

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

## Harmill House

Auclum Lane, Burghfield Common, Reading,  
RG7 3DB

Tel: 01189836368

Date of Inspection: 17 December 2012

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2013

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

<b>Consent to care and treatment</b>	✓	Met this standard
<b>Care and welfare of people who use services</b>	✓	Met this standard
<b>Management of medicines</b>	✓	Met this standard
<b>Supporting workers</b>	✓	Met this standard
<b>Complaints</b>	✓	Met this standard

## Details about this location

Registered Provider	Evelyn Grace Limited
Registered Manager	Mrs. Emma Devenny
Overview of the service	Harmill House is a domiciliary care agency operated by Evelyn Grace Limited, based in Burghfield Common near Reading. The agency provides support and care for forty people living in their own homes.
Type of service	Domiciliary care service
Regulated activity	Personal care

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## Summary of this inspection

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### Why we carried out this inspection

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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.

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### How we carried out this inspection

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We looked at the personal care or treatment records of people who use the service, carried out a visit on 17 December 2012, talked with people who use the service and talked with carers and / or family members. We talked with staff and talked with stakeholders.

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### What people told us and what we found

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We spoke to one of the people supported by the agency and seven relatives. They were all very happy with the quality of the care provided by Harmill House and spoke fondly of the staff who were described as "very helpful" "patient" and "kind".

People had been involved in planning their care and felt that staff supported them in the way they wanted. The care files demonstrated that staff had the necessary information to deliver individualised care and support.

People's medication was managed effectively where this was part of their care plan.

The staff received an appropriate induction and training to perform their role and had ready access to support should they need it.

No one had had any cause to complain about the service they received from Harmill House.

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

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### More information about the provider

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Please see our website [www.cqc.org.uk](http://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

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### 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.

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### Reasons for our judgement

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

The agency met with the people requiring support and their relative/representative to discuss their needs before providing support. A detailed assessment was completed from which a care plan was compiled. We examined a sample of people's files and saw that wherever possible, these included a record of the needs and individual wishes of the person to be supported. The assessments and care plans were not usually signed to confirm people's participation but contained good evidence of their involvement and provided information to enable personalised care and support. They contained detailed information about how the identified support should be provided and to what extent the person could be encouraged to contribute to their own care. For example, one care plan clearly detailed how the identified support with medication should be provided, so that the person's existing skills could be maintained.

People's right to decline the support offered was addressed within the care plans. For example the action to be taken in the event of a person refusing to take their prescribed medication was clearly identified within care plans as well as being addressed within the agency's medication policy/procedure.

Where people's care was funded by the local authority the contract for their care was between the local authority and the agency. Where people were privately funded, a copy of their contract with the agency was seen on file. Private contracts were signed by the person supported and/or their representative.

The responses to the agency's quality assurance survey (August 2011), from the people supported and their families were very positive with regard to consultation and involvement. One hundred percent of respondents agreed with the statement "My views are seen as important". Ninety percent of respondents agreed with the statement "I am able to comment on issues that affect me". The other ten percent answered "don't know".

The people we spoke with and their relatives all told us they had been involved in the assessment and care planning process. People told us the agency was in regular contact with them to ensure that needs were still being met. They said the staff supported them in the way they wanted. One person told us the agency met their relative's changing needs "with great flexibility". Another relative said that the management were "always available to speak to".

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

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**Our judgement**

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The provider was meeting this standard.

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

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**Reasons for our judgement**

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People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We examined a sample of care files which included assessments, care plans and relevant risk assessments relating to the individual. Detailed risk assessments were also completed for the home environment into which staff would be going. We saw that care plans and risk assessments had been reviewed regularly. Copies of reviewed care plans and other documents were retained on the office files.

The care plans included information, from the person supported or their family. This enabled staff to provide care in the way the individual wanted, as well as meeting their identified needs. The plans made reference to supporting people to manage aspects of their own care to maintain their dignity and independence. For example, one care plan referred to the person's clothing preferences so that staff could offer appropriate choices. Another file detailed the support needed around meals preparation and referred to offering the person choice. Staff also assisted the individual to prepare a food shopping list.

Where the staff had a role in supporting people with their medication, the level of involvement was clearly described. Where people were supported with the aid of specialist equipment such as hoists, staff were trained directly on using the equipment with the person. This helped ensure that the care was provided appropriately and that any necessary reassurance was offered to the person supported. One relative told us the staff had "explained things properly" to her mother and "got her confidence" before providing her support.

Where necessary, staff had advocated on behalf of people with regard to other agencies. In one case a 'Best Interests' meeting had been attended to ensure that appropriate arrangements were in place for a person coming out of hospital. The manager had also advocated on behalf of people with regards to medication and funding issues. The people we spoke with were happy that the agency provided support by a consistent small group of staff so they got to know and trust the staff individually.

The people supported and the relatives, to whom we spoke, all praised the high quality of the support and care offered by the agency. Several people told us the agency and its staff went well beyond what might be expected in supporting people. One relative said "I don't know how we would have managed without them" and another said "you can see the

difference in my mother since this agency took on her care". Others said they were "beyond happy" and "over the moon" about the support provided by Harmill House.

The staff we spoke with all said they had sufficient time to provide support to people at an appropriate pace for them. They said that where people's needs increased, the management would refer back to the local authority or the person funding the care, to try and extend the call time to address this. Staff had a good awareness of possible issues such as cross-gender care. They described ways in which they reassured and involved people in their own day-to-day care. We spoke to an external healthcare professional who told us the agency managed people's complex needs very well and also that they would advocate on people's behalf.

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

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## **Our judgement**

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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.

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## **Reasons for our judgement**

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Appropriate arrangements were in place in relation to obtaining and recording medication. Harmill House had some degree of involvement in medication, for 22 of the people supported at the time of our inspection. The agency had a detailed medication policy and procedure which detailed the range of support that was available. The policy made it clear that staff would only administer medication that was in labelled packs prepared by a pharmacist. The degree of support ranged from reminding or checking that the person had taken their medication, to administering people's medication to them. The policy also dealt appropriately with possible medication errors or refusals and any identified preparation errors by the pharmacist.

An administration process outside of the agency's policy was in place to meet one individual's very specific circumstances. The provider may find it useful to note that although this had been agreed verbally with the professionals involved and the family, it had not been documented or risk assessed in writing.

The agency had its own medication administration recording system which was adapted to the individual's needs. Copies of appropriately completed medication records were seen. People's files contained information on their prescribed medication and relevant risk assessments. The individual degree of support offered by staff was clearly described as were any specific details, to ensure consistency.

Staff all received training in medication administration and had been subject to a medication competency assessment by one of the senior staff. We saw certificates for this training and competency assessments on each of the staff files we looked at. The staff we spoke with all said they had received training on medication management and had been subject to a competency check. An update to medication training was scheduled for January 2013.

**Staff should be properly trained and supervised, and have the chance to develop and improve their skills**

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## Our judgement

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The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

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## Reasons for our judgement

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Staff received appropriate professional development.

The agency employed 22 staff at the time of our inspection. A variety of training methods had been used in the previous two years. Some face-to-face training had been provided as well as a range of computer-based e-learning courses. The current system involved study booklets completed by staff, which were then submitted to an external training provider for assessment. All new staff initially undertook a recognised induction covering the core areas. The signed off induction records were seen on staff files. They then attended a series of double-up calls with experienced colleagues or management, to enable them to take an increasing role in support and for their skills to be monitored. These monitored visits were also documented within staff files leading to the staff member being signed off by the manager to work alone.

Training on the use of hoists or other specialist equipment was provided by senior staff who had completed a 'training for trainers' course to equip them with the necessary knowledge. This training was delivered with the person being supported and using the specific equipment involved.

The staff files we saw contained certificated evidence of the range of training provided. Staff had all received the training necessary to ensure they had the skills required. A training programme of updates to all of the key areas was in place scheduled throughout 2012 and 2013. This was then to be updated on a three year cycle. The staff we spoke with all told us they had received the training they needed. Staff told us they could request additional training if they felt they needed it.

The manager and one of the senior staff undertook regular 'spot check' visits to observe the care practice of staff along with some double-up care visits which could also fulfil this role. Some records of these were seen within staff files. Ongoing supervision was mainly informal through regular dialogue by telephone. Staff had ready access to support and advice from senior staff 24 hours per day. The staff we spoke with confirmed this and all said they felt well supported in their role. Each staff member also had an annual personal development review. These included written contributions from the staff member and manager which were discussed face to face. Since the last inspection, records of the ad hoc 'supervision' and support offered to each staff member had been maintained.

We spoke with some of the staff who were very positive about all aspects of their employment by Harmill House. Staff were enthusiastic and motivated and gave examples of individualised care and support. They demonstrated a very good understanding of their role and of enabling and supporting people wherever possible, to be involved in their own care.

The feedback about the staff that we received from people supported and their relatives was very positive. People all said that the staff were competent and skilled. They gave examples where staff had exceeded their expectations. One person said that Harmill House staff were "the best they had ever come across" and another person described them as "very helpful". Feedback received from the agency's survey last year was that one hundred percent of respondents agreed with the statements that "staff are friendly and courteous", "show me kindness and understanding" and "I am treated with respect at all times".

## Complaints

✓ Met this standard

People should have their complaints listened to and acted on properly

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### Our judgement

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The provider was meeting this standard.

There was an effective complaints system available.

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### Reasons for our judgement

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People were made aware of the complaints system. This was provided in a format that met their needs. The agency had an appropriate complaints policy and procedure which was provided to them as part of the information pack.

The agency had not received any complaints about its service since the last inspection in March 2011. One hundred percent of respondents in the agency's quality assurance survey in 2011 felt that any complaints would be "listened to, taken seriously and acted upon". None felt they would be victimised if they made a complaint.

The people supported and their relatives to whom we spoke, all felt that the agency would listen to any concerns raised. None had ever had to raise any complaints about the support provided by Harmill House.

## 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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

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**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.

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**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.

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**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

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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)

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### **(Registered) Provider**

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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'.

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### **Regulations**

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We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

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### **Responsive inspection**

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This is carried out at any time in relation to identified concerns.

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### **Routine inspection**

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This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

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### **Themed inspection**

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This is targeted to look at specific standards, sectors or types of care.

## Contact us

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