Inspection Report

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

Bourne Bridge House

Bourne Bridge House, Meshaw, South Molton, EX36 4NL

Tel: 01884860909

Date of Inspection: 08 November 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
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Meadowbank Care Limited
Registered Manager	Miss Michelle Edwards
Overview of the service	Bourne Bridge House is a care home service for up to eight adults with learning disabilities or autistic spectrum disorders, physical disabilities and sensory impairments.
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'.

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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 8 November 2013, observed how people were being cared for and talked with people who use the service. We talked with staff and took advice from our specialist advisors.

What people told us and what we found

Bourne Bridge House provided a home for up to eight people. On the day of the inspection, there were six people living at the home and one person on a respite stay at weekends. People lived in either the main house or in adjoining cottages in the grounds. The home provided a home for life arrangement for people which gave them security that they could live at Bourne Bridge for as long as they chose.

Two people were out on the day of the inspection at a community skittles session and were then going out for lunch. We met with the other three people who were at home. One of these were about to go out to a swimming session. We spoke with another person who had chosen to stay at home. They showed us around their cottage, which included a kitchen, living room, bathroom and bedroom. Their bedroom had been personalised and we were told that it had been decorated to take account of the person's chosen wall paper and individual preference of decoration.

Although people's capacity to consent to their care and treatment was limited, we observed staff who gave people choice about what they did or what they chose to eat. People without verbal skills were able to make their wishes clear to staff and staff understood their needs. Best interest meetings were held regularly with people who knew the person well. Local advocates were used by people at the home to represent their views. People at the home had high and challenging behavioural needs. Staff were observed to know the people well. Staff worked on a ratio of one or two staff members to each person, which ensured individual needs were met and any risk reduced. People recognised and responded to staff in a comfortable manner.

We spoke with the acting manager who assisted us with the inspection and also spoke with four other members of staff. Staff said they enjoyed their work with people at the home and told us that 'everyone was very supportive' and that 'we all work as a close team to support people living here'. New staff followed a full induction programme at the start of their employment. Staff told us that received 'good' training on a regular basis.

People who use the service, their family and advocates can be confident that personal records were accurate, up to date and confidential. We were told that the provider visited the home each month to conduct a monthly quality audit to ensure high standards were maintained throughout the home.

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

All of the people living at the home had limited verbal communication and capacity to give consent to their care and support. Records in people's files showed that individuals had been assessed under the Mental Health Capacity Act.

Although people's capacity to consent to their care and treatment was limited, we observed staff who gave people choice about what they did during the day or what they chose to eat. People without verbal skills were able to make their wishes clear to staff and staff understood their needs and requests.

People were supported to make decisions and choices as independently as possible. People were given the relevant information needed to make a choice and then given time to respond. Staff used pictures and sign language which helped people understand more easily.

Any changes to a person's risk assessment or care plan were discussed at meetings, which included the person, to ascertain consent where that were possible. Best interest meetings were held regularly with people who knew the person well. Local advocates were used by people at the home to represent the views of individuals.

One member of staff told us that they had received training and understood the Mental Capacity Act. Staff were aware of their duty and reasonability under the deprivation of liberty safeguards and knew that were a person lack capacity to consent they had a duty to follow the Mental Health Capacity code of practice.

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

There were six people living at the home, three people were non-verbal and others had difficulties in verbal communication. One other person stayed at the home for respite periods at weekends, before making the decision to move in permanently.

People received appropriate care, treatment and support which was centred on each person as an individual which meant that safe support was provided to enable people to live as independently as possible.

We were told there were close working relationships with professionals locally. The acting manager told us that the provider had employed a psychiatrist who worked very closely with people at the home and who visited the home each month to monitor individual's progress and to ensure the well-being of everyone at the home.

We spoke with a visiting doctor who told us they were 'impressed' by the way staff worked with people at the home. They said staff were prompt in making contact with the surgery wherever they was a cause for concern. There was evidence in people's files of regular visits and contact with local doctors and medical personnel.

People at the home had high and challenging behavioural needs. Staff were observed to know the people well. Staff worked on a ratio of one or two staff members to each person, which ensured individual needs were met and any risk reduced. People recognised and responded to staff in a comfortable manner. Staff communicated with people using sign language and PECS, a picture board system which staff said worked well with people. People expressed their wishes and needs in individual ways which staff interpreted and responded to through observation of mannerisms.

We were told that a person who had been sharing a bungalow with another person, had requested a move to an alternative building and this had been arranged to help increase and encourage greater independence.

We examined the six care files for everyone living at the home. Documentation and records were comprehensive. Detailed risk assessments were held in each file. Where

they had been reviewed these were dated and signed. Full two monthly reports were completed which covered all aspects of the person's life at the home, and included general health needs, psychiatric reports and activities attended. Any changes which had occurred during the period covered by the report were recorded.

We also examined three people's daily record files which include daily notes, nutritional needs and behaviours. These were up to date and had been signed by staff.

We were familiarised with the 'Guide to a good day', a document prepared by people who knew people at the home well, with input from people themselves, family members, staff and advocates. The manager explained that the guide, introduced by the psychiatrist, supported people's behavioural needs and identified easily what was needed. By use of a traffic light system the guide helped staff to focus on a person's needs and be fully aware of individual situations, thoughts and feelings. One of the guides had been completed by the person themselves with support from staff. It included reference to escalating situations and identified what would help them, to deescalate a situation. We were told another of the guides had been developed alongside the person's longstanding advocate, social worker and staff.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were cared for in a clean, hygienic environment.

Reasons for our judgement

The home was clean and fresh. We were told that areas of the home were cleaned three times a day to ensure that risks to people's health were reduced. Shift rotas were seen which showed how the system operated. Staff told us they recognised the importance of vigilance in undertaking regular cleaning routines, in particular in regard to one person who liked to spend time on the floor. Records were seen which were signed by staff after cleaning had been done.

Infection control training records were examined. These showed that not all staff had attended infection control training. The acting manager told us that training was planned to ensure all staff were up to date with procedures for infection control. They also confirmed that ongoing discussion regarding risk of cross infection were highlighted at staff meetings. Disposable equipment was used wherever this was appropriate, e.g. medication pots.

Procedures for the safe handling and disposal of waste were seen which included the weekly removal of used continence pads. Disposable gloves and aprons were provided for staff which reduced the risk of cross infection when cleaning.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

There were comprehensive recruitment and selection processes in place for the appointment of new staff. Six staff files were examined, which contained all the relevant checks required before a person started work.

Where there were gaps in the rota bank staff were employed who had been recruited through the same selection process as other staff and were provided with the same training opportunities. We were told that recruitment was in progress for three new support workers. We appraised new staff files which were in the process of development, which showed how staff were recruited according to the home's policies.

Staff did not start work until a full and satisfactory disclosure and barring service check had been received. Procedures were in place for staff to report absence due to ill health. Staff were subject to a probationary period of six months. Staff files were well organised and up to date.

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.

Reasons for our judgement

We were told that the registered manager was on maternity leave but still in touch with day to day events at the home. We spoke with the deputy manager who had been appointed as the acting manager in the registered manager's absence.

We spoke with four members of staff who told us they enjoyed their work with people at the home and said that 'everyone was very supportive'. The newest member of staff said that they were 'given plenty of time' to get to know and understand the needs of people. They told they were confident that there would always be 'back up' if a difficult situation arose and they would 'never be left alone'.

There was a clear management structure in place and staff were clear about lines of accountability and recording methods
.
A team leader was duty at each shift to lead the staff team. Handover held at the end of the shift was observed. Details of the happenings of day with each individual were shared and discussed. Handover and debriefing books were used.

Staff told us they received supervision either from their team leader of the manager. Records showed that one to one supervision sessions took place approximately every six weeks and were recorded. In addition, frequent staff meetings were held together with in-house house meetings, which involved the people living at the home. We saw reference in files and policies, to staff appraisal but were not able to confirm that this took place. The acting manager also told us about arrangements for observational supervision which had been introduced. We saw records for this which highlighted a person's performance, professionalism and areas for improvement.

New staff followed a full induction programme at the start of their employment. Staff told us that they received 'good' training and looked forward to the next planned session which covered physical interventions.

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

People who use the service, their family and advocates can be confident that personal records were accurate, up to date and confidential.

The home had clear policies and procedures that were followed to ensure that personal records held were maintained for each person living at the home. Personal records were stored securely in a locked office.

We reviewed the majority of records held, which included, care plans, risk assessments, activities, maintenance and health and safety records. All meetings held in the home were recorded, dated and signed and included daily briefing sessions, staff meetings, and progress meetings between staff and people at the home.

The home employed a full time maintenance operative which meant that any repairs and on-going maintenance issues were quickly resolved. The maintenance operative worked with local contractors to ensure all necessary checks were undertaken in a timely manner. COSHH records were up to date.

Staff training records were examined. A range of certificates held in staff files, confirmed attendance at training sessions. We also examined the training matrix which indicated all the training undertaken by staff. From this record we found that some staff had not completed full mandatory training and several staff had not attended safeguarding training. The acting manager explained that all training issues were discussed at daily meetings and at staff meetings. They also confirmed that arrangements were in hand to ensure staff were up to date with training requirements to ensure staff understood and met the needs of people at the home.

The accident report book showed where accidents or incidents had occurred and how they had been managed. The acting manager told us there had been no complaints in the last year and the complaint file confirmed this. Staff confirmed that they would recognise where a person was unhappy or had a concern through a change in their behaviours. One of the people we spoke with said that they would speak to staff if they had any complaint.

We were told that CQC had been notified of the Registered Managers absence and of the temporary management arrangements put in place to cover the absence.

We were told that the provider was in regular contact with the home. Monthly quality audits were conducted by the provider to ensure high standards were maintained. Monthly audit reports were recorded. The most recent report was seen which showed detail of discussion and observations undertaken, which meant that people can be assured that quality systems were in place to protect the safety of people at the home.

We were told that a website had been developed to encourage comments from family members and others on any aspect of the home's operation.

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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