Inspection Report

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

Martin Close

36 Martin Close, Oakridge, Basingstoke, RG21 5JZ

Tel: 01256327894

Date of Inspection: 11 September 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
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Community Integrated Care
Registered Manager	Miss Tracey Kim Bugg
Overview of the service	Martin Close is a residential care home for up to five people with learning disabilities. People may also have associated physical or behavioural difficulties.
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 carried out a visit on 11 September 2013, observed how people were being cared for, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

The provider had suitable arrangements for obtaining consent from people who used the service in relation to their care and treatment. We saw that meetings had taken place to discuss best interest decisions, which were appropriately recorded within the care records.

Care plans were person centred and included clear instructions for staff on how to meet individual's needs. They clearly detailed the support people required, how to provide it and what they were able to do for themselves.

People and their relatives made positive comments about the quality of support provided. One person said, "They listen to me and help me to do what I want." A relative said, "You can tell the staff really care and it's not just their job".

We found that medicines were administered safely and that staff had recently received training from the local pharmacist.

People had their needs met by staff who had received appropriate personal development and were supported by an effective system of training and supervision.

There was a complaints system, although there had been no formal complaints made for several years. The manager said that staff made efforts to address any concerns quickly to prevent them developing into complaints.

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 found that the provider had suitable arrangements for obtaining consent from people who used the service in relation to their care and treatment. Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

On the day of our inspection there were five people living at Martin Close. We spoke with three of the people and their relatives. We also spoke with the manager and three support workers. Prior to moving into Martin Close people had a needs assessment completed by the manager. The manager told us that this assessment was carried out with the person and where necessary their relatives. Once their needs had been assessed, the required support was agreed and consent was obtained from people and their relatives. This was confirmed by people we spoke with and their relatives. This meant that the provider had sought consent from the person and where necessary someone who had sufficient knowledge of them.

We looked at five care records and found that each person had been involved in all aspects of their care and support plans. The provider had systems to ensure care plans and risk assessments were reviewed appropriately and reflected people's needs. We noted that people, their relatives, health professionals and staff from the home were involved in the reviews. Each person had individual risk assessments which had been created with and agreed by them. People who used the service and their relatives told us how they were involved in reviewing their care and risk assessments with staff. They told us that risks, benefits and alternative options were discussed in plain terms, in a way that they understood. We were told by people that they could change things if they wished by talking with staff.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. The manager had received training in relation to the Mental Capacity Act 2005. We saw mental capacity assessments completed in people's care plans which detailed their ability to retain and weigh information. We noted these detailed when people had capacity to make decisions and when they did not. When a person lacks capacity to make a decision, care workers must do what is in the person's best interests. The person should still be involved in making the decision and their views and wishes must be considered. People who know the person well, including family, friends and care staff should be consulted. These decisions are known as 'best interests decisions' and should limit restrictions placed on the person.

We saw that meetings had taken place to discuss best interest decisions, which were appropriately recorded within the care records. These detailed who was present and clearly defined the decision made and reasons for it. We saw one example where a person did not wish to undergo an intrusive cancer screening process. We looked at the care plans and found that the person's relatives had been involved in a best interest meeting, together with staff and health professionals. We spoke with relatives who confirmed their involvement in the best interest decisions. They also told us about the alternative solution, which we saw had been recorded in the care plan. This meant that the provider had ensured that risks, benefits and alternative options had been discussed and explained in a way that people who used the service understood.

We read how staff had considered people's capacity to consent in developing care plans and risk assessments. Staff we spoke with showed they had a clear understanding of people's needs and rights. We found that staff were aware of advanced decisions that had been made by people, including their wishes regarding end of life plans. People had been involved in planning for their end of life care and had made choices about preferred options, including organ donation. We saw that these decisions had been discussed with the person and their relatives and that their consent had been appropriately recorded.

The care plans recorded when a person had declined to take part in an aspect of their support, for example participation in an activity. Staff had also recorded that they had supported the decision but had explained to the person the consequences of their choice. This meant that people were involved in decisions about their care. They were able to change their decisions and understood what consequences this might have.

People's diversity and human rights were respected. The care records we looked at contained information about how people's diverse needs were met and their consent obtained. The information included details of their medical and spiritual needs, mobility, dietary requirements and communication needs. We found that people expressed their views and were involved in making decisions about their daily routines and treatment. People told us that staff always respected their decision if they chose not to do something or something which was out of the ordinary. We saw information communicated to one person with the use of pictures. An example of this was the provider's complicated residency agreement. The manager had rewritten the whole document using pictures and words that the person understood.

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

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plans. These care plans were person centred and included clear instructions for staff on how to meet individual's needs. They clearly detailed the support people required, how to provide it and what they were able to do for themselves. They gave information about the wishes of the individual, how they communicated, their likes, dislikes and their preferred routines.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. People were encouraged to plan holidays with their key workers and were involved in creating the necessary risk assessments to achieve their ambitions. We spoke with one person who was excitedly packing in preparation for a family wedding in Monte Carlo. We reviewed the support plan and appropriate risk assessments in relation to this holiday and spoke with the person's family. We were told that the manager and care workers were dedicated to ensuring that people realised their full potential. We spoke with one person who told us that they were looking forward to going swimming and sliding down the flumes. Staff were able to tell us about the support the person needed whilst swimming, which was consistent with their support plan. This meant that the provider had identified risks and shown how these should be managed and reviewed.

People were supported to promote their independence and to be involved within the community. One person told us how they enjoyed working in a supermarket canteen, whilst another person had been supported to attend college and travel independently. One person told us that they liked living at the home because staff supported them to become more independent. They said, "This is my home. I love it here because I can go to work and see my friends."

We found that people living in the home were involved in activities throughout the week. We saw the weekly list of planned activities available for each person and activity sheets which showed when these activities had been completed. People took part in varied activities such as curling, cycling, horse riding, woodworking, go-karting, gardening and badminton. We saw that people also went to social clubs in the evening to enjoy

entertainment. Staff accurately recorded people's reaction to activities to ensure that they remained enjoyable and focused towards their personal goals. We looked at daily records and saw that important events and favourite memories had been detailed. We noted that these had then been discussed in their monthly reviews with their key worker.

People's diversity, values and human rights were respected. People proudly showed us their own rooms, which had been personalised and decorated to their taste. During the inspection we observed staff speaking with people in a friendly and caring manner. We noticed that staff always knocked and sought permission before entering people's bedrooms. We found that staff were familiar with each person's likes and dislikes and had good relationships with the people in the home and other staff.

The manager ensured that the families of people were kept updated about any matters concerning their family member by way of phone calls and emails. Relatives we spoke with confirmed this and praised the staff for keeping them informed. We saw that people had received regular health appointments for a variety of needs including visits to the dentist, optician and other health professionals. This demonstrated people's health and social care needs were being met and reviewed regularly.

People who used services were only deprived of their liberty when this had been authorised by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards (DoLS). The manager told us that they had experience of making DoLS applications but had not had cause to make such an application whilst at Martin Close. All staff had been taught a recognised system for supporting people to manage their behaviour where this was necessary. People's behavioural support plans identified the appropriate approaches for the individual. Staff we spoke with knew the different approaches for different people. We saw that all incidents were recorded, monitored and analysed by the manager. Positive behaviour management and sensitive physical interventions ensured that people's human rights were protected.

We spoke with the support staff responsible for fire safety who told us about their fire drills and plans for urgent evacuation and other emergencies. We saw that these comments accurately reflected the guidance contained in the provider's emergency action plans. This meant that the provider had effective arrangements for dealing with foreseeable emergencies ensuring the safety of people who used the service.

All of the parents we spoke with made positive comments about the staff and quality of the health care being provided. One parent said, "The manager and staff are brilliant. I never worry because I know they really care about her and I know she is really happy." Another parent said, "She loves the home and is so happy and content there. She gets to do the things she wants to do and they are always there encouraging her." Another relative said, "They have got the balance and the mix of people and staff just right." The manager and staff told us that the good relationships between the people who used the service had also helped to create a friendly and peaceful environment within the home. One relative described the home as, "a peaceful oasis".

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

Appropriate arrangements were in place in relation to obtaining medicine. We saw the home had a protocol in place with a local pharmacy detailing how medicines should be obtained and returned where necessary. We were shown an effective system for advance ordering of prescriptions and effective recording of their receipt.

We found the medicines were kept safely. The manager had a key for the medicine cabinet which was bolted to a wall in the ground floor office. The medicines for each person were stored in lockable cabinets in their rooms so they could not be mixed accidentally. The manager told us there were no controlled drugs prescribed to people using the service but demonstrated knowledge of their responsibilities if this were to change.

Medicines were safely administered. Staff said that people had their medicines one at a time. Other people who used the service would be engaged elsewhere in the home at this time to ensure people were not disturbed whilst taking their medicine. There were arrangements to ensure any medicine administered was properly recorded. We examined records which showed that the staff present had signed to show what they had administered to who and when. Records we reviewed showed that people were given the medicines prescribed for them at the correct time. We found there were systems for staff to check that medicines had been given as recorded. Medicines were disposed of safely. We were told by staff that any damaged pre packed containers or unused medicines were correctly stored in the locked cabinet before return to the pharmacy.

We looked at staff files and saw that all of the staff had completed training in relation to the administration of medicines, which was up to date. We found that the manager had extensive experience in relation to the management of medicines and conducted several assessments of staff before they were allowed to administer medication unsupervised. We saw that the local pharmacist had conducted an inspection and delivered staff training in July 2013.

The manager and provider had an effective system for auditing the management of medicine. We reviewed the records relating to a medication error in July 2013. We found

that the error was immediately reported, recorded and effectively investigated to ensure the health and wellbeing of the person who used the service.

Relatives said they had seen staff supporting people with their medicine in an appropriate and friendly manner.

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

Staff received appropriate professional development. We examined four staff files and found that staff received a comprehensive induction and continued development, relevant to their workplace and role. We were shown all of the staff training certificates in relation to safeguarding, infection control, moving and handling, food hygiene, fire safety and behaviour management.

We spoke with the newest support worker who told us that the training had effectively prepared them for their role. We looked at their staff file and found that they had had detailed performance assessments after six and 12 weeks. People who used the service told us that the staff knew exactly what they were doing, which made them feel safe. Relatives told us that the staff provided excellent care, which gave them confidence in the quality of their training. This meant that people who used the service were safe and had their health and welfare needs met by competent staff.

The manager told us that mandatory training completed during induction was refreshed annually or as required with specific training days. The documents that we saw within staff files confirmed this and that their training was up to date. Staff we spoke with said their training and support was good. They told us they were encouraged to broaden their skills and supported by the manager if they wished to complete specialised training. We saw the training certificates within staff files to confirm this. Individual support workers had been encouraged to assume additional responsibilities. For example one had assumed the lead role for the management of medicines, whilst another was responsible for fire safety. This meant they were enabled from time to time to obtain further qualifications appropriate to the work they performed.

Staff told us that the manager was approachable and a good listener. They said the manager was friendly but professional and set high standards. They told us that they were able to talk through issues about their role or about the people they supported. We found that there was a structure for supervision which included one-to-one sessions and group meetings. Staff said that appraisals were held annually and that the manager always thanked and praised them for their hard work. Staff we spoke with told us that they received regular supervisions, which were documented, and their learning and

development was monitored. We saw these supervisions took place every two months and were recorded in the staff files. Staff told us that they were allowed to raise concerns and suggestions to the manager during these supervisions. We saw there were regular staff meetings every six to eight weeks which had an agenda published in advance. We looked at the minutes of these meetings, which were circulated to the staff and displayed on the office notice board. The manager told us that there was a family atmosphere within the home created by the staff willingness to help one another. We examined the staff records and found there were low levels of sickness absence. If someone had been ill we saw detailed return to work interviews had been completed. We found that the provider had worked continuously to maintain and improve high standards of care by creating an environment where clinical excellence could do well.

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

There was an effective complaints system, although there had been no formal complaints since the last inspection. The manager said that all of the people who used the service and their relatives had been made aware of the complaints procedure at their needs assessment. We were told that people also had a personal copy of the procedure in an easy to read format. There were visible copies of the procedure at the entrance to the home and also on the noticeboard in the office. We also saw a highly visible flow chart on the noticeboard detailing the process.

We read the provider's complaints policy and procedure. This showed that the provider had a clear system for receiving, handling and responding to comments. The manager told us that they gave a leaflet to people every year and sent a copy to their relatives, seeking comments to improve the service. This was in addition to their yearly satisfaction survey. The manager said that staff made efforts to address any concerns quickly to prevent them developing into complaints.

The manager told us that people often did not want to make a fuss so they were encouraged to make suggestions for improvements with regular monthly meetings. We saw minor problems had been reported and immediately addressed to the satisfaction of the people who used the service. This meant that the provider had supported people or those acting on their behalf to make comments and complaints.

People we spoke with told us they knew they had a copy of the complaints procedure but had no cause to read or use it. They told us that if they had a problem then they would speak directly to their key worker or the manager. Relatives we spoke with confirmed they had not made a complaint but were aware of how to do so and understood the process. People and their relatives told us that the manager and staff were so helpful and approachable that any problems were sorted out straight away.

People said they were confident that if they needed to complain they would be listened to and their grievance would be acted on swiftly. We were told that they had no fear of discrimination if they had to make a complaint and were confident they would be supported by the provider. Staff we spoke with knew about the complaints system but said they had

had no cause to refer to it.

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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