Care Quality Commission

Inspection Report

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

Abbeyfield Residential Care Home - Castle Farm

Castle Farm Road, Newcastle Upon Tyne, NE3 1RF

Tel: 01912841344

Date of Inspection: 08 October 2013

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

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	The Abbeyfield Newcastle Upon Tyne Society Limited
Registered Manager	Mrs. Christine Major
Overview of the service	Abbeyfield Castle Farm is a residential care home. It provides accommodation and personal care for 24 older people. It does not provide nursing care.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

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

Summary of this inspection

Why we carried out this inspection

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

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 8 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service and talked with staff.

What people told us and what we found

People were treated with respect by staff at all times, and they were asked to give their consent to their care and treatment.

People's care and personal needs were carefully assessed before any care was given. Detailed personalised care plans were in place to guide staff on how best to meet people's needs and their personal preferences. People told us they were very happy with their care. One person told us, "I'm very happy, here, and very settled. They do everything for me." Another person said, "The staff care for me in the way I want to be cared for. They are very friendly, and take a great interest in you and your family." A third person told us, "I am well looked after. I can't think how the home could be improved."

Where people were able and willing to take responsibility for their prescribed medicines, they were able to do so. For other people, appropriate arrangements were in place for the ordering, storage and administration of their medicines.

The home took care to make sure that only properly vetted and suitable people were employed to work in the home.

The home listened to what people said and acted accordingly. Very few complaints were received.

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

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted on their wishes. We observed this to be true in how staff interacted with people in communal settings. Staff were attentive, respectful, courteous and unhurried in their approach to people, and explained what they were intending to when, for example, assisting a person to reposition themselves in their armchair.

We asked people if the staff were equally respectful when giving them personal care in their own rooms: we were told they were. One person told us, "Staff always knock on my door and ask my permission to come in. They always treat me with respect." Another person said, "Yes, they ask my permission before doing anything." A third person told us, "The staff are lovely, I have no complaints at all about how they give me my care."

We spoke with staff and asked what they did if someone refused to give their consent, such as a planned bath or other care intervention. They told us they would always explain what they were asking to do. They said they might go away and return later, and try again; or sometimes another staff member might be more successful in gaining the person's consent. As one staff member told us, "They are all different, so we take an individual approach." All the staff we spoke with said they would respect a consistent refusal to accept care. This would be recorded in the person's care plan.

We looked for evidence of people (or, where appropriate, their representatives on their behalf) having given their formal written consent to their care plans. We saw that people were asked to sign a 'consent to treatment and personal care' form. This covered people's involvement in contributing to their own care plans, agreeing to the accessing by relevant professionals of their personal and care records, and agreeing to photographs being taken for identification purposes. Consent forms were signed by the person and/or their representative, and this consent was re-affirmed at each six monthly review of their care.

There was evidence that people were able to make use of trained advocates in issues

such as decision making and consent. The contact details of the local advocacy service were displayed on the communal notice board. Staff had recently been given training by advocates, and arrangements were being made for advocates to meet with the people living in the home, to explain the service they offered.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. The manager told us that, in line with the principles of the Mental Capacity Act, there was an assumption that people living in the home had the capacity to make their own decisions, unless a formal mental capacity assessment clearly indicated otherwise. Where appropriate, the manager undertook such an assessment to check a person's ability to understand, retain and weigh up the relevant information available to them about a specific decision, and be able to communicate their decision. Where the person lacked this capacity, specific care plans were drawn up to describe any decisions made on their behalf, and in their best interests.

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

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We talked to six people about their care. They were all very positive about the care and treatment they received in the home. One person told us, "I'm very happy, here, and very settled. They do everything for me." Another person said, "The staff care for me in the way I want to be cared for. They are very friendly, and take a great interest in you and your family." A third person told us, "I am well looked after. I can't think how the home could be improved."

We spoke with two visiting health professionals who regularly attended the home. One told us that staff were skilful and knowledgeable, made appropriate referrals and followed any advice given to them. This professional told us she trusted the judgement of the manager and staff. The second visiting professional commented on the "excellent care" given by a "well organised, well managed and very caring staff group". This professional told us, "I can't rate them highly enough."

People's needs were carefully assessed and care and treatment was planned to meet those needs. A range of assessments were used to identify people's physical and mental health needs. Specialist assessments used included skin care, nutrition, manual handling, falls and social care needs and wishes. These assessments were reviewed and updated every six months to make sure they continued to reflect people's needs.

Where needs were identified, a care plan was drawn up to guide staff in how best to meet each need. These were highly personalised to the individual, and included people's strengths and abilities as well as their needs. We saw that people's care plans were reviewed every month, to check progress towards goals and to ensure people's care was being delivered in line with their care plans. People we spoke with told us the staff knew their needs and were flexible and responsive.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Risk assessments were carried out on a regular basis and any risks identified were incorporated into people's care plans. A 'transfer to hospital' information pack was held on each person's file, detailing their medications, allergies and health conditions. Appointments with, and visits from, health and social care professionals were recorded in detail, with advice received added to the person's care plan.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. The home had appointed and trained a 'dignity champion' and a 'dementia care champion' to guide staff on how best to empower and support vulnerable people. All staff had been given equality and diversity training, to guard against unwitting discrimination. People we spoke with in the home told us they were treated with respect at all times, and that staff always listened to and acted upon their views.

There were arrangements in place to deal with foreseeable emergencies. An 'emergency contingency plan' was in place. This contained details of relocation arrangements, should the building be rendered uninhabitable. The home's fire safety plan was reviewed annually and agreed with the local Fire Prevention Officer.

The manager was knowledgeable about the Deprivation of Liberty Safeguards (DoLs), which provide legal protection for people who lack the mental capacity to make important decisions about their safety and movement. She was fully aware these safeguards were only used when it was considered to be in the person's best interest. She had had no cause to apply these safeguards in the past year.

Management of medicines ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

Appropriate arrangements were in place in relation to obtaining medicine. The home had a contract with a local pharmacy for supplying people's medicines. The manager said the service was very reliable and flexible. Senior staff ordered the required medicines on a four-weekly basis. Orders were based on the current prescriptions, checked against the Medication Administration Record (MAR), and with any newly prescribed drugs added. The list of medicines was taken to the relevant doctors' surgery for confirmation and signature, photocopied for audit purposes, then dispensed to the home.

Appropriate arrangements were in place in relation to the recording of medicine. We looked at the MAR and found it to be well completed, with no unexplained gaps. Staff told us they checked the MAR for any gaps in the administration record and reported such gaps to the manager to investigate. Appropriate codes were used to show why any medicines were not given at the prescribed times (for example, where a person had refused their medication). The manager told us the use of the codes was being reviewed, especially the use of the code 'o' for 'other reasons', to give more information.

Medicines were handled appropriately. The home used a 'monitored dosage system' which meant that staff did not normally need to touch the drugs whilst administering people's medicines. Disposable gloves and aprons were available for tasks such as the application of ointments or creams.

Medicines were kept safely. They were kept in a metal drugs trolley fixed to a wall in a locked room between administration rounds. During use, the drugs trolley was locked if it was not in the direct sight of the staff member administering the medicines. Keys to the drugs trolley and medication storage room were held only by the senior staff on duty. Temperature-sensitive medications were stored appropriately.

Medicines were prescribed and given to people appropriately. The manager told us every person had their prescribed medicines reviewed by their GP at least every six months, to make sure they were meeting the person's current needs, and were not being repeatedly prescribed without good reason.

Medicines were safely administered. People were able to take responsibility for their

prescribed medicines, but this was subject to an assessment of their ability to do so, and of any risks involved. All senior staff who administered people's medicines had been given training in the safe handling of medicines and regular updates. The manager told us her staff had been given 'refresher' training by the home's supplying pharmacist the previous week. Staff were also subject to an assessment of their competency to administer medicines every six months. Audit systems were in place to check that all medicines were administered as supplied.

Requirements relating to workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

We looked at a sample of three staff recruitment and selection records. There were effective recruitment and selection processes in place. Applicants were required to fill in an application form that included information about their employment history; declarations about any criminal convictions, disciplinary action and fitness to work; and give two work referees. Applicants were required to provide photographic and other proof of their identity.

Appropriate checks were undertaken before staff began work. Applicants had to agree to a check being made with the Disclosure and Barring Service (previously the Criminal Record Bureau, or CRB), so the service could be sure the person was not barred from working with vulnerable people. References were taken up and checked before new staff began work.

Appropriate policies and procedures were in place for dealing with any staff disciplinary issues. These were clear, transparent and included the rights of representation and appeal. The manager told us that only one staff member had been subject to disciplinary action in recent years, for unauthorised absence.

The manager was fully aware of her responsibilities for reporting staff who were no longer fit to work in health or social care to the appropriate bodies, but there had been no occasion to do this, to date.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People were made aware of the complaints system. This was provided in a format that met their needs. A clear complaints policy and procedure was made available to everyone in the home. It was displayed on the communal notice board and included in the 'service user guide', an information booklet about the home given to all people living in the home. This policy included timescales for resolving complaints, the right of appeal and the various alternative routes for addressing concerns, such as contacting the Ombudsman.

People were given support by the provider to make a comment or complaint where they needed assistance. The manager told us she or her staff would always seek to pick up any possible concern or expression of dissatisfaction as early as possible, and would talk sensitively with the person to establish what the problem was. We saw information was displayed giving people help and guidance on how to get support to raise any concerns they may have. These routes included contacting the Care Quality Commission, a solicitor, Citizens' Advice Bureau or a legal aid centre. People could also make use of the residents' committee, a 'suggestions' box and a 'comments book', to flag up a concern or complaint.

People had their comments and complaints listened to and acted on, without the fear that they would be discriminated against for making a complaint. People we spoke with in the home told us they had every confidence in the manager and staff, and felt that any issues were taken seriously, responded to quickly, and usually resolved amicably. We were told the manager was always available and approachable. Several people said they had lived in the home for years and had never had cause for complaint. One person told us, "I have had no complaint." Another person said, "I can always get my point across, and I'm listened to." Nobody felt they would be discriminated against in any form for raising a complaint.

We asked for and received a summary of complaints people had made and the provider's response. We saw that only one complaint, about a catering issue, had been raised in the previous twelve months. The records showed this had been responded to promptly and, whilst not upheld, had resulted in apologies being given for any distress caused. The complainant had signed the record to show they were satisfied with this outcome. This showed us that people's complaints were fully investigated and resolved, where possible, to their satisfaction.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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