Inspection Report

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

Borrage House

8 Borrage Lane, Ripon, HG4 2PZ

Tel: 01765690919

Date of Inspection: 16 May 2013

Date of Publication: June 2013

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	✗ Action needed
Management of medicines	✗ Action needed
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Anchor Trust
Overview of the service	Borrage House is close to the centre of Ripon. It is owned by Anchor Trust and is registered to provide accommodation for up to 40 people who require personal care. Borrage House is not a nursing home. Living accommodation for people using the service is on the ground and first floor. There is a passenger lift. Office and storage space is on the third floor. There is large garden and parking facilities.
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 16 May 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

We visited the home during the early hours to gain a wider view of the service provided, we arrived at 04:15am. This was part of an out of normal hour's pilot project being undertaken in the North East region.

Some people were not able to tell us about their experiences. We therefore used a number of different methods to help us to understand the experiences of people. We spoke with six people who used the service and two visitors. Everyone we spoke with told us the care and support at the home was good. However, people were not protected against the risks associated with medicines because appropriate arrangements were not in place to manage the administration of medicines safely.

Overall people's care plans contained a level of information that ensured their needs were being met. However, not all information was being followed up. For example where people who had lost weight and records did not accurately reflect the care being given. This meant that peoples care needs could be overlooked and we could not be assured that proper care was being given.

We saw records that showed people were involved in developing their care plans and that relatives or their representatives had been involved, where necessary.

There were enough qualified, skilled and experienced staff to meet people's needs. We saw how staff supported people, at their own pace, to make sure they knew how best to meet a person's need.

There was an effective complaints system in 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 20 June 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 ✓ 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 staff acted in accordance with their wishes. People's preferences and experiences were taken into account in relation to how care and support was delivered.

Reasons for our judgement

Some people were not able to tell us about their experiences because of their complex needs. We therefore used a number of different methods to help us understand these experiences, including talking to people, observing the care being delivered and looking at records. We noted that before people received any care or treatment they were asked for their consent and staff acted in accordance with their wishes.

At the time of our visit staff were in the process of rewriting care plans and introducing a new format for keeping records relating to care delivery. They were part way through the process so we looked at both new and 'old' care plans as both were being used. Overall, care plans were created with input from the people who used the service and/or their relative. People's wishes were respected where possible. The care plans were individual and reflected background, culture and individuals preferences. Information in the care plans showed the home had assessed people in relation to their capacity to make their own choices and decisions about the levels of care they needed. People and their families were involved in discussions about their care and the risk factors associated with this. Individual choices and decisions were well documented in the people's care plans.

Staff had an awareness of the Mental Capacity Act and deprivation of liberty safeguards and understood their obligations with respect to people's rights and choices when they appeared to lack the capacity to make informed and appropriate decisions. The care manager told us that staff had received training around the Mental Capacity Act and dementia awareness. We were told that new staff had yet to receive this training. However, the staff we spoke with had a clear understanding that where people had the mental capacity to make their own decisions, this would be respected. The care manager told us that when necessary, they would hold a best interest meeting to discuss a person's care and treatment. (Best interest meetings take place when informed choice cannot be made by a person using the service, and considers the views of all those involved in the individual's care). We saw written evidence of these discussions in people's care plans.

The staff we spoke with told us they were confident that they would recognise a person's lack of capacity so that best interest meetings could be arranged. One visitor we spoke with during the inspection told us, "I have been fully involved in my relative's care and have always felt part of the decision making." They also told us, "Staff here are really good at knowing when it is right to contact me and we talk about what needs changing." A visitor also told us that they were kept informed of services available to their relative and the best way to access them.

Two people using the service talked with us about how they had been helped to decide if 'a home' was the best way forward for them. They also told us how they had been given different options about how they could best use the service and every step was taken at their own pace and agreement. Both people wanted us to know how important that had been to them and had helped them to settle in and accept they needed additional support to keep well and healthy.

During our visit we saw examples of how staff respected people's privacy and dignity. We noticed staff knocking on doors, and waiting to check if anyone was in the room, before entering bedrooms, bathrooms and toilets. We also saw staff supporting people in a way which was respectful, professional and caring.

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. However, people did not always experience care, treatment and support that met their needs and protected their rights.

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

When we arrived at the service all of the people using the service were in bed. We were told that the majority of people choose to get up after 8am. This was confirmed by the people we spoke with later the same morning.

At the time of our visit there were 36 people in residence. We checked the night records and we were concerned to find that the record did not accurately reflect the times care was being delivered. Staff told us they checked people during the night, according to the person's wishes. Some people were being checked 'hourly' and others were checked 'at the start and end of the shift.' A 'check' was described by staff as 'popping your head around the door', assisting with personal care, repositioning people in bed or offering drinks. However, it was clear that the record was not being completed at the time the night staff were carrying out 'checks' or caring tasks and staff confirmed this to us. We saw that six people were recorded as being checked at the same moment, by the same member of staff. Some checks were recorded one minute apart. It was not possible therefore to know, the time people had received care, how long the care intervention had taken or indeed if any night checks had been made.

To check the validity of one record, we met a service user in their bedroom at 4.55am. This person was found in need of assistance to change their nightwear and bedding. The night log showed that this person had been checked at 3.11am. ('Hourly' checks were in place, so another check was due at around 4am.) It is of concern that none of the night staff could be sure when the person was last checked.

We observed the handover between the night and morning staff. This was detailed and included events which had occurred the previous day and night. This helped staff to deliver care that met people's health needs.

We looked at six care plans. We saw that an assessment had been completed before people had moved in. This meant that the service had sufficient information to be confident

that they could meet a person's needs. The care plans were person centred and detailed support needs and contained information about the person's preferred daily routines and their past histories including important events and people in their lives.

Risk assessments had been completed which included areas such as mobility, manual handling, falls, skin integrity and nutrition. The risk assessments detailed the actions required to reduce any identified risk. This meant that staff had clear guidance on how to ensure the safety and wellbeing for each person. However, despite the nutritional tool being used effectively in some cases, we were concerned that in other examples we saw that appropriate action had not been taken.

In one instance a person had lost a significant amount of weight over four months, from July 2012 to November 2012, and staff had not seen this weight loss as a trigger for referring them to the doctor. Another cause for concern is that the person had not been weighed again since November 2012, therefore there was no indication of whether weight loss had continued. Another person had lost 8kg in one month, between August 2012 and September 2012. The weight loss was monitored for a further two months, showing another loss. Again there was no action taken to refer this person to the doctor. There were no further weights recorded, again indicating that monitoring had stopped.

Not all care plans had been reviewed recently. One had not been reviewed for ten months. Some care plans had been reviewed and recorded as 'no change.' Indicating that the care plan in place remained unchanged. However, in two examples, the person's condition had changed, for example they had lost weight. This meant that the information was not up-to-date and did not accurately reflect the person's needs.

Some people needed their fluid and food intake monitoring and some people also had a 'repositioning' chart, which was used by staff to record when someone was 'turned' whilst in bed. We noted that there were significant gaps in the recording of interventions and in some instances, according to the records seen, some people had remained in one position or had not received fluids or food for several hours. We were told that the care had been given but that staff were not maintaining the records properly.

Some people we met with had complex needs and were not able to verbally communicate their views and experiences, we therefore observed how staff interacted with people, including observations of care delivery. This helped us to understand how people's needs were being met by the care workers on duty. We met people in their own rooms and observed breakfast being served in one communal area. People were supported to eat their meal in an appropriate way. Despite our concerns about the arrangements during the night shift, it was evident that people were comfortable in their surroundings and people were enabled to have freedom in their daily routines. This included taking part in individual interests and keeping in contact with friends and relatives. In general, people looked well cared for and visitors, including a healthcare professional, told us they thought people were treated well and that their experiences in the home were positive.

Throughout our observation we saw the staff treated people with kindness and courtesy. Staff approached people in a calm manner and in a way which showed they knew the person well. Staff spoke clearly to people and at a pace which was appropriate. There were arrangements in place to deal with foreseeable incidents, for example, medical emergencies.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at records about medication for twenty people who were living in the home on the day of our visit.

The service uses a pre dispensed system for medication. This means medication is dispensed by the pharmacist in a sealed package, which holds each days medication in a single container. The medication is delivered to the home, from the pharmacist with a printed medication administration record (MAR) which details who the medication is for, what the medication is and how often it should be given. However, some medication, although prescribed, did not have a printed MAR and staff had handwritten the instructions. This, we were told, was because the medication might have 'fallen' outside the monthly cycle and therefore had been dispensed separately or was a temporary treatment, for example a course of antibiotics and therefore was dispensed without a MAR. The homes policy for medication stated that all handwritten MAR sheets should be signed by the person completing it and countersigned. The reason for this was to make sure the information was correct and had been checked by two members of staff, therefore minimising the risk of an error being made. None of the handwritten MAR was saw had been signed or countersigned. We also found that a significant number of the handwritten MAR sheets had not been dated and the amounts of medication received had not been recorded. Therefore it was not possible to do an audit trail of the amount of medication coming into and out of the home, meaning medication could not be accounted for. We also saw that one person's MAR sheet, despite the person being in hospital at the time, had been signed by a member of staff, indicating that the person had received their medication in the home.

Some medication was prescribed "as required" or prescribed as a variable dose. However, staff did not have access to how they should determine when and how much medication should be given. This is important to ensure people were given their medicines safely and consistently. Also medication detailed as 'one or two tablets to be given' staff were not recording whether the person had received one or two tablets. Again making it difficult to account for the mediation in stock.

We noted that some medication was not being stored securely, having been left out on the medication trolley. Albeit the trolley was in a locked room, the medication should have been locked away securely.

During the visit, none of the night staff on duty were able to give out medication, despite one person having been trained. They told us that they would contact the 'on call' person to come in to give medication, including homely remedies, if medication needed to be administered. This could mean that there was a delay in people receiving medication, including medication used for pain relief.

Despite the shortfalls found, appropriate arrangements had been made in relation to the ordering, disposal of medication and the storage of controlled medication.

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.

Reasons for our judgement

The home employs care workers, a care manager, a business manager and activity organiser plus ancillary staff. At the time of our visit there were a number of staff vacancies, and despite new staff having been recruited, they had not started work as pre employment checks were pending. One of the night staff on duty during our visit had not received an appropriate induction and had had one 'shadowing' shift during the day, prior to working on shift as a full team member. The provider may wish to note that all new staff should have an appropriate induction and introductory programme prior to working unsupervised.

People spoke highly of the staff and described them as, 'friendly, caring' and 'kind.' People told us that they were happy with the care provided and staff respected their privacy. During our inspection we saw several examples of staff treating people with dignity and respect, by knocking on doors and speaking to people in an appropriate way. One visitor told us, "Staff seem to be good at their jobs and care about the people who live here."

We spoke with people who used the service and they told us that they received care from staff who they knew by name and that they had no concerns with regard to the standard of care provided. Comments included, "The staff here are very good, there are always plenty of them around." Another person told us, "I don't have to wait for attention. They come and check to see I am alright or need anything."

We spoke with three members of staff, including the care manager and 'business' manager. All of the staff told us how they enjoyed working at the Borrage House, that they worked together as a team and were proud of the level of care provided. Staff told us that residents had a choice about their daily life and were given options about getting up or going to bed, what they ate and where they spent their time. This demonstrated that people were able to make their own choices and were not restricted by rules or strict routines.

We reviewed the staffing rotas for the month prior to our inspection. These showed that consistent staffing levels were maintained. However, the provider may wish to note that there needs to be a clear structure in place as to who was in charge of each shift.

On the day of the visit, a member of staff had contacted the service to report they were not coming to work. The staff on duty told us that this did not have an impact on the shift as they could manage with the remaining staff on duty and that there had been an additional member of staff on duty anyway.

Our observations on the day of the inspection showed that there was a sufficient number of staff on duty during the night and morning to meet the individual needs and dependency levels of people at the service.

We spoke with all of the night staff and some of the day staff on duty. They told us that they thought there were enough staff, and that they could support the needs of people using the service. Staff told us that there were seldom problems covering shifts due to staff absence. No agency staff had been used in the last twelve months.
However, the provider may wish to note that none of the night staff knew who was 'in charge' of the shift and were unsure of the numbers of people in residence. This is of concern because if there was to be an emergency situation, then staff need to know the numbers of people in the home and also who is to take charge of the situation.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People we spoke with were very positive about the home and did not have any complaints. One person told us, "I haven't had reason to complain because I'm quite happy". There appeared to be an 'open door' atmosphere around complaints and suggestions and people we spoke with told us they knew the staff by name and that staff regularly sat with them to discuss the service and asked for comments about how the service could be improved. At the time of our visit there were no outstanding complaints.

The home had a complaints policy, which clearly set out what people could expect if they wished to complain about the services provided. There were leaflets in people's rooms telling them how they could complain if they were not happy.

Staff told us what they would do if the received a complaint, they confirmed that the managers were very approachable and that they were confident that any complaints would be investigated thoroughly and dealt with properly.

We were told that there had not been any formal complaints for a number of years and that people only raised 'minor niggles' with staff and were dealt with promptly. People told us that staff were keen to provide a good standard of care and this made it easier to talk to them if they had any concerns or needed information.

A recent survey by the service had shown that some people felt complaints and comments could be better heard by the provider. As a result of this plans were in place to revisit the way complaints are received and the manager had taken a decision to record all complaints, including minor ones, so that they could review the information to help improve the service.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. However, people did not always experience care, treatment and support that met their needs and protected their rights.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to safely manage them.

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 20 June 2013.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

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.

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