Inspection Report

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

Enstone House

Cox Lane, Chipping Norton, OX7 4LF

Tel: 01608677375

Date of Inspection: 18 June 2013

Date of Publication: July 2013

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

Details about this location

Registered Provider	Marcus Care Homes Limited
Overview of the service	Enstone House is a residential care home. It is registered for accommodation for up to 33 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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	5
Our judgements for each standard inspected:	
Consent to care and treatment	6
Care and welfare of people who use services	8
Management of medicines	10
Supporting workers	12
Assessing and monitoring the quality of service provision	14
About CQC Inspections	15
How we define our judgements	16
Glossary of terms we use in this report	18
Contact us	20

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 18 June 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, talked with staff and talked with commissioners of services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We spoke with five people who used the service. When asked about consent they all said that care workers asked permission before administering care. One person said "They don't do anything without asking me first". Another said "they listen to me, if I say no, they know it means no".

People told us they were happy at the home. One person told us, "I can't complain. I'm looked after. We have a bit of humour with the staff. The manager is very good". Another person told us, "they look after me, it's nice here". While one person told us, "I like it here, it's very nice. I like the carer's, it's alright".

Audits were conducted on peoples' medication on a monthly basis by the deputy manager and the home's pharmacist conduct a yearly audit of medications. This meant that peoples' medications were stored securely and appropriate systems were in place to ensure medications were kept safe.

People who used the service felt that staff were knowledgeable and received appropriate training. One person told us "staff are lovely, they know what assistance I need". One told us, "Staff are very good. If you want something, they'll help. They give as much time as they can".

The provider conducted care reviews every three months with people and their representatives. These reviews showed that the provider took into consideration peoples' and their representatives views. We saw one person's family member attended their relative's review, which was arranged at their convenience.

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.

Reasons for our judgement

We spoke with five people who used the service. When asked about consent they all said that care workers asked permission before administering care. One person said "They don't do anything without asking me first". Another said "they listen to me, if I say no, they know it means no".

We spoke with the deputy manager, one care leader and three care workers. All staff we spoke with demonstrated a good understanding of knowledge relating to consent. One care worker said "during care we keep explaining what's going on and work with people". Another said "most people you can explain things to, but we are aware of peoples' visual indicators". One care worker told us about a person who doesn't communicate verbally. They told us how they look at the person's body language and movement to ensure they consent to care. The care worker told us "he can show you what he wants done. He uses hand signals. If he points to his back then he wants assistance with toileting".

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We observed the manager talking to a person regarding their mobility and mobility aids. We saw the manager gave clear guidance and options to the person to enable them to make a choice. The person was given the option to try some different equipment, because the manager was concerned about the person being at a risk of falls while carrying books in a bag with their zimmer frame. We observed that the person was given the opportunity to try the new walking frame. The person told us, "It was my decision, the manager told me that. I like it; I have somewhere to store my books". This meant that the provider gave suitable information for the person regarding their care and treatment, sought their consent and acted in accordance with their wishes.

Suitable arrangements were in place for obtaining consent. We looked at four peoples' care files and saw evidence that consent had been obtained from people and where relevant their relatives, which helped to involve them in their care. We saw that the

provider conducted quarterly meetings with people and their representatives. People, or where necessary their representatives, signed care assessments to show they agreed with the care provision. This meant that the provider had suitable arrangements in place to obtain consent.

We saw records of do not attempt cardio pulmonary resuscitation (DNACPR) forms for three people. These forms had been completed in accordance with peoples' advance directives. Records showed that the person or their relatives had been involved in the decision about resuscitation. For example one person's file contained an advance directive which stated '[the person] is only to go to hospital as a last resort and not be kept alive artificially'. This meant that peoples' advanced directives were clearly documented.

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 spoke with five people who used the service. All of them told us they were happy at the home and they had no complaints regarding their care. One person told us, "I can't complain. I'm looked after. We have a bit of humour with the staff. The manager is very good". Another person told us, "they look after me, it's nice here". While one person told us, "I like it here, it's very nice. I like the carers, it's alright".

We conducted a Short Observational Framework for Inspection exercise and noted that people experienced care and genuine respect from care workers. All the interactions we observed were positive and in most cases this produced a response from the person that showed they had been stimulated. For example, we observed one care worker assisting a person with a cup of tea. The care workers assisted the person with warmth and at a relaxed pace. We saw another care worker talking to people; they acknowledged people and included them. We saw that people appeared happy and comfortable within the home.

Care workers we talked with were able to clearly discuss peoples' needs. One care worker told us, "We provide person centred care. It's great as it is all about the person". One care worker told us, "We have time to spend with the residents. We're here to make their lives better. It's a nice feeling to know we can sit down with them". Another care worker told us, "We get involved in activities, a lot quieter in afternoons so we do one to ones with residents and go outside". We observed care workers assisting people to access the home's gardens and look at the home's rabbits. This meant that people benefitted from positive interactions with care workers and other staff in the home.

Care and treatment was planned and delivered in a way that was intended to ensure peoples' safety and welfare. We saw that steps had been taken to ensure people were protected against the risks of receiving care that was unsafe. All care assessments we looked at showed that care workers had identified the needs of the person, and identified any risks to their safety and welfare. For example, we saw one person had mobility equipment issued by the local falls nurse but they declined to use it. There was clear guidance for care workers to follow to assist and encourage the person to ensure that the risk of falls was minimised. The person's Power of Attorney (PoA) had been involved regarding this care assessment and agreed that one care worker should assist the person.

Peoples' needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We saw that each person's care assessment contained a 'personalised information' document. This documented the person's preferences and showed that planned care was personalised to them. We saw that one person's care file showed that they could not eat beef or drink alcohol in line with their religious beliefs. The person's care file also showed that the person had been offered access to religious services of their choice, but they had declined. One care worker we spoke with told us that they never provided the person an unsuitable meal, as this would affect their dignity. On the day of our visit the home did not have beef on the menu. This meant that peoples' care and treatment was planned and delivered in line with their individual care plan.

Peoples' care and treatment reflected relevant research and guidance. We saw that peoples' care assessments contained guidance from various agencies including the Care Home Support Services Falls Team, Speech and Language Therapists and Community Mental Health Teams. We saw one person's care assessments which showed us that they needed a soft diet due to a poor swallowing reflex. We noted that at lunch time that this person had a meal which had a soft texture to enable them to eat independently whilst meeting their health needs.

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 the recording of medicine. The organisation had a comprehensive medications policy and procedure in place which had been updated in March 2011. This document provided clear information to staff regarding their roles and responsibilities, as well as clear protocols for the administration and prompting of medication.

We spoke with the deputy manager who was also the home's medication lead. They told us they ordered and audited all medications. We spoke to senior care workers who informed us they were aware of the provider's medication policy. Staff training records indicated that care workers who administered medication had completed the appropriate training. This meant care workers were given appropriate guidance regarding medication administration.

Medicines were safely administered. We observed a senior care worker administering medication at lunch time. We saw that they checked the medication records to ensure they were giving the medication to the correct person. They removed medication from storage containers into a beaker without touching them. They took the medication to the person and sat with them as the person provided consent and took the medication.

We saw that the senior care worker provided people with fluids to assist them in swallowing and gave them time to take the medication. This meant that people were protected from the risk of being given the incorrect medication.

Appropriate arrangements were in place in relation to the recording of medicine. Medication administration records were seen for four people. All records were completed consistently and in accordance with the organisations medication policy and procedure. We saw that medication records were only signed after the person had taken or refused their medication.

We saw copies of the deputy manager's medication audit. We saw that where the deputy manager had identified gaps in peoples' medication records that these were investigated and the concern raised with the care worker through supervision. This meant that the

provider had appropriate systems in place to ensure that when medication is administered that records are accurate.

Medicines were kept safely. We saw that medication was kept in two secured rooms within the home. The home's medication trolleys and control drugs cabinet were stored on the ground floor of the home. Creams, supplements and peoples' medication that needed to be stored or returned were stored in a room on the top floor. The keys to the room were held by the senior care worker on duty. We looked at the home's controlled drugs register and saw that the recorded stock for one person reflected the medication stored in the cupboard.

Audits were conducted on peoples' medication on a monthly basis by the deputy manager. The home's pharmacist conducted a yearly audit of medications. This meant that peoples' medications were stored securely and appropriate systems were in place to ensure medications were kept safe.

Supporting workers ✓ Met this standard

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

Our judgement

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.

Reasons for our judgement

Care workers received appropriate professional development. Care workers we spoke with felt that they were supported by the provider and had access to mandatory training, specific training and a structured supervision and appraisal programme.

People who used the service felt that staff were knowledgeable and received appropriate training. One person told us "staff are lovely, they know what assistance I need". Another told us, "Staff are very good. They're very welcome, if you want something, they'll help. They give as much time as they can".

We looked at training records for three care workers. Each care worker received a course of training which included training such as safeguarding, dementia, mental capacity act, moving and handling, food hygiene and first aid. The provider used a training matrix system to ensure all care workers completed training necessary for their role. We saw that the provider had arranged training for staff which included good recording keeping.

Care workers we spoke with said "If I want to do specific training, I can ask the manager". All staff we spoke with felt they could access specific training to enable them to meet peoples' needs. One care worker told us "If there's anything we feel we need training on we ask. One resident has schizophrenia and the manager is looking at specific training to help us meet this person's needs". This meant staff received training to enable them to meet peoples' needs.

Care workers were also able to access NVQ training and two care workers we spoke with told us that they had been encouraged to undertake an NVQ health and social care qualification. One care worker told us, "I went to the manager to request to do my NVQ". Another care worker told us, "I was asked to do it, it has been really beneficial". A senior care worker we spoke with told us they were completing their NVQ 3 health and social care qualification. This meant that care workers had access to qualifications to aid their career development.

Supervision records for three care workers indicated that they received structured supervision as well as an annual appraisal. Supervision records showed that the provider

took into account the training and personal development needs of care workers as well as current working practices regarding peoples' care provision. The provider also conducted frequent observations of care workers, to ensure that the quality of care was to an appropriate standard. This meant that provider had systems in place to ensure people received appropriate standards of care.

We spoke with three care workers and two senior care workers. Everyone we spoke with confirmed they had supervision and that they felt supported. Care workers told us they asked the manager for support and that the manager was always available. One care worker told us, "we get really good feedback. If you can improve, the manager will tell you. We always look at ways to improve". Another care worker told us, "I feel supported. If I am in a bad mood I can talk to the manager". This meant that care workers were supported in their work.

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

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. We saw a copy of the homes last quality assurance survey. This survey was completed in 2012. We saw that the provider had conducted an analysis of this survey, including where people and their representatives thought things were good and where improvements were needed. A copy of this analysis was on display in the home. We noticed that peoples' visitors had suggested a photo board of staff would be beneficial. We saw that a staff photo board was on display in the hallway of the home.

The provider also conducted three monthly care reviews with people and their representatives. We saw three monthly reviews on two people's care files. These reviews showed that the provider took into consideration people and their representatives views. We observed one person's family member attended a review, which was arranged at their convenience. This meant that people's and their representatives views were sought and acted upon.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who used the service. We saw that the provider kept a record of incidents and accidents. Incident reports were stored on people's care files and we saw that these informed people's care and risk assessments. The provider may find it useful to note that the manager did not conduct an audit on all incidents within the home, which have enabled them to identify any potential trends.

The provider took account of complaints and comments to improve the service. We saw that the home hadn't received a formal compliant since February 2012. We saw the last complaint had been responded to in accordance with the provider's complaints procedure. This meant that people had access to an appropriate complaints process and that complaints were appropriately acknowledged and investigated.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk