Inspection Report

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

Balmoral Care Home

6 Beighton Road, Woodhouse, Sheffield, S13 7PR

Tel: 01142540635

Date of Inspection: 01 July 2013

Date of Publication: August 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Four Seasons Health Care (England) Limited
Registered Manager	Mrs. Jane Watson
Overview of the service	Balmoral is a purpose built home, which provides nursing and personal care to older people. Balmoral is a large home (85 places) and accommodation is provided over two floors. There is a separate unit on the first floor where people with dementia are provided with residential care.
Type of services	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

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 1 July 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information sent to us by commissioners of services.

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

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

During our SOFI observation we found that staff had positive interactions with people, they spoke patiently and kindly whilst offering choices and involving people. People also had positive interactions and communication with each other.

People that we were able to communicate with told us that overall they were happy living at the home. Their comments included, "I can sum up this place in one word ? great" and "I was told I could have six months to decide if I wanted to stay. I decided in six minutes."

Records checked showed that before people received any care or treatment they were asked for their consent and the staff acted in accordance with their wishes.

During the inspection we spent time sitting with people in the communal areas of the home and with people individually in their rooms. We found that care and support was offered appropriately to people.

We spoke with five relatives who were visiting the home and they confirmed that they were satisfied with the care provided.

Our conversations with people, relatives and staff, together with observations on the day of our inspection evidenced that there were enough staff on duty and staff working in the home were appropriately qualified to do their jobs.

The provider had an appropriate system in place for gathering and evaluating information

about the quality of care the service provided.

We found that records were held securely and retained for an appropriate period of time.

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 home had in place policies and procedures relevant to this standard. These included the Mental Capacity Act 2005 Policy and the Mental Health and Capacity Assessment.

Various forms and checklists were available for staff to complete regarding a person's capacity to make decisions. For example, we saw on each person's care file a form that showed that people and/or their relative/advocate had been consulted about medication administration, handling their finances (personal allowance), social activity and photographs taken for identification purposes. People were able to either consent or refuse staff involvement with this. Staff told us that people were able to change at any time any decision that had been previously agreed.

The care plans that we looked at all had consent and decision making documents, which had been signed and dated by the person using the service or where appropriate their relative or advocate, other health professionals and the registered manager.

People told us that they were able to make choices in the way they were cared for. One person told us that they went to bed when they wanted to and got up when they wanted to. People told us that they were able to choose what clothes they wore and what activities they would like to participate in. All people spoken with said they felt that the staff treated them as individuals and respected their privacy and dignity. They described how staff always knocked on doors before they came in. They felt they were spoken to with kindness and were able to share jokes and humorous banter with staff.

All the care files we examined focussed on meeting people's needs whilst actively encouraging people to make choices where practicably possible in terms of their day to day needs. Peoples' preferences, likes and dislikes were documented clearly in the care files.

We observed staff providing people with choices as per their individual care plans. Where people had limited capacity we saw staff using various ways of assisting people to make a decision. For example we saw staff showing people different coloured/flavoured fruit juices and people using the service were able then decide which they would prefer.

During our SOFI observation we saw a member of staff ask people that were sitting in the lounge area if they would like the television putting on. The member of staff explained to people that the 'news' was on and asked them if they wanted to listen to what was happening in the outside world. One person said they "weren't interested" and others agreed. The staff member then said would they prefer to listen to some music and people said they would "much prefer this." The staff member then showed them different music CD's and after agreeing on which they would like to listen to we saw people singing along to the music and enjoying the atmosphere. This showed that people using the service were able to express their views and involved in making decisions about their day to day life.

We saw evidence that a person using the service, their relative and the staff had been involved in a 'best interest meeting' to discuss and decide upon the most appropriate solution regarding the person's care.

During our observations we saw that there were a significant number of people being cared for in 'low profile' beds with 'crash mats' on the floor at the side of their bed. The registered manager told us that company policy was that any person with a diagnosis of dementia was not permitted to have bed sides fitted to their bed. This was due to the risk of people becoming 'trapped' in the bed sides. In the care files we checked we found that there was no evidence that people using the service or their relatives/advocates had consented to this.

The provider may find it useful to note that this policy did not respect the right of people who use the service to manage risk through effective consent procedures.

Training records showed that all staff had received combined Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguard (DoLS) e-learning training.

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

During this visit, we spoke with people individually in their bedrooms and in the communal areas of the home. We also spoke with five relatives. People told us that they were happy with the way staff cared for them and felt their needs were being met by staff. One person said, "The staff have always got time for you"." Another person told us, ""If there is anything I need, anything I want, I don't have to ask. I just mention it and I get it."

Relatives spoken with described admission to the home as a positive experience and said they were given the opportunity to discuss their family member's needs with the staff. One relative said, "On admission to the home we were able to make decisions about all aspects of our relatives' care." Another relative who had seen several other homes said, "I felt welcomed as soon as I walked in. The place had a lovely atmosphere."

One relative explained to us that staff had recently noticed that their relative was becoming unwell and had arranged for the doctor to visit. The relative said that they were impressed by how quickly the staff had reacted and said they were pleased that prompt action had been taken. Another relative said, "Nothing is too much trouble for the staff, they are excellent at what they do."

We spoke with one visiting health professional. They told us, "I enjoy coming here and think this is a really good service. I have never had any worries or concerns about the standard of care that people living here receive. I am always made to feel welcome and feel that communication between myself and the staff is very good."

During the SOFI we saw that staff had positive interactions with people. They spoke patiently and kindly whilst offering choices and involving people. People also had positive interactions and communication with each other. Whilst people occasionally remained silent and withdrawn, they were not ignored by staff and appeared to enjoy watching interactions between other people and listening to music that was playing in the lounge and dining room.

During our visit, we found that people were provided with the support they needed when they needed it. Staff knew people well and were aware of their individual preferences. People seemed to be relaxed in the company of staff and made positive comments to us

about individual staff they could see. We saw people approach staff and engage in conversation, or ask for something and staff responded promptly to requests made by people. Staff also proactively engaged with people in communal areas and with people who chose to remain in their rooms to ensure their care needs were being met.

We examined three people's care files. All the care files contained good information about the person's biography, physical, medical and personal support needs. They also included people's likes, dislikes and preferences. All the care files had a range of individual risk assessments. There were clear links between the risk assessments and the care plans. All the care plans were reviewed at least each month, but more frequently if people's needs changed.

There was evidence in the care files that a range of health care professionals were involved in supporting staff to meet the needs of people as required. The files recorded information provided by relatives which was reflected in the care plans as appropriate. Two relatives told us they were actively involved in making decisions about their family member.

The home employed an activities coordinator who worked approximately 35 hours each week. People living at the home and staff spoken with said that there was a selection of activities provided for people. Examples of activities on offer were table top games, baking for coffee morning, chair aerobics, crafts and sing-a-long. Parties for occasions like Valentines Day and Easter were organised and performers were brought in to entertain people. One relative told us about singing along with her mother at one event. She said it was something special she could share with her mother. There were also opportunities for people to go on outings to shopping malls, pubs and places of interest. The activities coordinator also spent one to one time with people who either chose to remain in their rooms or were receiving care in bed.

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

At the time of our inspection there were 71 people in living at the home. The home was divided into three units. We discussed staffing levels with the manager. They told us that each unit had a designated number of staff on each shift. The manager said that the required number and skill mix of staff to meet the needs of the people on each unit was determined by their knowledge of the needs of people. Also that staffing numbers were decreased and increased as the number and dependency levels of people at the home changed.

Our inspection took place during the day and the staffing in place matched that documented within the staffing rota. In total there were two qualified nurses, one senior care worker and eight care workers. An extra care worker also worked over until 9am and the activities coordinator worked as a care worker throughout the morning. The manager, deputy manager and ancillary staff were also on duty.

On the day of the inspection we observed that staff were very busy. During the morning staff spent time providing care to people and assisting them out of bed. This meant that breakfast did not start to be served until 9.45am. People living in the home told us this was "quite late" and "we usually get breakfast before now." When we asked staff about this they told us that they had needed to spend more time with people that had recently been admitted. One care worker said, "So we can get to know them and all their preferred ways." The manager told us that six new people had been admitted into the home over the past eight days. Staff told us that on most days there were enough staff on duty to ensure that people received a high standard of care and attention.

The provider may find it useful to note that the high number of recent admissions had not been taken into account when staffing numbers were arranged.

People that we spoke with told us, "The staff always come as soon as they can, I press the buzzer and they will get here as soon as possible, it sometimes takes them a while" and "If I need help staff are usually always available."

Relatives spoken with told us, "There's always someone around and we only need to ask and staff will come" and "I've not had any concerns about staffing numbers."

We spoke with staff about the training they had received at Balmoral. Each member of staff felt that they received sufficient training to enable them to carry out their role and maintain their skills. Our conversations and our check of training records evidenced that training courses had been provided.

The provider may find it useful to note that there was no system in place to determine staffing levels. So that the manager could demonstrate that they had carried out a need's analysis and risk assessment as the basis for deciding sufficient staffing levels.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

The home manager is registered with CQC and has worked at the home for six years. She is an experienced and skilled manager that was able to meet the home's aims and objectives. She was supported by a deputy manager, qualified nurses and senior managers from head office.

We saw evidence that there were well established systems in place to ensure that the internal auditing of the service covered many areas. For example, medication, health and safety, food safety care plans and complaints.

We looked at a sample of the service's policies and procedures. We found the policies and procedures to be detailed, clearly written and easy to understand. The policies and procedures had been reviewed and updated as necessary.

A complaints procedure was in place so that people could voice any concerns. We saw that the complaints procedure was on display throughout the home. All of the people spoken with said that they had no worries or concerns, but that they could talk to the manager or the staff if they had any. Everyone spoken with said that staff would listen to them. There were no outstanding complaints about the service.

Staff told us that staff meetings were held frequently. Following the meetings staff were provided with a copy of the minutes of the meeting. This made sure that all staff were made aware of any discussions that had taken place and any actions they needed to take.

Regular resident/relative meetings were not held at the home. The manager told us that they had tried to encourage people to meetings but they were not interested. She said she thought this was because she was very visible around the home and people talked to her whenever they wished. Relatives spoken with said that they were invited to join in social activities, for example, a pub night and this meant there were plenty of opportunities to speak with staff about any issues or concerns. This was also a way of keeping people up to date and well informed about what was happening within the home. All relatives spoken with said they felt that they could approach the manager, or other members of staff with opinions about how the service was provided.

A 'Customer Satisfaction Survey' was completed in August 2012. Questionnaires had been sent out to people using the service, their relatives and advocates asking their opinions about such things as the environment, social activities, food, housekeeping and staff. The survey showed that overall; the proportion of people who rated the home good or very good was 73%. A report detailing the findings of the 'Customer Satisfaction Survey' had been completed.

The provider may find it useful to note that the report did not incorporate an action plan detailing what changes would be made following listening to people's views.

The provider may also find it useful to note that healthcare professionals and staff questionnaires were not included in the quality assurance review. This meant they did not have the same opportunity to give their views in relation to the standard of care and treatment provided to people.

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

We spoke with people using the service but their feedback did not relate to this standard.

Relatives spoken with told us that they had never seen any records at the home left unattended or in a place where a person's confidentiality and privacy could be compromised.

We spoke with the registered manager about how they assured themselves accurate records were kept of appropriate information. They said on admission they would ensure an accurate record of appropriate information was obtained through the pre-admission assessment and obtaining information from social workers. After admission qualified nurses and senior healthcare assistants were responsible for reviewing any changes in care needs and amending the care plan as necessary or at least monthly if there were no changes. To monitor this the registered manager said that all care plans were audited monthly by the deputy manager.

We looked at three care files. The documentation showed initial assessment and regular reviews of people's plan of care. These correlated with what we knew about the person through observation and speaking with staff. Documentation showed the involvement of social workers, medical staff and other health professionals, where necessary.

The registered manager and staff told us that care files were securely stored in lockable cupboards within the nurses' station. On the day of the inspection we found that all records could be located promptly and were kept safely and securely stored.

When records had been retained for an appropriate period of time, the service had a contract with an organisation that came to the home and removed records that were ready to be securely destroyed.

Staff spoken with were aware of their own responsibilities in ensuring that accurate records were kept and that records were maintained and held securely. Staff also had a good understanding of the Data Protection Act 1998.

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