Inspection Report

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

Shire House Care Home

Sidmouth Road, Lyme Regis, DT7 3ES

Tel: 01297442483

Date of Inspection: 10 January 2014

Date of Publication: January 2014

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
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Sentry Care Limited
Registered Manager	Miss Marie Chayro Bunao
Overview of the service	Shire House is a large detached house set in its own grounds on the outskirts of Lyme Regis. There are two communal lounges and a dining room. Bedrooms are available on all three floors of the home, which can be accessed by a lift.
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 10 January 2014, observed how people were being cared for and talked with people who use the service. We talked with staff.

What people told us and what we found

During our visit we spoke with three people who live in the home. We also observed people taking lunch in the home, and observed people who were involved in a board game activity in the afternoon.

People told us that they felt positive about the quality of care they received and with their relationships with the staff. We saw people moving freely around the home and interacting with the staff in a relaxed way. A person told us, "We are well catered for here. The food is good. We get a glass of wine with lunch -- We're a very happy bunch."

People told us that they were asked for their consent when making choices and decisions about their daily lives; and that their choices and decisions were respected by the staff. A person told us, "They do ask before they do anything."

The home had procedures in place to ensure that people received their medicines as prescribed. Medicines were handled in a secure way. The registered manager told us, "The owner is a qualified pharmacist."

We found that there were sufficient numbers of staff, with the right competencies. A person told us, "The staff are kind and helpful -- There are enough staff here -- I feel safe here."

The home was taking account of people's comments or complaints. People told us that they could be sure that their comments were listened to, and responded to appropriately.

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.

Reasons for our judgement

Overall, we found that people's consent to care and support was valid. People understood and knew how to change any decisions about their care and support. We found that people's human rights were respected.

The registered manager told us that there was no person in residence at the home who was the subject of a Deprivation of Liberty Safeguards (DoLS) assessment. DoLS ensure that there are systems in place so that if a person lacks the capacity to consent to their care or treatment, their freedom is not restricted more than necessary, and any restriction is in their best interests.

We saw that people's agreement was sought prior to staff supporting them. For example, during our lunch time observation, we saw a person ask a senior care assistant if they could have assistance to return to their room, as a telephone engineer had arrived to fix a problem with the person's personal telephone connection in their room. The senior care assistant asked a care assistant to provide the person with assistance to transfer from their dining chair to their walking frame. We saw the care assistant inform the person of what they intended to do, and ask the person whether they were, "OK with that ?"

We looked at four people's care records. We noted that the care records were signed, indicating that the person was aware of their care plan, and had given their consent to the home providing them with care. The registered manager told us that work was in progress for the home to produce a consent form for the use of photographs in people's records.

The registered manager told us, "If people don't want to be disturbed at night, and if they have the capacity to manage the call alarm, then they sign a consent form not to have night-time checks." We saw that the care records we viewed contained signed consent forms where night-time checks had been discussed with people. In two of the records we viewed people had chosen not to have night-time checks.

The registered manager told us, "All the people here have capacity for day to day

decisions. If we had any concerns about a person's capacity we would telephone the medical centre for advice. We have a very good relationship with the staff at the medical centre. If it involved a complex decision, we would hold a multi-disciplinary meeting and involve families. If staff were unsure about someone's capacity, they would ask me or the senior on duty." This meant that people were not at risk of being excluded from making decisions for which they were mentally capable on a day to day basis.

We spoke with a senior care assistant and two care assistants. They all confirmed that if they were concerned about a person's capacity, then they would inform their manager. All of the staff we spoke with told us that they had received training in the Mental Capacity Act 2005 (MCA). We viewed staff training records, and saw that staff MCA training was up to date.

The registered manager said, "Care is always the person's choice. For example, we have a bath rota. If people choose not to have a bath the staff record it. Our approach is person-centred. It's always their choice." A senior care assistant told us, "Before I start personal care I always ask if people are happy for me to do it. If they say no I report it to the manager, who will ask them if they would prefer someone else." A care assistant told us, "I ask people if they are O.K with me providing care. If they say no I tell them that they can call me later and I'll come back." Another care assistant said, "I ask people's permission before I do anything. I explain what I am going to do. If they say no, I inform the senior. It's their choice."

We noted that where people had a power of attorney (POA), their records contained details as to the type of POA held, and whether it gave the holder the right to make health and welfare decisions on behalf of the person. The registered manager told us, "We keep records of people's POA's. I always ask relatives to provide a copy. We know whether people's POA's are financial only, or whether they also include health and welfare decisions."

We saw that the home had discussed people's end of life care. People's care records contained information on advanced decisions people had made. For example, one person's advanced decision recorded, "Arrangements have been made with her son. She does not wish to discuss end of life care any further." We saw that some people had chosen to have, 'do not attempt cardiopulmonary resuscitation' (DNAR), forms included in their records. The registered manager told us, "We always ask people about DNAR. If people wish to have them we contact their G.P, and ask them to visit the person." This meant that the home could follow any advanced decisions people had made.

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

Overall, we found that the people who live in the home were involved in their assessment and care planning, and were treated with dignity and respect.

During our inspection we looked at four people's care records. The registered manager also explained the home's assessment procedures. The registered manager told us, "We base care plans on people's pre-assessment. This is the initial assessment. But, people's care plans are then built up over time."

We viewed four people's paper based care records. The records contained support plans that followed the home's procedures for assessment and care planning. These included assessments of people's personal care needs, mental state, communication needs, eating and drinking needs, elimination needs, tissue viability (skin), and mobility. For example, we saw that a person had a care plan in place for managing their diabetes. The care plan recorded that the person, "Has a sugar free diet, ensure carers and cooks are aware of her dietary needs: Carers to ensure that district nurses do HbA1C test every three months. Carers to ensure that results are communicated to all staff." The HbA1c test is a test for people with diabetes, it provides information on the person's blood glucose levels. We also saw that the home's chef had records in the kitchen on how to manage the person's diabetic needs.

We saw that people's care records contained risk assessments. These included plans for supporting people in the home who were assessed as being at risk of falls. We saw that people were weighed monthly, and that their weight was recorded and monitored by the registered manager. We noted that in one of the care records we viewed, the person's had a malnutrition universal screening tool MUST assessment. The MUST assessment is used to identify people who may be at risk of being malnourished or of being obese. The registered manager told us, "The person was losing weight. We contacted the G.P, who prescribed fortisips. We supplemented their diet with complan. We also offered liquidised meals. The G.P said we were doing the right sort of things." This meant that the risk of people receiving inappropriate care and treatment was reduced because the home was assessing people's needs, and planning appropriate care to meet people's identified needs. We noted that people's care had been reviewed regularly.

During our visit we spoke with three people who live at the home. They told us that they were involved in how their care was provided. We asked them how staff maintained their privacy and dignity. They told us that staff knocked before entering their room. A person told us, "They always knock. They always ask before they do anything – They discuss my care with me. They do reviews." Another person told us, "The staff really know how to look after you. The food is good and the laundry service is excellent – They ask my permission before they do things. They are not dictatorial."

We heard staff speaking to people in a respectful and polite manner. A person told us, "The staff are very polite and respectful. I choose to have my evening meal in my room and my meal at lunch time in the dining room. We get two choices at lunch time and in the evening. If you don't want what's on the menu they will get you something else."

We saw that the home had an activities co-ordinator who produced a monthly activities programme. We saw people engaged in activities on the day of our visit. The activities we observed included a board game and a reminiscence session. A person who lives in the home told us, "I'm not doing the activities this afternoon. I do get involved sometimes. We have an entertainments lady. You can choose if you want to get involved -- We had a panto at Christmas. I really enjoyed it."

People who live in the home told us they were supported to access healthcare professionals if needed. A person told us, "If I need to see the doctor they get him promptly." Another person told us, "If I need to see a doctor or dentist they arrange it; and they arrange transport."

We saw that people's records contained records of visits from other professionals. These recorded who the professional was, the reasons for the appointment, and any outcomes and advice given. We spoke with a district nurse via the telephone during our visit. The district nurse told us, "Whatever we ask them to do they do. I haven't seen any evidence of poor handling. I have no problems with them. They do contact us very quickly. On the whole they are very good."

The home had procedures for recording accidents and incidents. The registered manager told us, "Staff complete an accident report and the records are monitored by the quality assurance officer." We saw that the provider had reviewed and audited the accident and incident records on 23 December 2013. This meant that the home had systems in place to reduce the risk of accidents or incidents occurring.

We asked the registered manager about the home's procedures in the event of emergencies or situations that could lead to disruptions in services. We saw that people who live in the home had personal emergency evacuation plans (PEEP's) in place, which meant that in the event of the home needing to be evacuated people could be evacuated quickly.

The registered manager showed us the home's emergency plan. This included: the telephone numbers for utilities providers in the event of a disruption to services; the location of the home's mains supplies of electricity, gas, and water; G.P lists; hospital contact details; and the contact details for the local authority emergency planning unit. The registered manager told us that in adverse weather conditions, "We are very lucky, as most of our staff live in Lyme Regis and can walk into work." This meant that people were protected from emergencies or situations that could lead to disruptions in services.

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

Overall, the home was protecting people against the risks associated with the unsafe use and management of medicines, by means of the appropriate administration and management of medicines.

During our visit we saw that medicines were stored securely in a locked medication cupboard. Senior staff signed a record to say that they had taken responsibility for the keys during the shift. This meant that the home had appropriate arrangements for the safe keeping and handling of medications.

We did not see any medicines being administered to people at the time of our visit. However, we viewed people's Medical Administration Records (MAR). Staff we spoke with told us that they provided people with drinks of water to enable their swallowing of tablets. Staff told us that they supervised people until they were sure the medicines had been taken.

The registered manager told us that the home had one person in residence that self-administered their medication at the time of our visit. We saw that the person had a care plan in place to support them in managing their own medication. The person kept their medicines in a locked draw in their room. The person also completed their own MAR record, which they signed to confirm that their medications had been taken.

We saw that people who had their medications administered by the home's staff, had signed consent agreements for staff to administer their medications. We noted that entries on people's MAR had been signed. The registered manager told us, "We haven't had any medication errors. The owner is a qualified pharmacist. He is also our quality assurance officer. He audits medications monthly." Records we viewed confirmed that the provider regularly audited medications.

We saw that people's prescriptions were up to date, and that new quantities of medication were recorded on the MAR. The registered manager explained the home's procedure when medicines had not been administered. They told us that staff recorded the reasons why medicines had not been administered by completing a code on the MAR, and recording the reasons in full, why medicines had not been given, on the reverse of the

MAR. This meant that people's medications were given to people in line with their prescriptions.

We viewed the home's controlled drugs register at the time of our visit. The registered manager told us, "We store controlled drugs in the controlled drugs safe." Controlled drugs were stored in a controlled drugs safe which was locked when not in use. Controlled drugs were recorded in the controlled drugs register. The registered manager showed us that two members of staff sign the register when the drugs were received and administered, and that two staff members completed the returns documentation if medicines were returned to the pharmacy. This meant the home had arrangements in place for the safe administration and disposal of medicines.

We saw the home's medications policy. This was available in the medications file in the home's office. This gave guidance to staff on the safe supply, receipt, storage, and administration of medicines. The home also had policies in place which included medication errors; self-medicating; homely remedies; and the medication ordering procedure. Training records we viewed confirmed that staff had received training in medication administration. The registered manager told us, "I do daily visual competency checks. If issues are identified with a staff member's medications practice they will do a medications competency assessment."

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

Overall, we found that people's care needs were met by sufficient numbers of appropriately skilled and experienced staff.

During our visit we spoke with a senior care assistant and two care assistants. A senior care assistant told us, "I love it here. I've been here for seven years – I have NVQ 3, they are very supportive of people gaining qualifications – We get regular training opportunities. At the moment we are doing diabetes training - I get regular three monthly supervisions with the owner." A care assistant told us, "I've worked here for ten years. I have NVQ 3 – I love working here. I've been here for a long time – We get regular training opportunities. I am up to date with my training. We get training updates every two years – I get supervision on the job from the seniors and the manager. The manager also does observations. I get an annual appraisal from the owner."

We viewed the home's staffing rota and shift plan. We saw that staffing levels were consistent with the rota. The registered manager told us, "Out of 13 care staff we have nine with NVQ 3; three with NVQ 2, and one of them is enrolled to start NVQ 3 – All staff including the two cooks are enrolled on a level 2 certificate in understanding the care and management of diabetes. Even the activities co-ordinator is enrolled on it."

The registered manager told us that the home covered staff absence, holiday, and training by staff volunteering to take on extra shifts. They said, "The staff are very co-operative with planning holidays and annual leave. We also have bank staff who can cover staff absence at short notice." We asked people who live in the home, and the care staff, about the home's staffing levels. A person who lives in the home told us, "There are enough staff. I'm never left in the lurch." A member of the care staff told us, "There are enough staff here generally." This meant that there was enough staff who knew the needs of people who lived in the home, to ensure that people experienced a consistency of care.

The registered manager told us that they audited staff: annual leave; sickness absence; and staff training hours on a monthly basis. They said, "The owner audits staff rotas on a monthly basis as part of their quality assurance monitoring." This meant that the service had management structures and clear human resource procedures that were followed in practice, monitored, and reviewed that enabled the effective maintenance of staffing

levels.

We saw that the home's policies and procedures were available to staff in the home's office. The home also had a selection of training DVD's available to staff in the office. These included training in the Mental Capacity Act 2005.

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.

Reasons for our judgement

Overall, we found that people's comments and complaints were listened to and acted on effectively. The home had systems in place to support people who used services or others acting on their behalf to make comments and complaints.

We spoke with three people who live at the home. A person told us, "I've never had any complaints. The manager is a lovely woman; you can say what you like to her." Another person told us, "I don't have any complaints. If I did I would tell them. They do listen."

We saw that the home's complaints system was brought to the attention of people who live at the home, via complaints information being advertised in the home's dining room and in the home's reception area. The registered manager told us, "We haven't had any complaints in the past 12 months. We deal with things as they come up, before they become complaints – We stopped having regular residents meetings as people told us they would prefer 1-2-1 meetings. We now have a liaison officer who meets monthly with each resident. They discuss any issues or concerns they may have."

People received a welcome pack and service user guide when they took up residency. We viewed the home's welcome pack and service user guide. The guide contained step-by-step instructions on how people could make a complaint. The guide also contained contact information for the Care Quality Commission (CQC) and the complaints manager at the local authority adult services department. People we spoke with showed us that they had copies of the service user guide available in their rooms.

We viewed home's published complaints policy and procedures. The policy set down timescales for the acknowledgement and investigation of formal complaints. The registered manager told us that complaints would be monitored by the home's owner as an aspect of the provider's quality assurance monitoring. This meant that the home had procedures in place to ensure that complaints relating to the care provided to people were appropriately investigated.

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

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk