Inspection Report

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

Sursum Limited Bramley House

Bramley House, Castle Street, Mere, BA12 6JN

Tel: 01747860192

Date of Inspection: 02 May 2013

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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
Meeting nutritional needs	✓ Met this standard
Management of medicines	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Sursum Limited
Registered Manager	Mr. Simon Roger Jones
Overview of the service	Sursum Limited Bramley House is registered to provide care and support to 37 older people some of whom may have dementia.
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 Sursum Limited Bramley House had taken action to meet the following essential standards:

- Consent to care and treatment
- Meeting nutritional needs
- Management of medicines
- 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 2 May 2013, observed how people were being cared for and talked with people who use the service. We talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

This inspection was to follow up on shortfalls we identified in our previous inspection in medicines management and record keeping. Whilst we were there we looked at other outcomes as part of our routine inspection work.

We spoke with four people who used the service and three staff. People told us they thought the care was good. One person said "it's very good here. They help you to be independent." Another person told us "I have no complaints. I can go out when I want. That's important to me."

We observed staff were patient and kind. All staff interacted spontaneously with people to share a joke or offer a compliment. People seemed relaxed. They moved around the home freely and used all communal areas.

We observed people were involved in decisions about their care. The manager had made appropriate referrals to the relevant authorities when they had concerns about a person's mental capacity.

People told us they enjoyed the food. The menu was varied, offered choice and included meat, fish, vegetables and salad.

People's records were regularly updated and overall included enough information for staff to assist people with their care needs.

We found people's medicines records were accurately completed. Medicines were stored safely. Staff had received appropriate training to administer medicines.

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 with four people who used the service. They told us staff always sought their permission before they assisted with care. One person said "they don't make me do anything I don't want to do. I can go out whenever I want." Another person we spoke with was of a similar opinion. They told us "it's very good here. I can be independent. They don't force you to do things you don't want to do."

We observed staff explained how they were going to support people with patience and kindness. They asked peoples' permission before assisting with care. Staff we spoke with had worked in the home for a number of years and understood how to communicate effectively with each individual to gain consent. One staff member told us "one person tells us to go away in no uncertain terms! I know that I need to give them time or it sometimes works if another member of staff talks with them."

Staff we spoke with understood the term mental capacity and used their knowledge of the person to recognise when mental capacity may have diminished. They explained that increased confusion and forgetfulness, or changes in people's behaviour, may have meant people required more help in making decisions. This meant people would receive the appropriate support to maintain their independence. Staff knew about working in people's best interests if it had been established a person did not have the mental capacity to make decisions for themselves. This could involve speaking with people's representatives, for example family members, their GP or a social worker.

We saw in one person's records the provider was concerned about the person's welfare and their preferred place of care. Acting in line with guidance from the Mental Capacity Act 2005 they sought advice from the local authority with regards to a mental capacity assessment and a best interest meeting was arranged.

We looked at four people's care records. We saw consent had been obtained for some

care activities such as sharing personal information and use of photographs. The manager told us people were asked about the help they required with taking medicines. We saw some people chose to look after and take their own medicines. Other people had given consent for staff to store and administer their medicines.
We looked at how decisions were made and recorded regarding people's wishes about resuscitation being attempted in the event of cardiac arrest. We noted discussions had taken place with some people and a Do Not Attempt Resuscitation (DNAR)form was used to record their wishes. When people did not have the mental capacity to make these decisions themselves, people who had been involved in best interest discussions were clearly identified in the DNAR document. This was is in accordance with requirements of the Mental Capacity Act 2005. One person had clearly documented decisions about what care they would like and the treatment they would refuse at the end of life if they did not have the mental capacity to give consent at that time.

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 with four people who told us they enjoyed the food. People told us the meals were excellent. One person told us "the food is plus plus. Full marks."

The menu offered two hot options each lunchtime which included fresh meat or fish and vegetables as well as omelettes or salad. The chef told us they catered for diabetics and vegetarians. Some people required a soft diet as they had difficulty chewing or swallowing.

We observed the conduct of the lunchtime meal. Most people were seated at tables in the dining room or whilst some chose to eat in their rooms. The lunchtime was unhurried and calm. People were relaxed and conversed with each other during courses. There were enough staff to ensure people did not have long to wait for their meal. We noted people were not able to help themselves to vegetables or gravy as the food was already served onto their plates. We spoke with the chef who showed us a list of the choices people had already made and their preference of portion size. They explained people could change their mind on the day if they preferred an alternative to what they had ordered.

The food was hot and looked appetising. All the people in the home ate independently, some with adaptive crockery to assist them to eat. The provider may find it useful to note staff did not remind people with dementia and who had a soft diet what they had ordered for their meal. This may have meant people were not able to recognise what food they were eating. People seemed to enjoy their food. During the inspection we saw people had access to hot and cold drinks during the day.

We saw people's food and drink intake was appropriately monitored. Staff told us and records confirmed people were weighed regularly. Significant changes in people's appetites or weight would be reported to their GP for further guidance and referral to specialist services such as a dietician or speech and language therapist.

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

At our inspection on 11 December 2012 we found the medication administration records (MAR) had not been accurately completed. The provider sent us an action plan to demonstrate how they would address this shortfall.

We saw the provider had moved to a blister pack system for administration of medicines. A senior carer told us they felt this had improved the safety and effectiveness of administering people's medicines.

At this inspection we looked at all of the MAR sheets for April 2013 and found they had been completed accurately. Staff had used the appropriate key to indicate why any medicines had not been administered. The provider may find it useful to note staff found it difficult to clearly record when medicines prescribed 'as required' had been administered. The section for the signature, time and number of tablets given was too small to clearly document all of the necessary information easily. This could pose a risk of staff or other professionals not having accurate information about the medication administered. We observed part of a medicines round. Staff administered people's medicines safely and in line with the provider's policy.

We saw staff responsible for administering medicines had recently undertaken medications training in January 2013. The training was from an accredited training provider. The content was comprehensive and included subjects which would help staff administer safely and effectively such as legislation and methods of administration.

From the four care records we looked at we noted people had a plan of care for medicines. The plan of care provided staff with additional information to support people safely with their medicines. For example, how they liked to take their medicines, or possible side effects to be aware of.

People's MAR sheets were stored securely. The provider had a comprehensive and up to date medicines policy. We saw people's medicines were stored and disposed of in line with the provider's policy.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

During our inspection on 11 December 2012 we found the provider had not accurately maintained people's care records. They identified how they would address the shortfalls in record keeping.

At this inspection we looked at four people's records and charts. We saw people's risk assessments, for example concerning pressure ulcer and nutritional risk were assessed monthly or as a person's condition changed. This meant staff were able to detect and act upon changes in a person's condition in a timely manner. People at risk of pressure ulcer development now had a dedicated care plan to inform staff of the care required to minimise the risk of pressure ulcer development. Care plans were reviewed monthly and updated when care needs changed. The provider may find it useful to note people's plans of care did not always contain specific detail as to how staff should meet care needs. For example, how often to check a person's pressure areas, or how to communicate when managing aggressive behaviour. This may have meant staff not familiar with people in the home did not have enough information to care for the person effectively.

People's daily records were detailed and contained information from visiting health care professionals. This level of information was useful in updating staff at shift handover about changes in people's health and wellbeing.

The manager told us as part of the provider's quality monitoring systems they audited MAR sheets and medicines records monthly. Care plans were audited every three months. Concerns about the accuracy of record keeping would be raised in staff meetings or staff supervision sessions.

We saw staff personal records were kept securely in a locked cabinet in the manager's office. The manager told us only authorised personnel were able to access the records. People's care records were kept in a locked cabinet in the staff room only accessible to staff.

The manager was aware of how long records needed to be retained. The manager had a safe process for the destruction of confidential records.

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.

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