Inspection Report

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

Clayton House

Clayton House, Victoria Terrace, Saltburn By The Sea, TS12 1HN

Tel: 01287622468

Date of Inspection: 01 October 2013

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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
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Safety, availability and suitability of equipment	✓ Met this standard

Details about this location

Registered Provider	Mrs Robina Hird
Registered Manager	Ms. Karen Kirby
Overview of the service	Clayton House is a converted Victorian building with an extension added. The home is located in a quiet residential area of Saltburn and provides accommodation for nineteen older people who have long-term physical health needs.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 1 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

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.

We found that care was delivered in a person centred way and all needs, risks and preferences were documented.

All residents confirmed that the food was nutritious and tasty. One resident told us;

"I am really spoiled here, I get a choice of one thing or another."

We observed staff to be respectful and kind. There were a variety of activities on offer including access to the internet.

All residents we spoke to made positive comments about the home.

One resident told us "it's very homely here."

A relative told us;

I wouldn't hesitate to recommend it here, I was guilty when he first came but I know he is well looked after. The staff keep us informed, it's like a big family.

Cinder the Dog gave plenty of entertainment to the residents.

We observed many examples of good practice regarding personal care including hand and nail care and assistance with feeding when required.

The provider had appropriate arrangements in place in relation to all aspects of medicines

management. Staff had good practice in dealing with medicines.

People were protected from unsafe or unsuitable equipment because the provider had maintained regular checks of all equipment and records confirmed this.

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.

Reasons for our judgement

We spoke to ten residents, staff, the registered manager and one relative about consent. We also examined four care records.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Staff told us;
"We do the care plans with the residents and where possible they sign them." and;
"We take a step by step approach and always let the residents know why we do things."
Staff also commented;
"We do try to offer choice and care can be flexible, capacity is about decision making and choice, this is their home and we really like to get to know people well. When there are major decisions to be made we always talk to the person, their family and the general practitioner.

Staff confirmed that they had received training on the Mental Capacity Act (2005) and took part in regular e-learning updates annually.

Residents confirmed that they had access to outside garden areas and local amenities. Two relatives were observed to collect their relative to take them out for a couple of hours.

We also examined an activity file which contained photographs of trips out to Whitby and themed parties which took place during the Olympics and Diamond Jubilee. This meant that people's human rights were respected and the home promoted choice and engagement with the local community.

All of the care records we examined contained signed contracts and terms and conditions of residence. All care plans were signed to indicate agreement. The records also

contained documentation regarding deprivation of liberties safeguards, lasting power of attorney and access to independent mental capacity advocates.
This meant where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Some of the documentation contained specific documentation relating to people's end of life wishes. We were assured by relatives and staff that discussions had taken place with residents about their choices regarding resuscitation and funeral care. This documentation complied with relevant legislation and was completed by the resident's general practitioner.

One relative told us;
"Dad tells them what he wants, staff always ask."
The resident confirmed this by saying ;
"If i didn't like it here I would come to live with you."

We witnessed warm and respectful interactions between staff and residents. We saw that staff always checked with residents before undertaking direct care activities. During the medicine round we heard staff say to one resident;
"What would you like first your puffer or your tablets?" and
"Do you want any painkillers?"

Other staff helping residents to eat were heard to offer choices about which part of the meal the resident would like next.

One relative told us;
"Sometimes Dad does not feel like having a bath, the staff don't force him."

This meant that resident's consent was always sought and their preferences were respected.

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 examined four care records in detail. We also spoke to ten residents, staff and the registered manager.

We found that care was delivered in a person centred way and all needs, risks and preferences were documented. This was confirmed by all the residents and relatives we spoke to.

One resident told us;

"I am very pleased, the care is very good. The ladies are all very caring. I have a nice little bedroom with my own TV and no-one to annoy me!"

Another resident told us;

"It's very homely, there are plenty of people to look after us."

A relative told us;

"My Dad would not like those new clinical places, I can't recommend this place enough, I don't have a bad word to say about it"
They went on to say;
"When it was Mum's funeral, all the staff came and we had the funeral tea here so all her friends could join in. It was an extra special touch."

The care records were easy to read and understand. They comprised of three colour coded folders. One contained all care plans and risk assessments, the second contained the monthly reviews which were all current and up to date, and the third contained correspondence from other professionals and details of hospital appointments. In addition there was a separate daily records folder which detailed how the person had been during each shift.

This meant that all staff were updated on the resident's care and welfare regularly and

helped to ensure that care was delivered safely and in a timely way.

The care record contained a photograph of the resident. This meant that if two people had similar names then staff could make sure that they had selected the correct record ensuring care was delivered safely.

The care records identified a key and associate worker and contained detailed assessments of need prior to the resident being admitted to the service. The care records also contained full activities of daily living assessments which documented current needs. Risk assessment and management plans contained interventions for staff to address current risks. These were reviewed monthly by the manager and amended when necessary if people's needs and risks changed.

The care records also contained a "pen picture of my life document" this detailed the resident's job when of working age, a list of hobbies and interests and a description of what makes the person happy or sad. This meant that people's plans were completely individual to them. Residents also signed them to indicate agreement.

There were individual plans for the morning, afternoon, evening and night-time. The risk assessments detailed the level of care, for example, one or two carers, and how often the resident required checking on during the night. This helped to ensure that care was delivered safely and in line with people's needs and risks.

Staff told us that emergency procedures were in place for serious incidents such as fires. There were detailed fire procedures in the lobby with an escape route map for staff and residents. All residents had a "My Escape Plan" document as part of their risk assessment. This detailed the level of assistance the resident required in the event of an emergency.

We also examined the business continuity plan which included actions to take in the event of, accommodation loss, catering disruption, communications interruption, utilities and information technologies disruption.

This meant that the provider had measures in place to deal appropriately with emergencies and that the effect on people's health and welfare would be kept to a minimum.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

We spoke to ten residents, one relative, staff and the registered manager about how people's nutritional needs were assessed and met. We examined four care records and observed a lunch time.

All residents confirmed that the food was nutritious and tasty. One resident told us;

"I am really spoiled here, I get a choice of one thing or another."

Another resident told us;

"My favourite is spaghetti bolognese"

A third resident told us;

"I hate cheese, so they prepare something different for me when cheese is on the menu."

This was confirmed by speaking to staff and examining this resident's likes and dislikes charts contained within the care records. These also contained choices for alcoholic beverages when preferred.

Staff told us;

"We go round everyone, ask about their likes and dislikes and build the menus around them. Every now and again we will have a residents meeting to ask for new ideas for meals".

The lunch we observed comprised of two choices for main course and two choices for desert.

A resident told us;

" If I don't fancy what is on offer they make me something else."

All four care records we examined contained a completed Malnutrition Universal Screening

Tool (MUST). These contained regular recordings of the resident's weight. They gave instructions to staff on action to take if the resident's weight rose above or dropped below a certain level. This then triggered an assessment by a dietician. This meant that people's health and wellbeing were regularly monitored using objective measurements.

Staff were aware of residents individual dietary requirements and were able to identify those residents who required a diabetic diet. Staff were able to confirm that they attended annual food hygiene training and were able to outline the principles of health, nutrition and the importance of good food hygiene.

We inspected the kitchen. There were bowls of fresh fruit and a variety of snacks and drinks available. Staff were observed to offer these regularly to residents. There was a separate drinks kitchen.

We observed notices on the kitchen walls relating to hand hygiene and rules for a hygienic kitchen. There were daily, weekly and monthly tasks displayed for staff to sign when these had been completed.There were also reminders to staff to record when jars had been opened. This was confirmed by looking at opened foodstuffs. We found separate colour coded chopping boards for different foodstuffs. There were separate compartments in the fridge and freezer for raw and cooked meat and there was a separate dairy fridge.

This meant that resident's health and wellbeing benefitted from high standards of food hygiene.

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

Medicines were handled appropriately.

We confirmed this by observing a medicine round, speaking to the manager and staff and examining four medicine administration records (MAR). We also examined associated policies and procedures and storage arrangements for medicines and controlled drugs.

Staff confirmed that only those who had undertaken appropriate training were able to administer medicines. There were risk assessments available for the self-administration of medicines by residents,however no residents had chosen this option.

We saw that prescription medicines were supplied in weekly blister packs by the chemist which reduced the risk of medicine administration errors. Staff could not remember a time that a medication error had happened since this system had come in.

We observed staff followed good safety and hygiene practices when handling medicines and staff always asked people if they wished to take the medicine before administering. We observed that staff signed the medication administration records after residents had taken the medicine. This meant that appropriate arrangements were in place in relation to the recording of medicine.

We examined four medication administration records (MAR) and found these legible and easy to follow. Each medicine had been supplied with written instructions on dose, route and time to be administered. These came with a photograph of the tablet or the packaging. There were codes for reasons the medicine had not been given. Staff had signed the record to indicated these medicines had been disposed of appropriately. All records examined contained no gaps or missed signatures. This meant that medicines were safely administered and that medicines were disposed of appropriately.

We examined the storage facilities for medicines and found that prescription medicines were secured in a locked trolley attached to the wall when not in use. Controlled drugs (which may be subject to abuse) were secured in a locked safe and a register was signed

by two people each time these drugs were administered. This complied with current legislation on the misuse of drugs. We conducted a spot check on a controlled drug and found the number recorded in the register tallied with the number of tablets in the safe. This meant that medicines were kept safely and that controlled drugs were monitored appropriately.

There was a medicines policy in place and this included the following procedures; storage; controlled drugs; change of medication; self-medication; homely remedies and confidentiality and privacy.

Staff were able to confirm the steps they would take in relation to adverse or allergic reactions to medications which residents might have. These would include, contacting the pharmacist and GP and seeking advice.

This meant that the provider had appropriate arrangements in place in relation to all aspects of medicines management.

Safety, availability and suitability of equipment ✓ Met this standard

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was meeting this standard.

People were protected from unsafe or unsuitable equipment.

Reasons for our judgement

People were protected from unsafe or unsuitable equipment because the provider had maintained regular checks of all equipment and records confirmed this.

We examined the maintenance file and found there were regular checks of wheelchairs, nurse call system, stair lift and bath lift.

There was a policy and procedure for the use of hoists and reference to their safe use was detailed in the four risk assessments we examined. Staff confirmed that they had received training on their use. The business continuity plan contained references to actions for staff to take in the event of equipment failure.

There was enough equipment to promote the independence and comfort of people who use the service.

There were no medical devices such as syringe drivers at the home.

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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