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: 07 November 2013

Date of Publication: December 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	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	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

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 7 November 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

When people had capacity to consent they were asked for consent before care was provided and staff acted in accordance with their wishes. 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.

One person said, "They knock on the door gently in the morning and if you want to spend the day in bed, that's fine. If you want to see a doctor, one comes. If you don't want a male carer, they get you a female…They are very, very, very good". We saw several examples of excellent care, in particular in supporting people with dementia. The way staff interacted with people in the dementia care unit created a calm and reassuring atmosphere where people were enabled to engage with the activities taking place and the people around them.

Arrangements to safeguard people were clearly embedded, no safeguarding incidents had occurred at the home since our previous inspection. Staff felt well supported and told us they received appropriate training to enable them to meet people's needs. One said, "We have a lot of training courses. We are trained brilliantly". Another said, "The training is really really good".

Systems were in place to monitor the quality of the service and people were able to make complaints and suggestions. Staff demonstrated commitment to their roles. One person said, "I have never needed to complain. If they asked me to leave this place, I would weep. I love this place".

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 31 December 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.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. However, where people's capacity to consent was unclear, the provider had not always acted in accordance with legal requirements relating to 'best interests' decisions. Capacity assessments had not been carried out in a time and decision specific manner and consent had been obtained from a person who did not have the legal power to give this.

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

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The five people we spoke with about this outcome area told us that they had consented to moving to the home. They were satisfied that they had received enough information, support and time to make their decision. One person said, "There was plenty of written information given to me and there are 'visiting days', so I was able to come in here to see what it was like, but I didn't really need to. I understood all the conversations surrounding my admission". Our observations and discussions with staff demonstrated that agreement was routinely sought from people before day-to-day care was carried out. Staff told us how they responded to a person when care was refused, for example by giving people time, further explanation, or trying a different approach. One staff member said, "I would try and talk to them and find out what would be better for them".

However we found that where people did not have the capacity to consent, the provider had not acted in accordance with legal requirements. We found that there was no process in place to assess people's capacity to make specific decisions at the time the decision needed to be made. In three of the four records we reviewed we saw that a generalised statement/ assessment about people's capacity had been made by staff. For example, one said the person 'could make simple choices' but 'lacked insight into their care needs... care plans written in best interests'. In another person's records we saw that a person's relative had been documented as having 'power of attorney' (POA). No further details of this had been recorded. One staff member told us that this person had "all their faculties" so was able to make decisions for themselves.

We saw that several consent forms had been signed by this relative on behalf of the person, relating to aspects of their care. The registered manager told us that this relative had POA for financial decisions. They had not seen a copy of this document and did not know whether POA had been registered with the office of the public guardian. This meant that the person had only agreed to their relative's involvement in making financial decisions, not health and welfare decisions.

Furthermore, their power to do this would also not be valid if the person was able to make that decision for themselves and if the POA had not been registered. No capacity assessments had been undertaken in relation to consenting to those aspects of care. The registered manager explained that their relative may have signed the consent forms as the person had some difficulty using their hands. No record had been made about this or the discussions held with the person. Through our discussion, the registered manager understood where the shortfalls were and said they would revise policies and procedures in the light of this discussion.

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. The home worked well with external professionals and applied appropriate specialist knowledge to enhance people's well-being.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Each person's needs had been assessed and care had been planned to meet each person's individual needs. Our observations and conversations with staff demonstrated that people's diversity was respected. This meant that staff fitted in with people's needs and the way they liked to interact with others rather than expected them to conform to a particular norm or routine. One person said, "They knock on the door gently in the morning and if you want to spend the day in bed, that's fine. If you want to see a doctor, one comes. If you don't want a male carer, they get you a female…They are very, very, very good".

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Risk assessments were updated regularly and timely support had been sought from external health and social care professionals to manage any specialist or changing needs. People's care and treatment reflected relevant research and guidance. We saw that advice given by external professionals had been implemented when delivering care. The service had also worked with local GPs to improve outcomes for people, for example, by implementing use of a pain assessment tool for people who were unable to verbalise pain.

We saw several examples of excellent care, in particular in supporting people with dementia. The way staff interacted with people in the dementia care unit created a calm and reassuring atmosphere where people were enabled to engage with the activities taking place and the people around them. In the main house people participated in a wide range of solo and group activities. Many of the organised activities stimulated thinking, and included laughter and sharing memories. One staff member told us about their experience of working one-to-one with people who were unable to join in group activities saying, "It brings them back to life."

There were arrangements in place to deal with foreseeable emergencies. No restrictions were in place that required authorisation by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff were clear about their role in preventing abuse and people knew how to report their concerns.

Reasons for our judgement

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff had completed safeguarding training at a level appropriate to their role and had access to information to enable them to follow locally agreed procedures to safeguard people. Staff were clear about the various forms of abuse and demonstrated appropriate responses to the scenarios we presented them with. Safeguarding and whistleblowing policies were easy to follow and were consistent with local procedures and expectations.

Comments people made about this outcome area included;

"When I first came here a gentleman with dementia walked into my room and it worried me and so the home put a bolt on my door which I can use and which they can open from the outside with a key if necessary. I have not used it since the chap left, but it is nice to know that I have it."

"I have seen abuse on TV, but you are safe here, you can complain. I can say there is no-one here like that (abusers on TV)."

All four people we spoke with told us they would speak to the registered manager, the head nurse, or any of the carers if they had any concerns but they had not needed to report any. They said that staff spoke to them in a respectful manner and if they had asked a staff member to buy anything on their behalf, they had always been given a receipt for this.

The provider responded appropriately to any allegation of abuse. While staff were clear about the procedures to follow we saw there had been no safeguarding incidents since our last inspection. Physical restraint was not used at the home and people were not prescribed medications that may chemically restrain them.

Supporting workers ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Staff received appropriate support to enable them to meet people's needs.

Reasons for our judgement

Staff received appropriate professional development. Staff training records demonstrated that mandatory training was consistent with the common induction standards. However, the provider may find it useful to note that regular opportunities for new staff to complete mandatory training had not been provided in all relevant subject areas. Hence some staff had not completed all aspects of mandatory training including infection control, first aid and fire safety.

We saw that some staff members had received training in meeting specialist areas of need including dementia, end of life and 'skin bundles'. 'Skin bundles' is a comprehensive approach to preventing pressure area damage. This meant that these staff were able to support others in meeting these needs. We noted that 18 of the 41 care and nursing staff team had not received training in dementia awareness. However, the registered manager had completed the leadership in dementia award and we observed that they, supported by a dementia link worker, were particularly strong in this area. This meant that dementia care was well understood within the home and staff could observe and adopt good practices while working at the home.

The staff members we spoke with told us they received appropriate training to enable them to meet people's needs. One said, "We have a lot of training courses. We are trained brilliantly". Another said, "The training is really really good". Staff told us that they could approach the manager with any training needs they had. Frequency of supervision was tailored to staff member's individual needs and performance. Staff readily sought assistance from other appropriate staff members when they were uncertain. For example, one person told us, "I once said to a carer 'my legs are very painful, I think I have cellulitis, please don't touch them' and the carer went straight to the nurse to see how to proceed."

The four people we spoke with about staff training did not identify any shortfalls in staff competency. One person said, "The young ones are inclined to be a little bit brusque, but that doesn't take away from their competence". Despite this comment all of the people we spoke with told us that staff were respectful and friendly.

Staff were able, from time to time, to obtain further relevant qualifications. Records showed

that two care staff had recently completed the Level 2 award in Health and Social Care and two others were studying for this. While some care staff had achieved higher levels, a further nine care staff had not undertaken a relevant social care qualification. The manager told us that the provider had agreed to sponsor one staff member to complete their registered nurse qualification.

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. People were able to voice their opinions and to make suggestions about changes that were important to them.
The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others. Regular audits were carried out at the home and incident trends were analysed.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. The home's annual survey had been carried out in March 2013 and the results were available in the entrance hallway. Feedback forms and a suggestion box were also available. The registered manager told us that although regular residents and staff meetings were held they received continual feedback as they walked through the home. Often this had proved most valuable and informative.

The registered manager told us about the changes they had made since they came into post in 2012. This included changes to the staff team and careful selection of the "right people" for the roles. They described the home as a "work in progress". All staff members we spoke with thought highly of the care provided and demonstrated commitment to meeting the needs of people living at the home. One said, "I treat people as I would want my parents treated". Another said, "The staff work very hard, the clients are the priority. I love it here. The staff are so friendly, get on well and work as a team… they are willing and do what's asked of them… they have a positive attitude. I would recommend it (the home) to anyone".

Decisions about care and treatment were made by the appropriate staff at the appropriate level. We observed that staff readily sought assistance from the registered manager during our inspection. They told us, "The door is always open" and described their managers as "friendly and approachable". They felt confident that they could raise any issues and these would be dealt with effectively and in confidence. When issues were directly related to care, staff referred to their team leaders or to the registered nurses. The registered manager told us they met monthly with the company director who was always available to speak to.

There was evidence that learning from incidents / investigations took place and

appropriate changes were implemented. Information about the frequency and nature of incidents including falls, complaints or accidents was collated and presented to staff in the staff room. The registered manager told us that this helped staff to understand the trends and where improvements could be made. This was supported by a comprehensive audit programme completed by designated staff members within the home.

The provider took account of complaints and comments to improve the service. We saw that no recent complaints had been received but several families had expressed their appreciation of the care provided at Euroclydon Nursing Home. One person said, "I have never needed to complain. If they asked me to leave this place, I would weep. I love this place".

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 activities	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	**Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010** **Consent to care and treatment**
	How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining the consent of service users, or another person who is able lawfully to consent to care and treatment on that service user's behalf. As applies in Section 4 of the Mental Capacity Act 2005 (best interests) (Regulation 18(1)a(2)).

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 31 December 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

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