Inspection Report

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

Herncliffe Care Home

Spring Gardens Lane, Keighley, BD20 6LH

Tel: 01535681484

Date of Inspection: 17 December 2013

Date of Publication: January 2014

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
Cleanliness and infection control	✓ Met this standard
Management of medicines	✓ Met this standard
Safety and suitability of premises	✓ Met this standard

Details about this location

Registered Provider	P & B Kennedy Holdings Limited
Registered Manager	Mrs. Sheila Lambert
Overview of the service	Herncliffe Care Home is registered with the Care Quality Commission and can provide care and support for up to 129 older people. The home is divided into six units named Margaret, Constance, Terraces, Alexandra, Victoria and Garden. There are three lifts that access all levels of the home. Corridors and communal areas are spacious and provide appropriate access for people using wheelchairs. Each unit has its own communal day areas as well as toilets and bathrooms.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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 carried out a visit on 17 December 2013, talked with people who use the service, talked with carers and / or family members and talked with staff. We were accompanied by a specialist advisor.

What people told us and what we found

During the inspection we had the opportunity to speak with people who used the service, relatives, registered nurses, maintenance leads and other staff members.

The people who used the service and their relative told us they were looked after well and felt safe with the care and treatment provided. Their comments included: "Staff are really nice", "They are friendly" and "Staff are very nice and look after me".

We found that the service had appropriate systems in place to ensure consent was gained before staff proceeded with personal care.

We spent time observing the lounges and dining areas during the day of our inspection. We looked at how people spent their time and how staff interacted with people. The interactions we saw between staff and people who used the service and visitors were respectful. We saw some people engaged in activities with members of staff such as watching TV.

The home had recently had an external audit by the local pharmacy and it was noted that where issues had been raised actions had been taken.

The service obtained five stars from the local authority inspection team for the kitchen in summer 2013.

During the inspection we observed good security practices. We saw the external doors had access control in place. The manager told us each room had a call bell that was serviced on a regular basis.

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

During our visit we looked at consent in relation to people's care and treatment, especially where people did not have the capacity to make their own decisions or to understand information about the care that they received.

One person who used the service told us ""Staff are very nice. They ask me what I like to do. I am going to play bingo this afternoon". Another person told us ""They ask me if I want to get up".

We saw staff asked people for their consent before they helped with care. For example, we observed one member of staff asked a person if they wanted help with eating their lunch.

One relative said that he had a meeting with unit manager to review the care of his wife, who was not able to make any decisions herself. He said "I was sent a letter to come in to talk about the care that my wife was getting and then I signed a form". He said "My son and daughter visit regularly and they are happy about the care".

We observed staffs knocked before they entered rooms and asked people before they gave care. They were observed explaining to people what care they were carrying out. Where people were unable to communicate verbally staff were observed using hand gestures to help the person understand what they were asking. This showed us staff knew how to obtain consent before helping with care.

We looked at people's care plans. We saw that the service had information which provided a record of each person's capacity and consent to personal care. This was completed on admission and reviewed at any time when there was a significant change in the person's wellbeing. Consent forms were either signed by the person who used the service or an advocate. Other consent policies and procedures included, flu vaccination, chiropody, opticians and photographic consent form.

There was information on consent to participate in telemedicine consultations, which is where consultations are carried out with the GP or consultant via a telemedicine link, rather than the person having to go to the practice or to hospital. All the care plans that we looked at had been signed and dated by the person who used the service or their advocate

There was information in each of the care plans of a do not attempt cardio pulmonary resuscitation (DNACPR) which had been signed and dated by people who use the service, or family members and a doctor.

It is a general principle that valid consent must be obtained for a person before they are assisted with personal care. This principle reflected people's right to determine what happened to their own bodies and was a fundamental part of good practice.

For consent to be valid it must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse personal care. The consent must be given by an appropriately informed person who had the capacity to consent to the personal care in question.

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 had discussions with the manager and reviewed specific sections of three care records and spoke with people who used the service. It was evident care plans were developed with people in order they understood their care and the potential risks involved.

One person said "Staff are very nice and look after me". Another person said" Staff are really nice". Three people were observed carrying out activities in the dining room and laughing and joking with staff.

Staff were observed speaking to people in a kind and caring manner and allowing them choice about what they wanted to do, for example one person was observed wandering around the unit and staff said that this is how she liked to spend her day and would get distressed if you tried to get her to sit down.

One relative said "She is always well dressed and clean. She always eats well and I think she has probably put on weight here. Staff let her do what she wants. She walks around a lot but staff don't mind. I have not seen anything that would cause me concern".

People who used the service had a completed 'My Life History' section in the care plan before they received care. This was updated every time there was a change in circumstances or at the one month care plan review. A care history was important as it enabled the staff to make informed decisions about care options and understand potential risks as a result of past care information.

Care plans had information recorded on a pre-admission assessment carried out prior to admission and further assessments which covered areas such as medical condition; behaviour, cognitive impairment, mobility, nutrition, continence, falls and tissue viability.

All of the reviews were up to date. Each care plan had information on an emergency evacuation plan in case of fire.

There was information which showed involvement from other healthcare professionals such as GPs, dietitians, opticians, specialist nurses and chiropodists.

One person had information recorded in their care plan of a last day of life care plan . This covered specific areas of care such as pain, agitation, breathlessness, nausea and vomiting. This assessment was updated every four hours. It was noted that the nursing staff had communicated with the GP when the persons care needs had changed for example a change in medication. This showed us specific care plans were in place to meet people's individual needs.

We saw evidence that people living at the home had frequent contact with community based health professionals whenever people required their involvement such as Community Matrons and GPs. Staff and the relative we spoke with told us that the staff acted promptly where they had any concerns and that they kept the families informed.

The activities coordinator told us the staff were helpful and knowledgeable about the needs of people using the service. They said staff referred people to external health care professionals without delay and followed the advice they were given.

We saw that people looked well cared for and staff were aware of people's individual needs and preferences. We saw that people were offered drinks and snacks throughout the day. At lunch time we saw staff prompted and helped people in a discreet and sensitive way.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. Risk assessments were in place for people which included medication and moving and handling. The risk assessments provided guidance to staff on how to provide care and treatment to help minimise the risk of harm and deterioration to their health. Where risks had been identified reviews had been carried out which were signed and dated.

During our inspection we were told by staff that they referred to people's care records prior to delivering care. Staff also completed daily records following the end of the shift.

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

We looked around the home including bedrooms, toilets, bathrooms, the laundry, corridors and the lift accompanied by the manager. The home smelt fresh and looked clean.

The manager and house keeper told us the service employed cleaning staff and there were cleaners on duty seven days a week. The manager told us there were cleaning schedules in place for the staff to follow.

We found the stair cases were clear from dust. The communal areas were clean.

In the bedrooms we looked at we found they were odour free, the bed covers and sheets were clean and smelt fresh.

We found the base of all of the arm chairs and under the cushions were clean. Nearly all the chair cushions were free from splits.

The en-suite bathrooms floors were clean and free from any unpleasant odours and there was no dirt behind the waste pipes.

The home obtained five stars from the local authority inspection team for the kitchen in summer 2013.

PPE (Personal Protective Equipment) was being used by staff in an appropriate manner. We looked at the reorder of PPE and found that the service was reordering on a weekly basis.

We looked at the 'Fundamental Skills Domestic' training data which included information on cleaning, equipment and infection control. We also looked at the room check sheets which were completed on a daily basis. A three monthly infection control audit was undertaken at the home. We saw a copy of the last report with an action plan dated 9 September 2013. The service obtained 90% on this report.

The service also implemented a hand audit, in which every employee was tested for germs and bacteria on a regular basis. We saw a copy of the last audit in October 2013.

Herncliffe care home also had an infection control lead and an infection control policy which was last updated in May 2013. The policy detailed universal precautions, hand care, gloves, disposal of waste and MRSA.

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

On each of the units a registered nurse was responsible for the administration of medicines. The registered nurses said that one pharmacy was responsible for the dispensing of all medication to the home.

We spoke with two registered nurses who said that there was no one on their units who was able to self-medicate due to the complexity of their care needs.

Each person had a medication administration record (MAR) which recorded what medication each person was having. We looked at 12 MAR which had information on; the person's name, a photograph of the person, frequency of the medication, allergies to medication and was coded if medication had been omitted, and, the reason why.

All but two of the MAR were signed and demonstrated that medication had been given at the appropriate times. However the provider may wish to note, two of the MAR, had gaps where medication should have been given but had not. The registered nurse said that one had not been given because the person had refused the medication, which she did regularly, and that she had made an error by not signing .

Medication was stored in either a monitored dosage systems if people were having medication on a regular basis, or, where it was given "as required"(PRN) or was not able to be given via a dosage system, it was kept in the locked cabinet, labelled with the person's name on it and dated.

Each of the medication cabinets were locked and stored in a locked room. One of the registered nurses said that they were going to re-locate the medication storage room because there was insufficient space.

Each unit had a controlled drugs cabinet and information on usage of controlled drugs was recorded and monitored in the controlled drugs books. Each unit had three controlled drugs books one for liquid and tablets, one for patches and another for injections. It was noted that the information in each book was signed and up to date.

Each unit had a medication fridge which was audited every day to ensure the correct temperature was maintained.

The registered nurse said that night staff were responsible for monitoring the stock drugs and any found to be out of date were placed in a specified container for destruction.

The manager and deputy manager was responsible for the destruction of drugs.

One person who was terminally ill was having medication via a syringe driver. This is where drugs are given by a continuous subcutaneous infusion. The medication chart and the infusion site was monitored four hourly by the registered nurse, which was signed and up to date. All changes to the controlled drugs prescription form was completed signed and dated.

We saw information on medication audits having been carried out by the clinical lead. The manager said that information from the audits was fed back to the unit managers and the registered nurses immediately, if any issues were raised. They would then be discussed at the departmental meetings which were held every three months. The manager and deputy manager attended the meetings.

The home had recently had an external audit by the local pharmacy and it was noted that where issues had been raised actions had been taken.

Each registered nurse said that they maintained their competency with administration of medication through the guidelines set out by the Nursing and Midwifery Council (NMC). They said care workers had training on medication which was delivered by trainers from the home.

One of the registered nurses said that she had undergone training on the use of syringe drivers to maintain her competency.

We observed staff dispensed medication to people and that they waited until the person had taken the medication before leaving them. This ensured staff knew people had taken their medication.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

We undertook a tour of the premises escorted by the manager. We saw that bedroom accommodation situated in six areas of the home were clean and smelt fresh.

All of the people we spoke with on the day of our visit were satisfied with the facilities and cleanliness of the home. A person told us "My room is cleaned everyday". The bedrooms and en-suite toilet facilities throughout the home were clean and smelt fresh.

The corridors which led to each bedroom were clean and free from clutter.

We saw people's bedrooms were personalised with their personal possessions and pictures of relatives displayed. We found the building was pleasantly decorated throughout.

A staff member told us that when rooms were decorated the owners took into consideration the wishes of people who used the service. We saw several bedrooms where colours had been matched to the bedding curtains and carpet.

We saw fire detection devices, fire signage and fire fighting equipment installed throughout the premises. These were maintained and the maintenance logs reflected monthly testing of this equipment.

The laundry on site was safe, clean and smelt fresh. Practices to separate clean and dirty linen was adequate. Each person who used the service had their own labelled clothing basket.

The manager told us that there was a programme of redecoration and renewal in place which was currently being delivered throughout the home.

During the inspection we observed good security practices. We saw the external doors had access control in place. The manager told us each room had a call bell that was serviced on a regular basis.

We looked at the fire training, fire safety policy, firefighting equipment, fire alarm procedure, fire risk assessments and audits and the fire evacuation policy. These were all up to date and demonstrated that the service regularly inspects, monitors and regulate the services fire safety.

We saw fire alarm audits and we also looked at the Fire Service Certificate dated December 2012, Alarm System Fire Detection dated 13 June 2013, Legionella Testing dated 6 February 2013 and the Nurse Call Medicare System dated 29 August 2013.

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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