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: 02 October 2013

Date of Publication: November 2013

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

Consent to care and treatment	✖ Action needed
Care and welfare of people who use services	✖ Action needed
Cleanliness and infection control	✓ Met this standard
Complaints	✓ Met this standard
Records	✖ Action needed

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 and care for up to twenty six people. People living at the service are older people, most of whom have dementia.
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 2 October 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information sent to us by 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

Burnside Court is a long established care home, providing care for people with dementia. People we spoke with during our inspection told us the home was a nice place to live and they were happy with the services provided, One told us "I like it – it may not be everyone's cup of tea but it suits me". Another said "I am not sure where I am, but we are all here together and having a good time. I have had a good meal and expect I shall get a cup of tea soon."

However, on our inspection we found that the service was not considering people's capacity to consent to care and treatment or to put in place best interest decision making processes to protect people's rights. We also found concerns over some poor record keeping, assessment and delivery of care. We found that some polices and procedures were out of date. We found the care planning systems did not identify or give clear instructions to staff on how to manage behaviours that were challenging.

We found the home was clean and free from odours and that people understood how and to whom to raise any concerns about their care or the home.

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

What we have told the provider to do

We have asked the provider to send us a report by 16 November 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

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 ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Where people did not have the capacity to consent, the provider did not act in accordance with legal requirements.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

On this inspection we looked to see how people were being asked to give their consent for care and treatment. We looked to see how their rights were being respected when they did not have the capacity to consent. We found that many people living at the home were not able to give clear consent to care due to their level of dementia.

We looked in the care files for five people, spoke with care workers and management and observed how people were supported. We saw that at times care workers offered people choices with their care but that this was not consistent.

We saw that there were no formal assessments of people's capacity to consent to care and treatment in their files. Where specific decisions had been made there had been no documented process to show whether the person had capacity to consent or not. For example one person had been given medication in their food with no evidence to show they had given their permission for this. We were told the service had consulted with the GP, but this was not recorded. We saw that a 'best interests' decision making process had not been followed, as would be expected under the Mental capacity Act 2005 (MCA). This is legislation that protects people's rights to make decisions while they have the capacity to do so.

We asked the manager and care workers how they would understand if a person was consenting to care or not. They told us they would know this by the person's behaviour. We looked to see how this was recorded in the care plans. The plans we saw contained only brief and general information and no specific information on communication of consent or otherwise. In one file we looked at the care planning information had not been changed since February 2011, although records we saw told us this had been reviewed every month since then.

The files we saw contained little information on if the person had authorised someone to act on their behalf before they lost capacity to make decisions for themselves. Where this was identified in one file there was not enough detail to determine the extent of the decision making authority that had been given. For example it was not clear if this related to decisions of health and welfare or just financial decisions. This could leave the service without an understanding of how to support the person in the case of a sudden deterioration in their health.

We saw that in some files there was a treatment escalation plan, written by the GP and showing evidence that the individuals or their relatives had been consulted about their views regarding a sudden deterioration in their health. Care workers we spoke with understood this was for clinical decisions made by medical staff and did not relate to the care the home delivered.

We saw that the service had in the past made applications with regard to the deprivation of liberty safeguards for people, but that these had not been authorised. This demonstrated they had taken actions to consider and ensure that they were only depriving someone of their liberty in a safe and correct way. No-one at the service at the time of the inspection was under such a restriction.

We saw that there was some information available to care workers at the home about MCA, but this did not include much information on the need for best interest decisions to be made within a specific legal framework. We saw that care workers last received external training on MCA in 2011, but that four care workers had completed a distance learning package this year.

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care and treatment was not being planned and delivered in a way that ensured people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

On the inspection we looked at the assessment and care planning files for five people, observed the care being delivered and spoke with care workers and people living at the home. We also spoke with a visiting relative.

We saw that most people living at the home had dementia, which varied from having a poor memory to severe impairment, where the person was being cared for substantially in bed. In association with this people also had a number of health conditions and impaired mobility. Some people presented behaviours that were challenging.

We did not find evidence in people's care plans or through discussion with management and care workers that showed us that people's care needs were being regularly assessed and met consistently. As an example we spoke with one person who had two physical conditions that made sitting uncomfortable for them. They told us they were uncomfortable and in pain, but could not specifically tell us the cause. We saw they were placing themselves in different positions on the seat they were on in order to get comfortable. We saw that they had been prescribed cream to alleviate their conditions, and staff we spoke with could tell us about the conditions. However they were not recorded in their care plan, and despite the person's clear difficulties in making themselves comfortable, no seating assessment had been requested to see if alternative seating would support them. A member of staff said "Look at you, getting your legs up higher than I can" when speaking with them. This showed a lack of understanding or empathy with the person and the discomfort they were in.

We also found some more basic areas of grooming support were needed. One person we sat next to still had porridge from breakfast on their front at lunchtime. Another lady had not received attention to facial hair. We saw comments in the minutes of a staff meeting relating to problems with some male shaving not having been attended to consistently.

The home did not use a recognised pain assessment tool for people with dementia, and although we saw assessments in place for pressure area risk there was no action planning

associated with this. Three of the five people whose files we looked at had been assessed as being at high risk of developing pressure areas. However none had an action plan identifying what additional care or support was being provided to the individual to reduce the risks. This left people at risk of inappropriate or unsafe care.

Some other areas of risk assessment, for example for falls or nutrition were not completed in people's files. This meant that care workers could not assess easily if there had been deterioration in the person's condition or the effectiveness of any actions being taken to reduce risks. We saw that people were being weighed regularly and that one person had put on 10kg in weight since March. However this was not associated with any plan to support them with their nutrition, and no evaluation had been made of the weight gain.

We saw evidence in people's files of access to healthcare services in the community, for example optical or dental care. We saw that one person was in receipt of physiotherapy services and one person was being supported by the district nursing service. We saw that relatives were involved in reviews if they wished to be, and that information gained from people who knew the person being cared for well was included in the files. .

We did not find that the plans for supporting and managing people's dementia needs were well developed. We saw that some people had significant dementia that impaired many areas of their lives and presented challenges to care workers supporting them. The care plans and assessments we saw did not include specific information for care workers on the management of the person's needs with regard to dementia or how they were to support the individual. They did not contain information on the impact of the dementia on the individual.

We saw some evidence of good practice in supporting people. We saw one care worker who supported people well with eating their lunch. The care worker made sure that support offered was discreet and aimed at maximising the person's remaining skills and independence. We saw that the person was gently guided and encouraged to eat by themselves, and supported to clean themselves up afterwards.

A relative we spoke with told us they were very happy with the service provided at the home. They told us that from choice they washed their relative's clothing as they wanted to keep involved in their care. They said they were "always welcomed with a cup of tea, and can stay as long as I want".

Three people living at the home we spoke with told us they were happy there. One told us "I like it – it may not be everyone's cup of tea but it suits me". Another said "I am not sure where I am, but we are all here together and having a good time. I have had a good meal and expect I shall get a cup of tea soon."

We looked at activities and stimulation provided for people. The home had two lounges on the lower ground and ground floor, but on the day of our visit people had all chosen to spend time in the lower lounge. There was music playing and in the afternoon a pianist and singer came to entertain people. One person we spoke with told us they liked the music and "wouldn't want it quiet". We saw that some information was available in people's files about their pre-existing hobbies and interests, but the home had not adopted a more person centred approach to individualised activity planning. This told us that the home was not following current best practice guidance on supporting people with dementia with activities.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

On this visit we toured the premises looking at areas of cleanliness and infection control. We also spoke with a member of the cleaning staff.

The home presented as clean and odour free, despite the high numbers of people with incontinence. Bathrooms were cleaned after use and the members of the cleaning team had schedules for cleaning to ensure that all areas were addressed regularly. Cleaners were at work at the home seven days a week, to ensure they could keep on top of the cleaning routines and respond in the case of a sudden incident.

The home had copies of the 'Department of Health Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance'. This is guidance on good practice in relation to the control of infection in care settings. The registered manager was the designated infection control lead for the home, and the home had policies and procedures of its own in relation to the management of infection.

We were told that there were no identified infection risks at the home at the time of our inspection. The provider may wish to note that the home did not have a tool for assessing or managing identified individual risks, and the clinical waste disposal policy was out of date. We saw that the home had procedures for managing Methicillin resistant staphylococcus aureas infections (MRSA) or legionnaire's disease.

We saw that staff had access to personal protective equipment, such as gloves and aprons. Antibacterial hand gels were situated at the front and rear exits to the home to prevent infection being bought in and people living at the service were offered preventative vaccinations such as for influenza. Waterproof mattress covers were in use on beds.

The laundry was clean and free from a build-up of soiled linens. Separation of soiled and clean linen was achieved through the use of dispersible bags for the transfer of soiled linen to the laundry in a sealed environment. The home had new washing machines which were capable of achieving a full sluicing cycle to ensure bacteria could be destroyed during the cycle.

During our tour of the home the provider may wish to note that we found two safety razors

left out in a locked bathroom. We also found that although there were paper towels out in this bathroom there was no bin in which to place used towels. This gave us concern that people were not using the hand washing facilities regularly. We found hand washing facilities were available in the bedrooms we visited.

We found that 11 of the care workers at the home had completed infection control training via a distance learning package in 2013. This told us care workers were receiving updated or refresher training on risks and how to manage them. We saw staff wearing aprons and gloves when supporting people.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

Comments and complaints people made were responded to appropriately.

Reasons for our judgement

We looked at the way the home managed complaints. We found that the home had not received any complaints since our last inspection which had been carried out in February 2013.

Two people we spoke with told us they knew how to make a complaint. They told us they felt able to do so. One said "I would speak with one of the girls". A relative told us they would have no hesitation in speaking with the manager if they were not happy with something. A questionnaire was sent to relatives each year to encourage their views on the service and anything that could be improved. The manager told us she had an 'open door' policy where people could come to her at any time to discuss any issues of concern to them.

We asked the manager and a care worker how they would tell that someone who lived at the service who could not communicate verbally was unhappy about something. They told us "We would know – we know them all so well." The provider may wish to note that the interpretation of people's behaviour as communication was not included in any detail in the care plan.

The home had a complaints procedure, and this was on display at both entrances to the home as well as being in the home's information pack. The provider may wish to note that this procedure and others linked to it did not include enough information on people's access to the Ombudsman or other agencies to whom they could also direct concerns. It did not contain a guarantee that people would not be victimised as a result of making a complaint or the timescales in which the provider would act to respond to their concerns.

Care workers contracts contained information on grievance procedures and there were whistleblowing policies in place to support workers in raising concerns outside of the organisation if needed.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not being protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not being maintained.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

On the inspection we identified concerns over the management of records at the home.

We found that the care planning systems were not comprehensive or individualised enough to ensure people were receiving appropriate or safe care. We found that although records were in some cases being completed to assess people's needs, for some areas identified such as pressure area risks or nutrition no action plans were drawn up as a result. In one record we found the person had been referred to using two different people's names, one of which related to another individual.

We found that the care records, although written regularly, were not always written in appropriate language or written in ways that demonstrated an understanding of people's needs. As an example one record we read described someone as being "in a bad mood" and another that the person was described as being "Quite argumentative today ". This did not demonstrate an understanding of the needs of people with dementia.

We looked at a care worker's file. We found that the file was in order and contained information about the workers experience and qualifications. It also contained some information such as a form for monitoring equal opportunities, with information on the worker's ethnic group. The manager was not clear however what this information was used for or why it was collected. Some information was available on the Data Protection Act and the home had policies on access to records, and confidentiality.

We saw that forms had been partially completed to support the transfer of people's information via an ambulance service in the case of an emergency admission to hospital. These were in people's care files. We saw that the home had been recently assessed by Investors In People, The Quality Institute and was contracted to a mentoring service who provided updates on records and policies practice. The home had also recently undergone an external health and safety audit. We saw that minutes had been kept of the last staff meeting and these had included ways suggested by the mentoring service on how to make the meetings more productive. The agenda indicated this had been successful.

We saw that many of the policies had last been checked for accuracy or updated in February 2012. We found some policies that had been checked and marked as not needing changes to actually be out of date or incorrect. For example, we found a policy on abuse which had apparently been reviewed in February 2012 and found to be accurate. However it referred to a previous regulatory agency that had been in existence prior to the formation of the Care Quality Commission in 2009. This told us that the reviews of these records had not been robust enough.

We found that the environmental risk assessments for the home were also out of date, with some not having been reviewed since April 2012.

The home had a shredder for the secure disposal of confidential information and records were kept securely in the office or medicine room.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The registered provider did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users in relation to the care and treatment provided for them. This is a breach of Regulation 18 of the Health and Social care act 2008 (Regulated Activities) Regulations 2010.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People using the service were not being protected against the risks of inappropriate or unsafe care as the assessment, planning and delivery of care did not meet people's needs, or ensure their safety or welfare.
Regulated activity	Regulation

This section is primarily information for the provider

Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider had not ensured that people were protected against the risks of inappropriate or unsafe care arising from a lack of the maintenance of an accurate record of their care and treatment and records of the management of the regulated activity. This is a breach of Regulation 20 (10 (a) and (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 16 November 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

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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