Inspection Report

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

Ralphland Care Home

Ralphs Lane, Frampton West, Boston, PE20 1QU Tel: 01205722332

Date of Inspection: 26 June 2013 Date of Publication: July 2013

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Leong E N T Limited
Registered Manager	Mrs. Janet Joan Pragnall
Overview of the service	Ralphlands is a purpose built care home situated on the outskirts of Boston. It is registered to provide accommodation and personal care for up to 34 older people, some of whom may have needs associated with dementia.
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 26 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by other authorities.

Spoke with professionals

What people told us and what we found

During our visit we spoke with three people, two staff and a relative. We observed the care people received and looked at records.

During our visit we looked particularly at areas where concerns had previously been raised. For example the transfer of people to hospital and administration of medicines. We found medicines were administered and stored safely. We saw the home had in place procedures for transferring people and when we looked in the records found they had been followed.

Overall we observed people were supported by skilled and experienced staff who understood their roles and responsibilities.
We observed care and saw staff were responsive to people and interacted with them positively.

We spoke with a relative. They told us the staff were pleasant but very busy at times. They said they felt confident with the care their relative received.

People told us the staff were caring and looked after them well.

We observed staff offering activities to people. For example we observed a member of staff reading a magazine with a person.

We saw staff explained the care they were giving to people. For example when they offered medicines to people they explained what they were.

When we looked at the records we found there were gaps and they did not accurately reflect the care people were being given or required.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 01 August 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

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.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

We observed staff supporting people to move and saw this was done at the person's own pace and in a safe way. We saw when staff supported people they provided reassurance.

We spent time observing how staff interacted with people. The interactions we saw during our visit were positive. We heard staff talking with people in a caring manner.

We heard staff speaking to people about the things they were worried about. For example one person was worried about attending work and staff reassured them that they would be alright.

We observed people had access to drinks throughout the day and staff supported people to get drinks. We observed staff supported a person who was nursed in bed to have a drink.

We spoke with a relative. They told us when their relative needed to go to hospital the home provided a member of staff to support them. They said they felt informed about their relative's care.

We observed lunchtime and saw staff offered to assist people with their meals and were responsive to their needs. For example we heard a member of staff ask a person if they wanted a clothes protector to wear during lunch.

We observed people being given choices during lunch. For example they were asked whether they wanted salt and pepper. We saw where people needed they had adapted cups and plates to assist them in their independence at mealtimes.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare.

We looked at three care plans and saw they were person centred and had information about people's care and personal preferences. We saw care plans had been updated and reviewed on a monthly basis and changes recorded. For example we saw in one record changes had been made to a person's diabetic control care plan following review.

Risk assessments had been carried out to identify specific risks to each individual and care had been planned to manage those risks. For example, risk assessments were in place for nutrition and pressure area care.

Where people had bed rails we saw risk assessments had been completed to ensure the care met their needs.

The provider may find it useful to note the manager told us a person preferred their room door to be locked from the outside as they didn't want people wandering into their room. When we looked in the care plans we did not see any reference to this or an assessment of the risk this posed to the person. This could put the person at risk in an emergency situation.

Care plans explained how people liked to be communicated with. For example one care plan said, "Can say small words" and "Has flash cards for choosing food."

We saw daily history/care sheets were kept in people's bedrooms. This meant staff could ensure records were completed as care occurred.

When we spoke with staff they were able to tell us about people's care.

The Deprivation of Liberty Safeguards were only used when it was considered to be in the person's best interest. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We looked at the records and saw mental capacity statements were in place where required, for people who were unable to make decisions for themselves. Mental Capacity Act (2005) and Deprivation of Liberty Safeguards is law protecting people who are unable to make decisions for themselves.

We saw in two care plans people had signed to say they had been consulted and given choices in the way care was given. The provider may find it useful to note this was not completed in the two other records we looked at. This would mean people could receive care they had not agreed to.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

We spoke with a district nurse who told us they didn't have any concerns about the care that was provided. They told us they felt the home would contact them if they had any concerns.

We looked at the care records. We saw discharge information for people who had had a stay in hospital was kept in the medication administration record (MARS) records for a month after discharge, to ensure people received the correct medicines.

In order to ensure continuity of care for people we saw there were information sheets about people's care and needs completed for people to support their care needs if they were admitted to hospital. These included copies of the current MARS.

During our visit we observed a member of staff requesting a visit for a person who had become unwell. We saw the visit took place later that day and observed staff supported the person during the visit.

We saw records had been maintained of visits by GPs and other professionals. For example a person required a visit by the out of hours GP service and this was recorded in the daily notes and the record for professional visits.

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

Medicines were prescribed and given to people appropriately.

Appropriate arrangements were in place in relation to the recording of the administration of medicine. We looked at the medication administration sheets (MARS) for June 2013. We observed they were completed and appropriately signed by staff. We saw they were easy to follow and indicated when medicines were to be given in order to ensure staff administered medicines at the right time.

We saw in the MARS staff recorded when people were at hospital or on leave to ensure people received the correct medicines.

The provider may find it useful to note we did not see photographs on the MARS. The staff told us this was because the home had recently changed the provider of their medicines. The manager told us they were in the process of addressing this.

The manager told us the senior member of staff on duty or the manager carried out the medicines round. We looked at training records and saw evidence staff had completed appropriate training to be able to give people medicines.

Medicines were handled appropriately. We observed a medicine round. When giving people medicines we observed staff called people by their name and explained what they were doing. Staff offered people water with their medicines and waited for them to confirm they had swallowed their medicines. We saw they wore protective clothing to prevent cross infection and used disposable cups for the medicines for each person.

We observed staff addressed people by their name and told them what they were doing. For example,"xxxx I've just got your antibiotics." We also observed staff asked people if they had taken their medicines

Staff told us one person didn't like taking their medicines and we observed the member of staff supporting and encouraging them to take their medicines. For example they said, "It will make you feel better." We saw their approach was effective and the person took their

medicines. When we looked at the records for June 2013 we did not see any time when the medicine had been refused

The provider may find it useful to note we observed when the staff member was administering medicines they were interrupted to take a phone call. This meant there was a potential risk of errors being made if staff were distracted from the task.

We saw the medicines policy included guidance on self administration and administering medicines in food or drink.

Medicines were kept safely. We saw the medicines trolleys were secured according to guidance.

We looked in the controlled medicines book and saw it was signed and logged according to statutory guidance. We looked in the controlled drugs cabinet and checked the medicines in the cupboard matched with the record for one person.

We spoke with staff about the process for returns which ensured out of date medicines and medicine that was no longer required was managed appropriately. We reviewed the records for the system and saw this was the case.

We looked at the records for the temperature of the medicine fridge and saw these were recorded regularly and were within normal range. The provider may find it useful to note staff told us the fridge was cleaned on a weekly basis but there was no record of this.

We saw the provider had in place a process for auditing staff's competency in administering medicines and these had been completed regularly.

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 found support to staff was well led and organised.

We looked at the record of training. The record detailed when people had completed training and when updates were due to ensure staff had the skills to care for people safely.

When we spoke with staff they told us they had received an induction and found it useful. They also told us they had recently had training in areas such as moving and handling, infection control and health and safety.

We saw evidence in people's personal files of attendance at training on areas such as first aid, food safety, infection control and safeguarding.

Staff they told us they had received an appraisal in the last year. The manager told us they were in the process of planning appraisals for this year. We saw evidence of this.

We looked at records of supervision which had taken place in March 2013. The records had evidence of discussion about people's training, performance and role responsibilities.

The two members of staff we spoke with told us they thought the staff numbers were sufficient and staff received appropriate training to meet people's needs.

When we spoke with staff they told us they had staff meetings and found these useful. They said they felt able to raise concerns.

We looked at staff files and saw they had records of the recruitment process including application forms, proof of identity and records of an induction taking place. We saw the provider had in place policies to support staff, for example harassment and bullying and sickness policies. Staff told us they were aware of these policies and we saw evidence they had signed to say they had received and understood these.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because inaccurate records were maintained.

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

Reasons for our judgement

People's personal records including medical records were not accurate. People were at risk of receiving inappropriate care due to gaps in the records.

We looked at care records. We saw in two care plans people were assessed as requiring their level of risk for developing pressure sores reviewed on a monthly basis. When we looked in the records we did not see evidence of review. This would put people at risk of not receiving care at the appropriate level and of acquiring pressure sores.

We also saw where a person was assessed as being at a high risk of skin damage the care plan did not detail what care was required to prevent this. We observed the appropriate aids and support were in place.The lack of accurate records could put the person at risk of receiving inappropriate care.

We saw another person was assessesed as being at a high nutritional risk however this was not reflected in the nutritional care plan.

The manager told us a person did not have some of their belongings in their room in order to keep them safe. However when we looked at the care records we did not find this was reflected in the care plans.

When we looked at the records we saw a person required two hourly turning. We saw in the records for June 2013 gaps of up to four hours. When we spoke with the manager who looked at the records they told us they thought some of the gaps would be due to staff not recording the turns at mealtimes.

We saw in one record a person was assessed as being at risk of weight loss but the nutrition care plan did not reflect this.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider was not meeting Regulation 20 (1) (a)-people were not protected against the risks of unsafe or inappropriate care and treatment because records were not accurate in relation to the care and treatment for people.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 01 August 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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