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: 14 August 2013

Date of Publication: September 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
Meeting nutritional needs	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ 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 14 August 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 staff and reviewed information given to us by the provider.

What people told us and what we found

We found that people were asked for their consent on a daily basis and staff understood people's ability to consent. People told us, "I can choose things for myself but staff help me a lot of the time".

We saw that people were respected and were given care as described in their plan of care. People told us or indicated that they were happy living in the home, one person said, "I love my home, I'm very happy here".

People were provided with fresh, varied and nutritious food in ways that met their individual needs. They were involved in the planning of menus and preparation of food. People told us that they liked the food provided, one person said, "the food is very yummy".

We saw that the houses were homely, comfortable and well maintained. People were provided with accommodation and equipment which helped them to maintain an enjoyable lifestyle.

The home made sure, as far as possible, that staff were safe and suitable to work with the people who lived in the home.

We found that the home had ways of making sure that they listened to the views of those who lived there and other interested people. We saw that they took action to make it a nicer place to live.

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

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. The assessments and plans of care identified areas where people needed help to give consent. They noted people's methods of communicating consent if they were unable to use speech. The provider may find it useful to note that plans of care did not always describe when and how individuals had agreed to the content. This meant that it was not always clear that consent had been obtained. Two people told us they knew what was in their plans of care and agreed with them.

We saw that plans of care included how staff were to ensure that people could make choices and decisions. We noted examples of people being given opportunities to make choices throughout the day. We observed staff treating people with respect at all times. Examples included, discreetly talking to people about acceptable behaviour and including them in all conversations. People told us that they talk to staff about "what I want to do and who (staff) I want to do it with". They said, "I can choose things for myself but staff help me a lot of the time".

Where people did not have the capacity to consent the provider acted in accordance with legal requirements. We found that risk assessments clearly stated why they had been developed. Information about the person's level of capacity and understanding of each element of the risk assessment was recorded. Examples included managing anxiety and managing finances.

We looked at five plans of care which showed that mental capacity was considered in all areas of the care of the person. An example included the home completing mental capacity assessments on a daily basis for someone whose abilities fluctuated. Staff understood that people were able to consent in some areas of daily living and not others

and there were differences depending on time of day and mood.

We saw that the home actively sought advocates for people and some people's families were able to legally represent their best interests (enduring power of attorney) with regard to their finances and well - being. The manager fully understood 'best interests' meetings with regard to people's health needs and described an incident when such a meeting was appropriately held.

We saw that five senior staff had received specific training in the Mental Capacity Act (MCA). The manager described when it may be necessary to use the act because of people's lack of capacity. The staff members we spoke with showed an understanding of consent and knew which senior staff to refer to, if necessary. The home had not made a deprivation of liberty safeguards (DoLS) referral.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

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

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care 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'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 were assisting an individual to access religious events in the community, specialised equipment to meet people's deteriorating physical needs and specialised training.

A monthly report was completed with individuals by their key workers (staff with specific responsibility for individuals). These noted a summary of events, if people were happy living in the home and if there were any changes they wanted to plans of care. Examples included different social and daily activities such as horse riding and 'outings'. They also summarised any health needs and behavioural issues.

Daily notes were detailed and up to date. The provider may find it useful to note that they did not always note the choices people had made. This meant that it was not always clear whether people had been offered the choices as described in their plans of care.

Care and treatment was planned and delivered in a way that ensured people's health, safety and welfare. The plans of care included risk assessments. The risk assessments we saw were person centred and met the needs of the particular individual. Examples included financial, physical and sexual abuse and unaccompanied access to the community. The risk assessments we looked at had been reviewed in 2013 and necessary changes were made to them.

We saw that staffing levels increased to meet the needs of individuals, as necessary. The numbers of staff varied over the day from three to six with additional staff made available to cover 'special events' or people's needs. Specialist training was provided to meet peoples' individual specific needs.

Health care and well-being records were kept, as necessary. These included a health care

booklet which recorded regular check- ups and referrals to external professionals such as GPs and speech and language therapists. We saw that the home took timely action if there was any deterioration in people's health or well- being. An example was an immediate referral to the district nurse for sore skin. How people showed they were in pain was also included.

People whose behaviour could cause distress or harm to themselves or others were referred to other professionals such as psychologists and psychiatrists. The home had detailed behavioural guidelines and the staff were trained in positive behaviour management techniques. Behaviour and incident reports were kept along with behavioural guidelines and risk assessments.

The home provided people with a variety of activities including access to the community, computers, gardening and art and craft. They had an activity co-ordinator who developed an activity programme for the individual who could choose what activities they participated in. People told us, "we do loads, I like the garden and going out on my own". The activities provided were varied and appropriate to the age, ability, gender and interests of the people who lived in the home.

The five people we spoke with told us or indicated that they were happy living in the home. One person said, "I love my home, I'm very happy here". Another told us that they really liked living at the Old Vicarage.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

Reasons for our judgement

People's food and drink met their religious or cultural needs. People who lived in the home did not have any religious beliefs with regard to their food. We saw that people participated in the development of menus which included personal choices. People told us "we take it in turns to choose our favourites".

People were supported to be able to eat and drink sufficient amounts to meet their needs. The five plans of care we looked at showed that people's nutritional needs were assessed using a recognised assessment tool, as appropriate. We noted that weight, fluid and food intake charts were kept as necessary. We saw that action was taken if records showed any nutritional issues, these included fortified diets and food presented in soft or liquidised form. We noted that the home followed the recommendations of the speech and language therapist.

People were provided with a choice of suitable and nutritious food and drink. We observed the dinner time period. We noted that people assisted staff in the preparation of the main meal on a 'rota' basis. The meal they helped to prepare was the one they chose to add to the menu. People told us that the food was "very yummy".

We saw that there were fresh vegetables and fruit available and people told us that they eat some fresh fruit and vegetables that they grow in their garden.

The home had a large kitchen in the main building and kitchenettes in the small annexes. They were clean and hygienic on the day of the inspection. Food was safely stored and a dishwasher was used for washing dishes at a safe temperature. Training records showed that 12 of the 22 staff had completed specific food safety and hygiene training.

The provider may find it useful to note that some staff felt that the cooker was too small to cater for the number of people who lived and worked in the home. The cooker was not working on the day of the inspection. This meant that staff were using the 'range' for cooking and could not control the temperature of the appliance to enable them to keep food warm.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

The home was arranged over four buildings, all had two floors. The main building had nine bedrooms and communal areas and the other three had one bedroom and sitting areas and kitchenettes. The people who lived in the 'annexes' had indiviual support packages appropriate to their needs.

The provider had taken steps to provide care in an environment that was suitably designed and adequately maintained. All areas of the home looked well-kept and well maintained. The home's annual development plan included any necessary refurbishments and replacements.

The garden was well maintained and well used by people. An activity room, vegetable plots, garden furniture and games were available for people to use. People said they ''really liked'' the garden and told us that they had recently enjoyed a barbeque.

The registered manager had authority to access any necessary maintenance, repairs or replacements. The home had provided en-suites or access to private bathing facilities for the people who lived in the home. Facilities were available to enable people to choose to have a bath or shower.

We saw Health and Safety risk assessments that covered all areas of safety in the home. Examples included lifting and handling and infection control. Control of Substances Hazardous to Health (COSHH) procedures were in place. We looked at maintenance records and saw that health and safety checks were current. Examples included an annual boiler check, portable electrical appliance testing and hoist and fire equipment checks.

The home ensured the people who lived in the home were secure. There were sensor security lights on the outside of the building and locks on gates that were secured as necessary.

The home had detailed fire evacuation procedures which were practiced on a monthly basis. A detailed generic contingency policy and procedure was in place and informed staff of all the necessary actions to take in the event of an emergency.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

Appropriate checks were undertaken before staff began work. We looked at the staffing records of the three newest staff members. We saw that the home made sure that the results of the checks were received before staff began working alone. Examples included two references, a police check and verification of people's identity.

There were effective recruitment processes in place. Staff files showed that potential staff completed an interview process which included meeting with the people who lived in the home. Records of the questions asked and answers given at interviews were kept on staff files.

Staff members completed a comprehensive induction process to prepare them to work with the people in the home. The staff member we spoke with confirmed that they had completed the induction before being left to work alone. They said they felt well equipped to work with the people who lived in the home.

We saw that staff had the skills or experience to care for people appropriately. 20 of the 22 staff had completed a two day course entitled 'positive behaviour management of challenging behaviours' on the 1st August 2013. However, the provider may find it useful to note that some staff told us that they did not feel they were always supported to do their job safely. The lack of support was particularly with regard to dealing with people whose behaviours may cause harm or distress to themselves or others. This meant that some staff did not feel totally confident when dealing with people who were having difficulty in controlling their behaviour. However other staff told us they felt well supported by the management team.

Staff told us that they had good training opportunities and that their mandatory training was up-dated as necessary. They were supervised approximately monthly and received an annual appraisal.

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 to regularly assess and monitor the quality of service that people receive.

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 had a quality assurance system which included auditing accident and incidents, complaints and plans of care. There were eleven people who lived in the home and the registered manager had a comprehensive knowledge of individuals' needs and any issues that affected them.

The manager told us that the providers visited the home regularly, noted any issues and spoke with people who lived and worked in the home. The records of the visits were held at head office and informed the quality assurance process. The provider may find it useful to note that there were no records of the visits or the issues discussed kept in the home. This meant that the people who lived in the home and the staff team did not have easy access to them.

There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. Accident and incident forms were completed and detailed the event that had occurred. We looked at records that showed an investigation into the cause of the incident or accident had taken place. However, the provider may find it useful to note that the incident/accident forms did not always state the action that had been taken to minimise the risk of recurrence. They did not always fully detail the 'investigation' or cross reference to the records that did. This meant that it could be difficult for staff to identify what action had been taken to minimise immediate and long term risk of repetition.

We saw individual risk assessments which were included in people's plans of care. Additionally health and safety and safe working practice risk assessments were in place.

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. The home sent annual questionnaires to people who lived in the home, families, friends, other professionals and other interested parties. The results of the surveys were collated at head office, an action

plan was written and both were made available to the public, on line. Comments received from the latest survey included 'outdoor activities are really excellent' and 'the work that's been done both inside and outside the home has been amazing'.

Examples of actions taken as a result of listening to people's views on the care given were the installation of four new bathrooms. All bedrooms had been decorated and an there was an increase in the variety and frequency of activities.

We saw that people's plans of care were reviewed a minimum of annually and were attended by the people who lived in the home and others who they chose/agreed should go to the meeting. Key workers also reviewed people's plans of care on a monthly basis.

The provider took account of complaints and comments to improve the service. The home had a detailed complaints policy and procedure. The procedure was provided in any easy to read format, which included symbols and simple language so that people had the best chance of understanding it. The home had received no complaints since the last inspection.People who used the service told us or indicated that they had no complaints or concerns about the service.

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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