Inspection Report

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

Burnside Court

104-106 Torquay Road, Paignton, TQ3 2AA

Tel: 01803551342

Date of Inspection: 25 February 2013

Date of Publication: March 2013

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

Respecting and involving people who use services	✓ 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	A B C Care Home Limited
Registered Manager	Miss Emma Hume
Overview of the service	Burnside Court is a residential home in Paignton, Devon providing accommodation for up to twenty six people.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 February 2013, observed how people were being cared for and talked with carers and / or family members. We talked with staff.

What people told us and what we found

People living at Burnside Court were not able to tell us what they thought about the service they received. We observed staff interacting with people and spoke with relatives. People told us they were involved in their relatives care. One person said that people are "treated respectfully, it is a nice friendly place".

We looked at five care files. These were well organised and easy to follow and all care plans had been regularly reviewed. The files contained a Residents Profile which had a summary of key details including things that were important to the person, such as "loves interaction with staff".

During our visit we saw a care worker giving a person their tablets. Before giving the tablets they told the person that "the GP had prescribed the tablets and reminded the person that they had their tablets every day". This helped the person to understand what was happening to them and why.

Staff we spoke with told us that in normal circumstances there was sufficient staff to meet people's needs as identified in their care plan. One carer told us that in normal circumstances they had time to "play games with the person, do their nails or their hair".

There are a number of systems in place to assess and monitor the quality of care provided. One relative we spoke with told us that they "could not think of anything bad to say" and "were happy with everything they had seen".

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

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected.

Reasons for our judgement

There were twenty five people living at Burnside Court. On the day of our inspection seven people stayed in their room for different of reasons. People were not able to tell us about their experience of living at Burnside and so we observed people in the lounge and dining room.

We arrived early and saw people just finishing their breakfast. We observed staff asking people what they would like eat and how many pieces of toast people wanted. During the morning we saw people being transferred from wheelchairs to armchairs using a hoist. During the transfers staff explained to people what was going to happen and spoke reassuringly throughout the process. Time was taken to ensure people were comfortable and gentle prompts were given as required. At lunch time we saw people asked if they wanted to come to the table for their meal. People that needed assistance were helped appropriately. One person was a little disorientated when they stood up the care worker reassured them and explained they "could get their bearings, there was no rush". We observed staff offering people the choice of salt and vinegar with their meal of egg, chips and beans. One person said she didn't want chips and so the carer arranged for the chef to provide mashed potatoes. Staff responded quickly when one person asked for a drink and throughout the meal people were asked if the had eaten enough and offered a choice of drinks. We spoke with a Podiatrist who was visiting on the day of the inspection. She told us that "people were treated respectfully and there was no indication of people being treated inappropriately". This showed that staff treated people with respect and took time to ask people what they wanted and offered people choices.

We spoke with three staff, two senior care staff and a care worker who had worked with the organisation for between four and eight years. They all told us that some people required help with all personal care tasks but they tried to help people remain independent for as long as possible by offering choices and encouraging people to do as much as they could for themselves. One care worker told us that in the morning they "knock on the person's door and ask them if they would like to get up and get dressed". They told us that if the person refused to get up their action would depend on what the situation was. They gave the example of someone just wanting a lie in and said "this was fine and they would

come in twenty minutes or so and ask them again". If they noticed that the person had been incontinent and therefore it was preferable for them to get up they would explain why this was important and work hard to encourage them to do so. All care staff we spoke with told us that they asked what they would like to wear and made choices as "simple as possible". They told us that they break tasks down into little steps and gave an example of putting the soap and water on the flannel so the person could wash themselves or they might run the water and ask the person if they would like to wash. This showed that staff encouraged people to do as much for themselves as possible to help retain their independence.

We were told that there are usually activities organised each day of the week. These activities range from quizzes, gentle exercise and music and singing sessions. Every two weeks animals are brought for people to stroke and talk about. People came to Burnside Court to facilitate these group sessions. On the day of our inspection we observed a gentle exercise session being run which a small group of people actively participated in.

Burnside Court specialises in caring for people with dementia we asked staff about the Mental Capacity Act (2005). They told us that people can make unwise decisions and this does not mean that they lack capacity. They understood that people's capacity to make decisions can change from day to day and vary between different decisions. Staff told us that they tried to explain to the person so they understood what the choices about the decision where but if they had concerns that someone may lack the capacity to make an important decision they would discuss this with the Manager. They went on to tell us that such a situation may require other people, such as the GP, Social Worker and family to be consulted to make a decision in the person's best interest. This showed that staff understood that people had the right to make choices and knew what to do if they had concerns that the person was not able to make an informed decision.

We noted in some care files we looked at that the front of the file contained an NHS Treatment Escalation Plan and Resuscitation Decision Record that noted if the person had capacity to be involved in decisions regarding their treatment. We saw letters from the GP that confirmed discussion with family members regarding treatment decisions. This showed that the organisation is following local policies and procedures regarding life sustaining treatments.

We spoke with relatives visiting two people living at Burnside Court who told us that they were involved in their relatives care. One person said that people are "treated respectfully, it is a nice friendly place". Another person told us that "staff are very caring". This showed that relatives were happy with the way people were treated and felt involved in their care.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We looked at five care files during our visit these were well organised and easy to follow. The first section of each folder contained a Residents Profile. This was a summary of key details including things that were important to the person, such as "loves interaction with staff" and "wears a hearing aid and without this is unable to communicate." The profile included risks that staff needed to be aware of. Care plans had a picture of the person and noted the person's preferred name. The care plan included a Personal Fact Notes sheet. This had a range of questions that included historical details, such as where the person was born and went to school to family details and hobbies and current information including likes and dislikes The manager told us that it was sometimes very difficult to complete these sheets because it usually relied on families being able to provide the necessary details. Sometimes people did not have close families and some families did not have the information. We noted that three of these sheets had been fully completed in the five files we looked at. This showed that the organisation tries to obtain important historical and current person centred information that will enhance the care offered.

Care plans covered all key areas of need such as communication, mobility, continence, etc. Each section of the care plan included possible risks and detailed the service to be provided and objectives to be met. With each care plan there was a sheet that noted when a review of the care plan had been undertaken and what, if any, changes had been made as a result of the review. In all of the files we reviewed care plans had been reviewed monthly. On an annual basis the person's close relatives were invited to review the care plan and also asked if they wanted to be involved on a more regular basis. One relative we spoke with told us that they were "very involved in the annual review (of the person's care plan)." In one file we reviewed we saw a letter to relatives inviting them to a care plan review. This showed that the organisation regularly reviews care plans and invites relatives to be involved in reviews at least once a year.

Information in the care plans was presented in a person centred way and there was lots of evidence of personal preferences being recorded. For example in the "Dietary Preferences" section of one file, in addition to noting the person's preferred food and their preferred meal times, the notes stated that the person "likes to sit with other ladies at meal times but likes to sit up last and move straight back into a comfortable chair in the lounge". We observed this happening during our visit. In another person's care plan in the

Communication section we read that the person was "unable to engage in meaningful conversation" and that staff "need to anticipate needs and note body language". The care plan also noted that staff should "talk slowly and use short sentences, smile and have positive body language". This showed that the organisation pays attention to individual needs and care plans included sufficient details to ensure the person's needs were met appropriately.

In care plans we noted risk assessments of mobility and a general risk assessment forms. In one file we saw reference to "risk of falling" and in another "risk of going out without an escort". In another file it was noted in the "Diet and Weight" section that the person was "at risk of not drinking enough". The care plan noted that the person should be "encouraged to take fluids and if not wanting a hot drink offer a cold drink and vice versa. Encourage little and often". This file also contained a "Use of Bed Rail Assessment" completed on 30.08.12 and reviewed monthly since then with the last review on 12.02.13. We noted Waterlow Skin Condition assessments in flies we looked at. These had been reviewed on a monthly basis. This showed that the organisation identifies possible risks to people and takes action to minimise these risks by providing clear guidance to staff.

We spoke with the chef who had worked for the organisation for sixteen years. She showed us a list of the food that people liked and disliked but also commented that on some days people did not like something but on another day they will. The menus work on a monthly rota but there is always a choice for people and special requests would be accommodated. When people needed to have liquidised food this would be liquidised separately rather than all together so it could be presented as attractively as possible on the plate. The chef told us that she works closely with the Speech and Language Therapy and Dietetics teams and if she had any concerns over a persons diet would speak to the manager about it. One care worker we spoke with told us that one person was vegetarian and they did not have the capacity to make decisions about their preferences. The care worker alerted the manager to this and a vegetarian diet is maintained for this person unless she actively indicated she wanted something else. A relative told us that people can "ask for different food, nothing is too much trouble." This showed that the organisation reflects people's preferences.

We noted in one care file that, following consultation with a Speech and Language Therapist, the person's diet had been changed to provide more texture. We asked a care worker about this and we were told that when the person was first admitted to Burnside Court she was on a liquidised diet. Staff had observed that she was talking a lot more and swallowing better and that she asked for a biscuit. As a result of the observations advice was sort from a Speech and Language Therapist who undertook an assessment and said that the diet could be changed. Observations of any changes were noted on the daily record sheet and also information was shared at handover meetings. This showed that staff were closely observing people, noting changes and taking action as a result.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We looked at the organisations Medication policy which had been reviewed in 2012. The policy was very easy to follow and covered key areas such as storage, obtaining and dispensing, refusal of medication, controlled drugs, covert medication, medication errors, returning drugs and self administration. The policy noted that only staff members who are trained can handle medication and gave detailed guidance on giving medication, recording and what to do if someone refused to have their medication.

We spoke to three care staff who told us that tablets are in blister packs. They emphasised the need to carefully check the tablets in the packs against the medical administration record sheet that had printed details of the medication and included information such as strength, dose, times to be given and other directions. They told us that they wear gloves and pop the tablets into pots and take these to the person with their preferred drink. One carer said that "some times the person can take the tablets from our hand and other times we need to give them the tablets". If the person refused medication this would be noted on the medicine administration record and daily notes and also reported to the manager. The policy stated "never force a person to take medication". We were told that when the person has had their medication the pots are taken for washing and the medication administration record is signed. Staff told us that they had received training in handling medications and this was updated on an annual basis. They explained that the higher level training is updated every three years. During our visit we saw a care worker giving a person their tablets. Before giving the tablets they told the person that "the GP had prescribed the tablets and reminded the person that they had their tablets every day". This showed that the organisation has procedures for giving medication and these are followed by staff.

In the medication section of one care plan file we viewed it was stated that the person "did not wish to self medicate". It was also noted that the person would "forget to take their medication due to short term memory loss". In another file it was identified that the person had to have their tablets "crushed or in liquid form due to difficulty in swallowing". This had been agreed by the person's GP. Care workers we spoke with told us that if medication needed to be given covertly this decision required involvement of the person's GP, family and an MDT meeting. This showed that staff were aware of individual needs when giving medication and procedures to follow when special requirements had to be met.

Medication was stored in locked cupboards and in locked medicine cabinets or a trolley these were tidy and well ordered. Medication administration records included a picture of the person, included all required information and were up to date and signed as required. The controlled drug register was up to date and signed as required by two people and the balance of drugs tallied with the number of tablets in stock. The medicines policy noted that medicines are ordered on week two of an eight week cycle and medication to be returned to the Pharmacy is sent back at the same time. On the day of our inspection medication had just been returned to the pharmacy and all records were up to date. There was an up to date list of staff that had received medication training complete with their usual signature. This showed that polices are followed appropriately.

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

In addition to the manager there were usually four or five staff working in the morning and three staff in the afternoon. There were two waking night staff. Shifts would usually be from 8.00 to 14.00 and 14.00 to 20.00 but some staff worked from 8.00 to 20.00. The manager told us that she had previously sought advice on staffing levels and these had developed over time. She told us that staff worked well as a team and had developed good systems of working. Staff we spoke with told us that in normal circumstances there was sufficient staff to meet people's needs as identified in their care plan but sometimes events diverted them from the things they should be doing. One carer told us that in normal circumstances they had time to "play games with the person, do their nails or their hair". One relative we spoke with told us that they thought that staff were "sometimes stretched". This showed that at most times there were sufficient staff to care for people as required.

The manager told us that 87% of staff working at Burnside had a National Vocational Qualification (NVQ) or Diploma at level two or three. Staff records we looked at showed that of the fifteen care staff employed eight had an NVQ three and five an NVQ two. Opportunity was given to new staff to undertake this training. Staff we spoke with told us that they were encouraged to undertake training and they enjoyed this. We saw staff training records that showed staff had training in a broad range of areas including such things as manual handling, dementia, dementia and communication, basic first aid, safeguarding adults, coping with aggression, diet and nutrition. Care staff spoke positively about the support they received from the manager and felt suitable trained to do the work expected of them. This showed that the organisation ensures that staff are adequately trained and supported to provide the necessary level of care.

The manager told us that it is very rare that agency staff were required to cover shortfalls in staffing. Usually staff from the team undertook additional shifts if required and every effort was made to ensure that agency staff do not work night shifts. Care staff we spoke with told us that agency staff were seldom used. One carer told us that "most times people cover and we don't need to use agency staff". Another carer said that nine times out of ten we cover shifts from the staff team. Sometimes we have to use agency staff." This showed that the organisation is able to provide consistent care from an established staff team.

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

The manager told us that there are a number of systems in place to assess and monitor the quality of care provided.

Two annual surveys were undertaken one of visitors and one of Residents/Relatives. The last two surveys were undertaken in 2012 and the results of these showed that five people had returned the visitors survey with 100% of returns having positive comments. Eight people had returned the residents/relatives survey and 100% of these returns were also positive. The questionnaires included questions such as "How do you feel residents are care for by staff?" and if people had the opportunity to express their views about the home. Responses included comments such as "a very good service", "the staff are always cheerful and friendly", staff are always helpful, "staff very attentive towards residents" and residents are well cared for".

The organisation also subscribes to the British Standards Institute Quality Management System ISO 9001:2008. This is quality management system that helps organisations to continually monitor and manage quality and involves two inspection visits a year. The last inspection undertaken by the British Standards Institute was on 30.11.12. The outcome of the inspection was that all areas assessed during the visit were found to be effective and necessary corrective action identified at the previous inspection had been implemented. Burnside Court also holds the Investors in People award and has done so for a number of years. This showed that the organisation involves external agencies in assessing quality of the services it provides.

We looked at the accident/incident report file. We noticed that incidents were reported when no apparent injuries had been observed, most of which were a result of falls. This suggested good recording of accidents. The front of the file contained a summary sheet which included reference to the incident, the outcome and who had been informed, i.e. Accident and Emergency or Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR). This gave an up to date picture accidents and incidents. Handover meetings and handover notes provided a means of communicating with staff any issues related to learning through these reports. The organisation subscribes to Mentor (Royal Bank of Scotland) that provides advice and updates on Employment Law and Health and Safety

Issues. This showed that the organisation has advice and processes in place to deal with and learn from accidents and incidents.

One relative we spoke with told us that they "could not think of anything bad to say" and "were happy with everything they had seen". Another relative told us that they had been "impressed with the homes leadership" and that was why they decided Burnside Court as a suitable place for their relative.

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.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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