Inspection Report

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

Euroclydon Nursing Home

Hawthorns, Drybrook, GL17 9BW

Tel: 01594543982

Date of Inspection: 10 March 2014

Date of Publication: March 2014

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

Consent to care and treatment	✓ Met this standard
Staffing	✓ Met this standard

Details about this location

Registered Provider	Chantry Retirement Homes Limited
Registered Manager	Mrs. Helena Majcan Hadzihajdic
Overview of the service	Euroclydon is a care home for people with nursing and residential care needs. The home also has a small unit for people with dementia. The majority of people living at the home are over 65 years.
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

We carried out this inspection to check whether Euroclydon Nursing Home had taken action to meet the following essential standards:

- Consent to care and treatment
- Staffing

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 10 March 2014 and talked with staff.

What people told us and what we found

We carried out this visit to check if shortfalls found at our inspection in November 2013 had been met. Our inspection of 7 November 2013 found when a person's capacity to consent was unclear, due to their having an illness such as dementia, legal requirements had not always been met. The provider wrote to us and told us mental capacity assessments would be completed for people where they may lack capacity and these would be kept under regular review. Where people were assessed as lacking mental capacity for specific decisions consent would be sought from appropriate relatives and professionals. The provider told us these changes would be implemented by 30 January 2014.

At this visit we found the compliance action set in November 2013 had been met. We looked at the care records for five people and found assessments of individual's overall mental capacity and their ability to make specific day-to-day decisions had been completed. We saw where significant decisions needed to be made for people best interest meetings had taken place, involving other professionals as well as family members and advocates.

We also checked how the home was staffed because we had received information raising concerns about inadequate staffing levels. We looked at staff rotas, spoke with staff and observed people during a lunchtime period. We found there were enough qualified, skilled and experienced staff to meet people's needs.

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

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent

judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

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

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.The provider involved relatives and other professionals when making best interest decisions on people's behalf where they did not have capacity.

Reasons for our judgement

Our inspection of 7 November 2013 found when a person's capacity to consent was unclear, due to their having an illness such as dementia, legal requirements had not always been met. There was no process in place to assess people's mental capacity to make specific decisions. The provider wrote to us and told us mental capacity assessments would be completed for people where they may lack capacity and these would be kept under regular review. Where people were assessed as lacking mental capacity for specific decisions consent would be sought from appropriate relatives and professionals. The provider told us these changes would be implemented by 30 January 2014.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. Since our last visit the registered manager and nursing staff had attended Mental Capacity Act 2005 (MCA) training to update their practice. From this training the registered manager had developed a new protocol and guidance for staff to follow when assessing people's mental capacity. We looked at this guidance which detailed how, if people had a diagnosis of any mental impairment, an initial mental capacity assessment would be completed on admittance to the home. If this assessment determined that the individual lacked mental capacity then further assessments would be completed for specific day-to-day decisions.

We looked at the care records for four people who, because of their diagnosis of dementia, may lack mental capacity in some areas of their daily living. In all these care records we found assessments of individual's overall mental capacity and further assessments of their ability to make specific day-to-day decisions. For example one person had been assessed as not being able to consent to or make decisions about washing and dressing. Records explained that staff should still seek verbal consent from the person before carrying out

personal care. The assessment was cross-referenced to the relevant section of their care plan. The care plan recorded the person's known preferences about washing and dressing to enable staff to make decisions on the person's behalf.

We also looked at care records for two other people who had fluctuating mental capacity due to other physical or mental health conditions. We saw mental capacity assessments had been completed for decisions they may not always have the ability to make. For example one person did not have the capacity to give consent to being admitted to hospital if they required treatment during an acute anxiety attack. Care records explained how staff should use the agreed calming techniques in the first instance. If this did not alleviate the situation staff should make a best interest decision and make the necessary arrangements for them to be admitted to hospital for treatment. Records showed that this arrangement had been discussed and agreed with the person at a time when they had the capacity to understand. This meant the home had taken into account the individual's rights and wishes.

We found there was a system in place to review all mental capacity assessments every six months or more frequently as people's needs changed.

We saw where significant decisions needed to be made for people best interest meetings had taken place, involving other professionals as well as family members and advocates. Where people lacked the mental capacity to be involved in writing and agreeing to their care plans records showed these had been written in people's best interest. Since our last visit the home had written to people's families to ask if they held a 'power of attorney' (POA) and to request a copy. This was to ensure the home was aware if a POA existed and to check what areas relatives had the authority to give consent to. For example whether the relative holding the POA had the authority to make financial decisions, health and wellbeing decisions or both.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs. The provider had assessed staffing levels in line with people's needs and had systems in place to change staffing levels as people's needs changed.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. Prior to this visit we received information raising concerns about inadequate staffing levels in the home, especially during meal times and at night in the dementia unit. During this inspection we checked staffing levels by looking at staff rotas, speaking with staff and observing people during a lunchtime period. At the time of our visit there were 42 people living in the home. 36 people in the main house and six people in a separate dementia unit. We looked at the rotas for the previous four weeks for the main house and the dementia unit.

Rotas for the main house showed two nurses and seven care staff on duty every morning and one nurse and six care staff in the afternoon. In addition to the nurses and care staff a member of staff was employed to help with breakfast and lunch from 08.30am – 01.30pm. Rotas for the dementia unit showed that two staff were on duty every day from 08.00am – 8.00pm.

We arrived at the home just before lunchtime and observed people having their lunch in the main house and the dementia unit. In the main house we saw two nurses in the dining room, one administrating medication, and four care staff helping people with their meals. Three care staff were supporting some people on a one-to-one basis to eat lunch in their rooms. In addition to the care staff on duty the activities co-ordinator and a senior care worker were in the dining room.

The activities co-ordinator told us they always helped people at lunchtime. The senior carer allocated staff to people either in the dining room or their own rooms to ensure everyone received the support they needed. Some people in the dining room needed support from staff to eat their lunch and we saw there were enough staff to support everyone who needed help.

There was a calm atmosphere in the dining room and people had chosen where they wished to sit. Some people sat at dining tables, others at small tables and some people chose to sit in the conservatory because it was quieter. We spoke with three people at

lunchtime who were able to tell us about their experience of living in the home. They all told us they were happy living in the home and there were always staff available to help them whenever they needed support.

The dementia unit had two staff on duty and when we first arrived at the home they were just finishing a craft activity. These staff remained in the unit for the lunchtime period. Most people in the dementia unit were able to eat their lunch unaided but required some gentle prompting to remind them to eat. We observed staff interacting with people in a sensitive and respectful manner.

We also looked at the rotas for night staff and records showed one nurse and three care staff were on duty every night. These staff covered the main house and the dementia unit. We looked at records completed by night staff in the dementia unit to see what arrangements were in place to check people during the night. Three people in this unit had door sensors which activated an alarm if they walked out of their room. Night staff would check the unit whenever an alarm was activated. If it was not necessary to go into the unit in response to an alarm staff still carried out hourly checks. Records we looked at showed night staff carried out checks at least hourly and the majority of the recorded checks were completed with gaps of less than an hour.

Staff we spoke with during our visit told us, although they were busy, they felt there were enough staff on duty most days. Staff also told us managers listened to requests for additional staff and efforts were always made to increase staffing levels in line with people's needs.

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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