Inspection Report

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

# Ardgowan House Residential Care Home (Mrs Annie Jobson)

4 Middle Street, Newsham, Blyth, NE24 4AB

Tel: 01670367072

Date of Inspections: 14 May 2013
13 May 2013

Date of Publication: June 2013

We inspected the following standards to check that action had been taken to meet them. This is what we found:

| | |
|---|---|
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Supporting workers** | ✗ Action needed |
| **Assessing and monitoring the quality of service provision** | ✓ Met this standard |
| **Records** | ✗ Enforcement action taken |

## Details about this location

| | |
|---|---|
| Registered Provider | Mrs A Jobson |
| Overview of the service | Ardgowan House is a detached house situated in a residential area on the outskirts of Blyth and provides accommodation for up to ten people. Ardgowan does not provide nursing care. Each person has their own bedroom and shares communal areas. |
| 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

We carried out this inspection to check whether Ardgowan House Residential Care Home (Mrs Annie Jobson) had taken action to meet the following essential standards:

- Care and welfare of people who use services
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

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 13 May 2013 and 14 May 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

### What people told us and what we found

During our inspection we looked at four care records, spoke to two people who used the service and two members of staff.

People who used the service looked comfortable in the home, well cared for and told us they were happy with the service. One person told us, "I've lived here for 25 years and the staff are superb." Another person told us, "The staff look after me very well." We concluded care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Staff were unsure about the presentation of certain conditions and side effects of medications that people who used the service were taking. We concluded staff had not received appropriate professional development or additional training.

The provider had systems in place to monitor and assess the quality of the service and took account of people's views and wishes.

We found people's personal records were not up to date, accurate or fit for purpose.

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 21 June 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have taken enforcement action against Ardgowan House Residential Care Home (Mrs

Annie Jobson) to protect the health, safety and welfare of people using this service.

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

**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

During our previous inspection on the 21st January 2013 we told the provider they were not meeting this essential standard. We said, "The provider was not taking the proper steps to ensure that service users were protected against the risks of receiving care or treatment that is inappropriate or unsafe." We judged that this had a minor impact on people who used the service and told the provider to take action. In response to our concerns, the provider wrote to us and told us what actions they had taken to improve.

During our inspection we looked at four care records, spoke to two people who used the service and two members of staff.

People who used the service looked comfortable in the home, well cared for and told us they were happy with the service. One person told us, "I've lived here for 25 years and the staff are superb." Another person told us, "The staff look after me very well."

We saw staff dealt with people sensitively, asked people if they were happy with the care provided and checked if they required anything. For example, one person, who was sat in the lounge, was asked whether they wanted the television on or not. One member of staff told us, "I always try and check if there is anything that they need."

We saw people who used the service where supported to access appointments to support their health needs. For example, one person told us they were regularly seen by the district nurse. We also saw entries in the daily records indicating people had been accompanied to hospital or general practitioner appointments. We found letters from people's consultants or other health professionals indicating people had attended clinic appointments for assessment or review.

We noted staff maintained observation of people if they felt they may be unwell. For example, we saw an entry in the daily records that one person appeared to be short of breath. This was commented on later during the day and by the night staff, who indicated

the person's condition had improved.

Care plans were in place to support people's identified needs, including their physical health, mental health and social needs. The provider may wish to note that some detail of people's care were not always in a format easily identifiable as a care plan and was sometimes incorporated into risk assessments.

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

**Supporting workers** ✖ Action needed

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

## Our judgement

The provider was not meeting this standard.

People were cared for by staff who had not received support and training to an appropriate standard.

We have judged that this has a minor 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

We had not intended to look at this outcome but identified some issues that warranted further investigation during the inspection.

Staff we spoke with told us they were unsure about the presentation of certain conditions that people who used the service had; such as diabetes. One staff member we spoke with told us, "I couldn't recognise if blood sugars were too low." The deputy manager told us, "The staff probably don't know what a high or low blood sugar is."

Staff were also unsure about the side effects of certain medications that people who used the service were taking, such as warfarin. Warfarin is a medicine used to thin people's blood and prevent blood clots forming. It is important that it is carefully monitored. Staff told us they were unsure of the side effects of this medication or what to look for when monitoring people who were taking it.

The deputy manager told us staff had not been given information or training about these issues.

We concluded that because staff were unable to tell us about these issues they had not received appropriate professional development or additional training.

**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

During our previous inspection on the 21st January 2013 we told the provider they were not meeting this essential standard. We said, "The provider was not protecting service users against the risk of inappropriate or unsafe care and treatment, by means of the effective operation of systems, in that they did not regularly assess and monitor the quality of the service provided or manage risk relating to health, welfare and safety." We judged that this had a minor impact on people who used the service and told the provider to take action. In response to our concerns, the provider wrote to us and told us what actions they had taken to improve.

We saw that the provider had put in place a number of systems to help monitor the quality and safety of the service.

We noted, from examining people's care records that existing care plans had be reviewed and updated and had an indication when they were to be next reviewed.

We saw that weekly audits of the people's medication were undertaken and a record of any issues noted. We checked a number of items and found that the number recorded matched the amount of medication in boxes. We noted that boxes sometimes ran over between medication changeover dates, rather than change at the same time as medicines provided ready packaged by the pharmacy. We spoke to the provider about this. They told us that they had spoken to people's general practitioners before about this issue but that they would raise it again.

One area of concern at our last inspection was regarding people's money, which was held by the provider, and was not being checked regularly. We looked at a number of cash books for people who used the service and found that checks were now made weekly and that these were signed to say the amounts of cash tallied with the record in the books.

The provider told us regular meetings with people who used the service took place and we saw minutes from these meetings to confirm this. We noted people's wishes were taken into consideration and acted upon. For example, people had suggested that a walking

group was restarted and we noted that this had taken place.

We saw that the provider had maintained other checking and quality monitoring systems such as; fire safety, fire drills and temperature checks for fridges and freezers in the kitchen.

We concluded the provider had systems in place to monitor and assess the quality of the service and took account of people's views and wishes.

**Records**

✖ Enforcement action taken

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

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

## Reasons for our judgement

We had not intended to look at this outcome but identified some issues that warranted further investigation during the inspection.

During our inspection we examined four people's care records. We found risk assessments were not specific or detailed. For example, one person's risk assessment stated their blood sugars needed to be monitored for being too high or too low. However, there was no indication as to what a figure was considered to be too high or what a figure was considered to be too low.

We noted one person's blood sugar levels should be monitored and recorded weekly. We saw that the last entry recorded was 11 April 2013. The manager told us the checks had been done but not transferred into the file.

Two people who used the service had risk assessments that indicated they should be reviewed every year. We noted there was no record they had been updated. Staff we spoke with told us that the information contained within the risk assessments no longer applied and were unsure why it had not been updated.

We saw people's care plans indicated key worker staff should meet with people who used the service on a weekly basis. These meetings were recorded in people's individual note books. We found one person's note book that had no entry made since 3 December 2011.

We concluded people's personal records were not accurate or fit for purpose.

**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 23 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Supporting workers** |
| | **How the regulation was not being met:**<br><br>The provider did not have suitable arrangements in place to ensure staff received appropriate training and professional development. Regulation 23(1)(a) |

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 21 June 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.

**This section is primarily information for the provider**

## ✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

### Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

| **We have served a warning notice to be met by 13 June 2013**<br><br>This action has been taken in relation to: | |
|---|---|
| Regulated activity | Regulation or section of the Act |
| Accommodation for persons who require nursing or personal care | **Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Records** |
| | **How the regulation was not being met:**<br><br>People's personal records were not always correct and accurate records were not always maintained. Regulation 20(1)(a). |

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

## 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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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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