. Any concern is looked into and action taken to put things right. The care home safeguards people from abuse and neglect and takes action to follow up any allegations.
People's legal rights are protected, including being able to vote in elections.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People's complaints are heard and acted upon. They are generally kept safe and protected from harm.

Evidence:

Most - but not all - surveys returned from people living at the home indicated that they knew who to speak to if they were not happy, and knew how to make a formal complaint. The home's AQAA said they had received 9 complaints, all of which were upheld. We found action had been taken to address the concerns raised. When we spoke with someone who had raised concerns, their responses indicated that the issues had been resolved. They, with others, told us staff 'do try to put things right'. The health professional who completed our survey also reflected this.

We saw the Service User Guide was provided in each bedroom. This included the complaints policy and how people should give feedback if they felt the home was 'not achieving desirable and acceptable standards'.

One person living at the home commented, 'I am very happy, feel safe and am well looked after.' Staff had received training in safeguarding people. They demonstrated good knowledge of what abuse is, and said they would report any allegations or suspicions to the manager, or external agencies if more appropriate.

Evidence:

We saw people's valuables were listed on their admission to the home.

The use of bed-rails creates potential risks to individuals' welfare. This had been considered, with risk assessments written, for some people we case-tracked. These records showed a variety of outcomes, with decisions made that using them was not the safest action for some individuals. Alternative strategies for reducing risks to the person's wellbeing were then given.

One person said that their call-bell was sometimes not available to them, because staff left the bell near their weak arm rather than where they could use it. Staff we spoke with were aware of the need to mindful of such a problem, but the manager said she would address this matter further. We were told one person without a call-bell available would not use it if it were provided. Their care plan did not specify how staff were to ensure their comfort and safety when the individual could not summon help, and staff gave different frequencies for checks they said they would make to see if the person was alright.

Environment

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People stay in a safe and well-maintained home that is homely, clean, pleasant and hygienic.

People stay in a home that has enough space and facilities for them to lead the life they choose and to meet their needs. The home makes sure they have the right specialist equipment that encourages and promotes their independence. Their room feels like their own, it is comfortable and they feel safe when they use it.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People benefit from accommodation that is safe and homely. It is being improved to make it safer and easier to access for those people who are disabled, although further action is needed to ensure improvements are made in a timely way and it is hygienic.

Evidence:

When asked what the home did well, comments on surveys from people who lived at the home included, 'I have my own room', 'Comfortable beds', 'Pleasant environment to move around with many different places to be seated inside & outside. Extensive grounds for wheelchair use. Freedom of movement yet with plenty of attention from staff.' Asked what could be improved, one person said, 'Make a more interesting garden.'

Where a carpet presented a tripping hazard on our last visit, we found this had been addressed. People told us they did not encounter any problems getting around the home, including those who used walking aids.

The AQAA said the programme for re-decoration and re-carpeting in the home was ongoing, and we met two people who had had their bedrooms redecorated and re-carpeted recently. Most people we spoke with could tell us they were happy with their bedroom and its facilities.

Evidence:

We case-tracked one person because they had few visitors, and were cared for in their bed, being relatively frail. The carpet in and outside their room was heavily stained, with staff telling us that because the person was bed-bound this could not be addressed properly. The person had very little of interest to look at from their bed. The Activities Organiser described ways in which she had tried to improve the room, but had encountered difficulties finding something the person liked. She and the manager agreed to try further to address this matter, to improve the quality of this person's day and environment.

The home's lift had broken down 3 times since our last inspection, as one person raised with us during our visit. This was despite regular servicing, evidenced by the engineers' reports we saw. The home is now considering installation of a chair lift to avoid inconveniencing people again.

The handyman usually worked at the home full time, and was on call at week-ends for emergencies. People said that minor repairs were attended to quickly. The maintenance log we saw confirmed most repairs were carried out in 1-3 days.

The home is a Grade II Listed Building, which affects some alterations. Some changes had been made, in response to people's diverse needs or their suggestions. Pre-admission assessments we saw for people who had since moved into the home included equipment, rails, etc. that were to be in place ready for their arrival.

The home had two level-access showers, as well as adapted baths for people with certain mobility problems. A comment in one survey was that the respondent would appreciate it if baths were available. The manager explained that the current baths did not accommodate people who needed hoisting. We spoke with one person who told us they did not have a bath or shower, and didn't like having their hair washed in bed. The manager told us the home had recently obtained a specialist chair for use in the shower, that would enable this person to have a shower. Other aids (such as raised seats or surrounding frames), to help people remain independent, were available. Whilst other shared areas looked homely, toilets and bathrooms tended to look more institutional and less welcoming.

The home had a number of communal areas for people to sit in. This included a 'chapel', accessible for those wanting a quieter place to sit. On our last visit, someone said they were not able to sit in one area any more, because seating had been removed. On this visit, we found people sitting happily in the area again. New seating had been provided around the home, to suit people needing differing heights of furniture to promote their independence and comfort. People we spoke with and our

Evidence:

observations confirmed they were able to use the seating available.

There is level access to the gardens and grounds, which are usable by wheelchair users, as we saw during our visit. People enjoyed the sunny weather by using the paved areas of the garden, where seating was available, flowers were growing (- some planted by people living at the home), and shaded areas had been provided.

Staff surveys raised the point that there were no staff rooms at the home. During our visit, we observed the dining room for use by the people living at the home was used by staff for their breaks. Some individuals looked uneasy at disturbing the staff as they walked through the area.

When we carried out our Annual Service Review, servicing of gas appliances was overdue, but we were told this was being looked into. On this inspection we found kitchen appliances had been serviced since then, but not the gas boilers (which were to be serviced the week after our visit). Some portable electrical appliances had not been tested in the last year. The manager confirmed this testing would be completed by early July 2009. We saw evidence that 5 hoists were serviced recently.

The AQAA said a Home Services Manager visited the home on a weekly basis to review the housekeeping services. Surveys from people living at the home the home was 'always' or 'usually' clean and fresh. A relative praised the home for their achievements in keeping one person's room clean and fresh. We too generally found the home clean and without malodours when we arrived at a relatively early hour. Furniture had been moved for thorough cleaning. However, there was a slight odour on entering the home, and one room remained very odorous, despite being aired all day. A lounge carpet was stained in places. A domestic staff member was still working her way around the home in the mid-afternoon; a carpet cleaner was used during the day.

The laundry had washing machines with programmes suitable to deal appropriately with items, including soiled linen. It was orderly on the days of our visit, with a variety of wash programmes used.

Disposable gloves and aprons were distributed throughout the home for staff to use in preventing the spread of any infections. Staff we spoke with described appropriate infection control practises also. However, we pointed out to the manager that the AQAA said that of 31 staff, only 16 had had infection control training, and that the infection control policy had not been reviewed since 2005.

The home had sluicing facilities, but not all were mechanical so staff would have to

Evidence:

deal with some items by hand, which creates cross-infection risks. This is not appropriate in a care home for people with nursing needs. One sluice room had damaged tiling, which would affect the levels of cleanliness that could be achieved there. The kitchen walls and floor had been repaired as recommended at our last visit, which would help to maintain the hygiene of that area.

Staffing

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have safe and appropriate support as there are enough competent staff on duty at all times. They have confidence in the staff at the home because checks have been done to make sure that they are suitable to care for them. Their needs are met and they are cared for by staff who get the relevant training and support from their managers.

There are no additional outcomes.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People living at the home are supported by sufficient numbers of suitable, caring staff. They will benefit further from ongoing staff training and support, which is being developed so as to ensure people's needs are met and they are in safe hands at all times.

Evidence:

Asked what the home did well, some people replied in their surveys, 'Staff are very good', 'Staff very friendly', and 'All staff - from kitchen, cleaners, carers, sisters - they're all angels.' One person living at the home told us they were good friends with the carers, and a visitor said staff were '100% caring'.

The great majority of surveys from people living at the home said staff were always or usually available when needed. Most staff thought staffing levels were sufficient except when affected by sickness or holiday leave. Asked how the home could improve, one person wanted action about staff who called in sick, and on our visit, we noted sickness absences on work rotas. The manager was clear that this was being addressed with individuals concerned.

When we first arrived, there were 38 people living at the home, with just over half of them needing nursing care. Two Registered Nurses were on duty with 6 care assistants

Evidence:

to provide care and support for them. In the afternoon, the team was reduced by 1 care assistant, with another reduction to 4 carers at 5pm. Overnight, there was 1 Registered Nurse with 3 carers.

The manager, also a nurse, was supernumerary to the care team. In addition there was a cook, a kitchen assistant, 2 cleaners and an administrator on duty. The handyman was on holiday, so maintenance cover was provided from another of the provider's homes. The AQAA indicated that there was relatively little use of agency staff.

People told us that, generally, staff were fairly punctual with meals, medications, assistance to get up or go to bed when they wanted, etc., although some said that call bells were not always answered promptly. A visitor said staff always went to sit with people who lived at the home rather than just 'sitting around' together.

Someone living at the home had been charged the flat rate for a staff escort for an appointment that was unexpectedly short, feeling this was unfair. The manager explained that the fee covered costs of an additional staff member to accompany individuals, rather than sending staff who were rostered to work as part of the usual numbers.

Staff recruitment was ongoing. We checked the recruitment files of 3 staff members recruited since our last inspection. Each contained an application form, written references and proof of identity, and timely police checks as is good practise to ensure that appropriate people are recruited to work in the home. The registration status of nurses in this sample had been checked by the home with their registering body, with evidence kept to show they were permitted to work in the capacity of nurses.

We saw that the staff induction programme was now based on a recognised induction for care staff. The AQAA said that new staff are given the relevant code of conduct (for social care staff) in their first language.

One comment made was 'The majority (of staff) are excellent, but English language a problem for other staff & patients.' A certificate displayed, given by a college of further education in April 2009, evidenced that the home had taken steps to help staff from overseas to improve their English language skills. When we asked people at the home about ease of communication with staff, one said that they came from another part of England and did not always understand staff from Devon.

Other comments on what the home could do better included 'Staff training, especially the young and foreign staff' and 'Maybe more training in basic needs would ensure

Evidence:

quality care - not easy for staff under pressure,' which reflected our findings about aspects of personal care. Of 22 staff, 10 had a recognised care qualification, and 7 others were undertaking one. The home also employed a company to provide training to staff who were not currently able to undertake a care qualification, which included some of the staff from overseas. The health professional who completed our survey said the staff usually had the right skills and experience to support people's needs and respond to their more diverse needs.

Staff had a limited understanding of the implications that the Mental Capacity Act 2005 had for their work and responsibilities, but further training on the subject was held during our visit. We asked staff what a 'diabetic diet' meant, having read in someone's care plan that they required this. We got various responses, most of which were not in line with current guidance. One staff member said they had not had any training on diabetes and would find it helpful. Two people we case-tracked had sight problems, and staff were knowledgeable about the support they consequently needed as individuals.

The manager confirmed a group of staff were undertaking accredited long-distance learning on dementia, palliative care, and equality and diversity matters.The health professional we surveyed said they were 'Impressed by evidence of recent training taken up by the home aimed at improving understanding and care for individuals with cognitive deficits.'

Management and administration

These are the outcomes that people staying in care homes should experience. They reflect the things that people have said are important to them:

People have confidence in the care home because it is led and managed appropriately. People control their own money and choose how they spend it. If they or someone close to them cannot manage their money, it is managed by the care home in their best interests. The environment is safe for people and staff because appropriate health and safety practices are carried out.

People get the right support from the care home because the manager runs it appropriately with an open approach that makes them feel valued and respected. The people staying at the home are safeguarded because it follows clear financial and accounting procedures, keeps records appropriately and ensures their staff understand the way things should be done. They get the right care because the staff are supervised and supported by their managers.

This is what people staying in this care home experience:

Judgement:

People using this service experience **good** quality outcomes in this area. We have made this judgement using a range of evidence, including a visit to this service.

People benefit from living in a well managed home which is striving to improve person-centred care and which is working hard to make sure it is run in their best interests. People's health and safety is not protected robustly.

Evidence:

Mrs Paula Burtoft was registered as the home's manager in May 2007, having previously worked as a Registered Nurse in hospital settings. Comments made in the surveys we received from people living at the home included, 'The leadership through Paula creates a very pleasant efficient working atmosphere,' and from staff surveys, 'Over the past few years it (ie the home) has improved.' Positive comments about the management of the home were also made to us by people we spoke with, and we found action had been taken to address issues raised at our last inspection. Staff felt well supported. They and other people we spoke with said the manager - and senior staff in general - were very approachable.

Evidence:

There was no-one living at the home who was subject to a deprivation of liberty authorisation, and we did not find that anyone was having their liberty deprived without an authorisation. The home's AQAA included that they needed to do more in relation to this relatively new legislation. However, there was no guidance available for staff that staff were aware of, to ensure the the requirements of the Mental Capacity Act 2005 will be met.

When we carried out the Annual Service Review, we noted that some policies had not been reviewed for three or more years but were told by the manager that these were currently being re-drafted. On this inspection, we found that this has still not been addressed.

A notice on display informed about a forthcoming relatives' meeting. Minutes for the last residents' meeting showed topics discussed included meals, decor, staffing matters, individual care, activities, and a request that home-made cakes be provided with the mid-afternoon tea again. People confirmed that action was taken to address suggestions or other comments made at such meetings.

We were shown the home's quality assurance plan, which included regular meetings or reviews concerning catering services and activities provided by the home, as well as making provision for subsequent action plans.

The AQAA informed us that the home had begun surveys specifically for new residents, carried out after they had been at the home for 14 days. This, as we saw, included a comment cards about their pre- and post-admission experiences.

The manager told us that the annual survey had just been sent out by the company's head office to people living at the home and their relatives, with surveys sent out late last year to the home's staff and visiting professionals. We saw these surveys asked people about cleanliness, decor, activities, the laundry, staff meals, and the home's response to any concerns, among other things. We found where people had raised matters they felt could be improved, action had already been taken about some of these, addressing the issue.

We checked the personal monies records of 3 people for whom the home kept monies on their behalf. Good records were kept, along with receipts, with transactions witnessed and verified by 2 signatories. This ensured that these accounts were auditable and monies accounted for. The manager confirmed that no employees of the company acted as appointee for anyone living at the home. We also saw people had been notified in writing, in advance, of changes to care fees and the extras they could be charged for.

Evidence:

We saw records of regular maintenance or safety checks for bed-rails, hot water temperatures, window restrictors, and fire equipment. The manager told us that thermostatic valves were being fitted to sinks, to control risks from very hot water. Risk assessments had been written meanwhile for people who were considered at particular risk from very hot water. We have discussed elsewhere issues relating to overdue servicing of some gas appliances.

We discussed that other environmental risk assessments also needed to consider all individuals likely to put themselves at risk, and not just the environment alone. Window restrictors were in place where we checked. Kitchen fridge and freezer temperatures had been recorded weekly, and showed food was stored at within recommended ranges. An inspection of catering facilities, in the last year, by Environmental Health staff stated no further action was required by the home.

The home had to undertake some work by mid August 2009, following a visit by the local fire service. The manager told us that fire drills had since been carried out for night staff that had met the required timescale, and other action had been taken to improve fire safety at the home. However, when we spoke with staff about procedures in the event of the fire alarms sounding, they all gave different responses. The manager said she would speak to the home's fire safety trainer to address this matter urgently, and also to address training for a very small number of staff who had not attended recent fire safety updates as required by the home.

A form had just been devised to record the support each individual living at the home might need in an emergency such as a fire - information needed to also inform the home's fire risk assessment. The manager confirmed this information was in place for everyone living at the home by the second day of our visit.

Several staff had undertaken first aid courses, meaning that it was likely that an appropriately trained person would be on duty every shift. However, there was no system at present for ensuring this was the case, which the manager said she would address.

Are there any outstanding requirements from the last inspection?				
	Yes	☑	No	☐

Outstanding statutory requirements

These are requirements that were set at the previous inspection, but have still not been met. They say what the registered person had to do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards.

No.	Standard	Regulation	Requirement	Timescale for action
1	9	13 (2)	To ensure that people receive their medicines safely: All creams prescribed for people must be signed as being applied by the person who did this. A record should be kept of the use by date of all medications with a limited shelf life, so that they are not used beyond this date. All medications in the home that are no longer used (e.g. because the person for whom they were prescribed has died) must not be kept in the home for any longer than necessary.	31/08/2007

Requirements and recommendations from this inspection:

Immediate requirements:

These are immediate requirements that were set on the day we visited this care home. The registered person had to meet these within 48 hours.

No.	Standard	Regulation	Requirement	Timescale for action

Statutory requirements

These requirements set out what the registered person must do to meet the Care Standards Act 2000, Care Homes Regulations 2001 and the National Minimum Standards. The registered person(s) must do this within the timescales we have set.

No.	Standard	Regulation	Requirement	Timescale for action
1	9	13	You must have effective arrangements for the administration and safe storage of medication, especially: All topical creams & other preparations prescribed for people must be signed for, to evidence they have been given and who applied them; Systems that ensure medication with a limited shelf-life once opened is not used after the 'use by' period or date To ensure that people receive their medicines safely. Previous timescale of 31/08/07 not fully met.	24/08/2009

2	38	18	You must ensure that all staff receive training for the work they are to perform, particularly with regard to fire safety To promote and protect the safety and welfare of everyone at the home.	24/08/2009

Recommendations

These recommendations are taken from the best practice described in the National Minimum Standards and the registered person(s) should consider them as a way of improving their service.

No.	Refer to Standard	Good Practice Recommendations
1	10	It is recommended that personal care be such as to ensure people's dignity is upheld at all times, with regard for nail-care and cleanliness of people's spectacles, etc.
2	12	It is recommended that you continue to develop provision of opportunities for improving the quality of individuals' lives through leisure and recreational activities, especially where they are not able to initiate or control their social lives as much as more able people.
3	15	It is recommended that you ensure people receive a varied diet, and do not have the same meal twice in one day unless they have made a positive choice about this.
4	18	It is recommended that procedures for ensuring people get timely attention are made more robust, whether they have a callbell or not, to safeguard them from neglect.
5	22	It is recommended that bathing facilities are improved so that people with a range of disabilities, as likely to be found in a care home registered to provide nursing care, can have a bath if they wish.
6	28	You should continue to work toward ensuring that 50% of care staff hold a National Vocational Qualification (NVQ) in care to level 2 or above to ensure that the people who live here will have their needs met safely at all times.
7	30	You should continue to develop the training programme to ensure that staff receive training that helps them to meet all the needs of the people who live here.
8	26	It is recommended that you ensure that the sluicing facilities at the home are appropriate for a care home registered to provide nursing care - thus where people's

		needs will be greater or more complex than non-nursing settings - to minimise cross-infection risks.
9	26	It is recommended that the home is kept clean (including where staining of carpets is evident), and free from offensive odours, throughout the building.
10	33	It is recommended that the home has policies that are a) Regularly reviewed in the light of changing legislation and good practise guidance (as noted in Standard 33.9); and b) Provided for staff to ensure that the requirements of the Mental Capacity Act 2005 will be fully met.
11	38	It is recommended that servicing of all gas appliances is done in a timely manner.

Helpline:

Telephone: 03000 616161 or
Textphone: or
Email: enquiries@cqc.org.uk
Web: www.cqc.org.uk

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