Inspection Report

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

The Old Vicarage

Parsonage Lane, Hungerford, RG17 0JB

Tel: 01488683634

Date of Inspection: 18 December 2012

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

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Oakview Care (Berkshire) Limited
Registered Manager	Mr. Gary Devlin
Overview of the service	The Old Vicarage is a residential care home that offers a service for up to 12 people with learning and associated disabilities. Some people may have behaviours that can cause distress or harm to themselves or others.
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 18 December 2012, 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 and talked with staff.

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.

What people told us and what we found

We spoke with four people who used the service and observed the care of another. People told us that it was "great " to live there. They told us that there was lots to do and that they went to their reviews so they could "speak up for themselves". People told us or indicated by nodding their heads or smiling that staff treated them well. One person said " they help you whenever you need them, there's always plenty of them around". We saw that staff delivered care in the way that was specifically described in people's plans of care. We found that staff were well trained and knowledgeable about the needs of the individuals and their care.

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

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People, who used the service, where they were able, expressed their views and were involved in making decisions about their care. Relatives were involved in care planning processes to support people, as appropriate. The individual or their representative signed their plans of care to show that they had read and agreed with them. People told us and staff confirmed that relatives and individuals were involved in the annual care planning reviews if they chose to be. Relatives or representatives attended reviews with people's permission, as appropriate. Each individual care plan included people's ability to make decisions about that particular area of their care.

Individual plans of care included how staff were to ensure that people could make choices and decisions. Likes and dislikes and preferred daily routines were included in the care plans. The four staff spoken with described, in detail, how they ensured that they maintained people's dignity. We saw examples of staff treating people with dignity and respect. We saw that they respected people's choice of food and when to eat it. They explained respectfully why people should not act in particular way, for example not shouting loudly which was disturbing others. Staff were seen communicating respectfully with people who used the service, throughout the duration of the inspection visit.

The four people we spoke with told us or indicated that they could choose what to wear, what activities to participate in and what time they got up and went to bed. Plans of care showed that people were sometimes offered a limited amount of choices to assist them to make an informed decision and so as not to cause confusion.

People were supported in promoting their independence and community involvement. People's independence levels were described in all plans of care. They instructed staff how to ensure people did as much as possible for themselves. Learning programmes were developed for individuals for some areas of daily living, as appropriate to their age, future needs, interests and ability levels.

Activities included accessing the community and using all local services including local

shops, leisure facilities and public transport, as appropriate. People's individual activity plans reflected their level of independence and specific behavioural needs.

One person was observed using the Short Observational Framework for Inspection (SOFI). They were observed for 20 minutes in the dining area. Staff were seen speaking to them respectfully, giving them a choice of food and drinks in the way that was noted on their plans of care. Staff were seen communicating with them as described on their individual communication plans. Staff displayed patience and an understanding of the individual's complex needs.

People's diversity, values and human rights were respected. Any cultural needs, religious beliefs or special physical needs were noted on plans of care along with the action needed to meet those needs. Examples seen included speciality equipment provided for people with particular skin conditions, specialised staff training and different methods of communication for individuals.

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. The five plans of care we looked at contained the relevant information to enable staff to appropriately support people, in the way they preferred. People told us that there were always staff around to help them.

Plans of care were reviewed regularly and when behaviour or needs changed. A formal multi-disciplinary review was held at least once a year. The five plans of care were up-to-date and had been reviewed in 2012. One person whose needs were changing frequently had been reviewed every month and plans of care had been amended according to their changing needs. Daily notes were detailed and up to date and cross referenced with other records held for the individual such as the communication book.

Care and treatment was planned and delivered in a way that ensured people's health, safety and welfare. All the plans of care we looked at included risk assessments. The risk assessments noted how to minimise the risk for the individual. Individual's risk assessments included areas such as transport, community presence, relationships and behaviour. We saw that these were reviewed regularly and necessary changes were made to them. An example was risk assessments that stated how staff were to deal with behaviour that may cause distress or harm to individuals themselves or to those around them. These risk assessments were used in conjunction with detailed behavioural management plans and guidelines. These were developed by the mental health professionals who supported individuals who lived in the home. Staff were observed following the guidelines supplied by supporting external health care professionals.

Health care records were kept and included referrals to external professionals such as district nurses, GPs, tissue viability nurses and community psychiatric nurses. District nurses visited the home, as necessary, to support the staff to deal with pressure area and any nursing care. We saw that daily notes, the communication book and health care records were accurately cross referenced. Staff were able to easily track people's health care needs and any necessary follow up referrals or appointments.

The Deprivation of Liberty Safeguards (DoLS) were only used when it was considered to be in the person's best interest. Staff were trained in the Mental Health Act and DoLS and sought advice from senior staff as necessary. The home had not made any DoLS referrals

or held any best interests meetings since the last inspection in February 2012.

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

There were appropriate arrangements for obtaining and recording medicines. The home used a monitored dosage system. This meant that each dose of medication had been prepared by the pharmacy and sealed into packs. Medication was ordered by the home on a monthly basis according to prescriptions issued by the GP. The medication deliveries were checked in by senior staff. Any unused medication was sent back to the pharmacy and records of the returns were kept. The home had noted in care plans why people were unable to self administer their medication.

Medicines were kept and administered safely. The medication was administered by care staff who had been appropriately trained. A list of staff who were able to administer medication was kept in the front of the medication administration file. The medication file included photographs of individuals, medication protocols and guidelines and medication administration sheets (MAR). The MAR sheets we looked at were up-to-date and accurate.

The provider may find it useful to note that individual guidelines for the use of medication prescribed to be taken as necessary were not available during the morning of the inspection. This meant that people could be at risk of receiving medication that helped them to control their behaviours or pain, inappropriately. However detailed guidelines for the administration of this type of medication were developed before the end of the inspection.

Medication was kept in locked cabinets. The home was not using any controlled medication but had a policy and procedure to follow should this become necessary. Medication was audited monthly by senior staff.

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

The home had a staff team of 18. Minimum staffing was five staff from 8am to 4.30pm, four staff from 4.30 to 8.00pm and two staff during the night (one waking , one sleeping). The manager provides additional staffing to cover activities, illnessES or other out of the ordinary circumstances that arose in the home.

Staff received appropriate professional development. Staff we spoke with told us that they had good training opportunities. Training records showed that staff had completed training in areas such as dementia care for people with Down's Syndrome, autism and challenging behaviours. Staff told us that specialist training gave them confidence when working with people with specific and complex needs. Supervision records showed that staff were supervised regularly and received an annual appraisal. Staff spoken with told us that the manager was very approachable and they could ask for additional supervision or informal 'support' sessions whenever they felt it necessary.

Staff were able, from time to time, to obtain further relevant qualifications. Training records showed that 15 of the 18 staff had achieved a National Vocational Qualification (NVQ) level 2 or above.

The home held regular staff meetings which covered all aspects of the running of the home such as health and safety, resident issues and keeping staff informed of any up-dated or new policies and procedures. There was a daily handover and the home kept a detailed communication book to ensure safe and consistent care was maintained.

Staff told us that it was a good working environment and an efficient and supportive staff team. They said they gave good care to the people who lived there. Staff told us that they felt well supported and equipped to do their jobs. People who lived in the home told us, or indicated that staff treated them well.

Records ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

Reasons for our judgement

People's personal records, including medical records were accurate and fit for purpose. The five plans of care we looked at showed that information was accurate and up-to-date. They were used to plan appropriate care and support. Health care records were detailed and enabled staff to monitor and meet people's health care needs.

Records were kept securely and could be located promptly when needed. The manager located all the records we needed to look at quickly. All records were kept in an office which was locked when not in use. All records were kept confidentially and only staff at the appropriate level had access to them.

Records were kept for the appropriate period of time. The home had not destroyed any records because it had only been registered for two years. The provider may find it useful to note that the home did not have a detailed record retention and disposal policy available. This means that the home would have no guidelines of when and how to archive or dispose of records, should it become necessary.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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