Inspection Report

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

Turfcote Care Home with Nursing

Helmshore Road, Haslingden, Rossendale, BB4 4DP

Tel: 01706229735

Date of Inspection: 17 September 2013

Date of Publication: September 2013

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
Meeting nutritional needs	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Marshmead Limited
Registered Manager	Mrs. Elizabeth Ford Irwin
Overview of the service	Turfcote is registered to provide care, support and accommodation for 76 people. The home has two units. Grane View provides nursing and personal care for to up to 30 people who have mental ill-health and Tor View provides general nursing and personal care for up to 46 people.
Type of service	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 17 September 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 given to us by the provider. We talked with other authorities.

What people told us and what we found

During this visit we spoke with six people who lived in the home and with two visitors.

We conducted an early morning visit as we had received information from a whistle blower. The concerns were shared with the local authority and reviewed as part of this inspection.

We found people's care and treatment was delivered in line with their individual needs. However, the records did not always reflect people's choices or reasons for decisions around care and support. People said there were opportunities for involvement in daily activities but generally this was when staff were available.

People were encouraged to discuss any concerns. One person said, "I'm always asked if I am okay; I am given lots of opportunities to discuss any concerns I might have".

People's nutritional needs had been assessed which helped determine whether they were at risk of dehydration or malnutrition. People told us they were provided with a choice of nutritious food and drink. Comments included, "The food is lovely; it's like being in a hotel" and "We get plenty to drink through the day and something at supper time".

People told us there were enough staff to meet their needs and said, "Staff are lovely; they work very hard" and "Staff are very good; they often bob in for a quick chat or just to check I am alright". We spoke with five staff who told us they had the training and support they needed.

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 02 October 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

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 who used the service were given appropriate support regarding their care or treatment.

Reasons for our judgement

We looked at this outcome as a whistle blower had told us people's choices regarding getting up and dressed in the morning were not considered. We visited the home at 07:00 to observe the routines and practices of the night staff.

During our visit we found 5 people were having their breakfast in the dining room of Tor View (the 'general' unit). Two people were able to tell us they had wanted to get up early and a member of staff told us that one person was 'always' up early and that this was her normal routine. One person said, "I've always been an early riser and I like to get up when I wake up. I let the staff know and they come and help me". We looked at two people's care plans and found there was sufficient information about their preferences and routines to support their wishes.

On Grane View, for people who have mental ill-health, we found 6 people were up and dressed and another 2 people arrived in the lounge before 8am. Due to people's lack of understanding and mental ill health only one person was able to speak with us. We spoke with staff who were able to give a good account of why people were up early and of the reasons why this varied from day to day. However, the provider may find it useful to note that whilst the records showed that people were unable to make decisions about their care, they were not clear about people's preferences, routines or needs regarding early morning showering, rising and also retiring. The records were also unclear about the reasons why people were up showered and dressed early, at what time they had risen or retired or whether they had been given a snack and a drink before breakfast. This meant it was difficult to determine the reasons behind 'best interest' decisions taken by staff and could lead to 'institutional' type practice. We shared our concerns with the nurse in charge of the unit and with the manager. We were told the information in the care plan and the way that information was being recorded on this unit would be reviewed as a matter of urgency.

On both units we observed staff treating people in a patient, kind, friendly and respectful

way. We observed people being offered choices and being supported in a way that respected their privacy and encouraged their independence. Records showed staff had attended training to help them understand how to treat people with dignity and respect.

We spoke with six people living in the home. They told us they could make choices and decisions about how they spent their time and how they were cared for. This helped to ensure they received the care and support they needed and wanted. Comments included, "I can do as I like and make my own choices", "I like to do things for myself; staff respect this but are there to help me if I need", "I prefer to get up later in the morning; I let the staff know when I am ready" and "Staff explain things to me; they talk to me about my care and what I would like to do". A visitor told us they had been involved in decisions about their relatives care.

People were encouraged to express their views and opinions of the service by taking part in annual customer surveys, by attending regular meetings and through discussions with staff and management.

People were given clear information about the services available at Turfcote. This should help people make informed choices about their care. Information was also available about local organisations who could provide people with independent advice and support.

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

We looked at this outcome as we were sent information about how people were looked after. The concerns related to moving and handling practices resulting in bruising, call units being unplugged, lack of positional changes resulting in skin breakdown and medicines being left out. We shared this information with the local safeguarding team who visited the service and we visited when their initial investigations were completed.

We looked at four people's records. We found their needs were assessed and care, treatment and support was planned and delivered in line with their individual care plan. We found the care records generally contained some useful information about people's preferred routines and likes and dislikes. However, on Grane View, we noted there was insufficient information to support or reflect the choices made for people and the care being given. This information was needed to help staff look after people properly and ensure people received the care and support they needed.

There were a number of people who had 'challenging or aggressive behaviours' towards other residents and staff. Records reflected the action to be taken by staff to keep people safe.

Records showed that regular reviews were carried out to respond to any changes in people's needs and to ensure the level of care was appropriate. People living in the home, and their relatives, told us they were involved in discussions about their care and kept up to date with any changes. Staff told us they were able to discuss people's needs at regular 'handovers' which should make sure they were up to date and should make sure everyone received the care they needed.

People's health and well-being was monitored and appropriate advice and support had been sought in response to changes in their condition. We found the service had good links with other health care professionals to make sure people received prompt, co-ordinated and effective care. The nurse practitioner visited on a regular basis; she had informed the local authority that she had no concerns regarding abnormal bruising or skin damage.

We observed moving and handling practices on both units and looked at information in people's care plans. We found various types of equipment available, including hoists, turn tables, slings and slide sheets. We found each person had an assessment indicating their mobility status, how many staff were needed and what equipment should be used. However, the provider may find it useful to note the care plans did not always detail the type of equipment being used. For example, records did not indicate the sling to be used. This meant people may be at risk if the wrong sling was used. The occupational therapist had visited and had advised that each person should have their own 'sling'; the manager told us this was being actioned. The manager also told us that adjustable height beds had been provided to ensure people's night time handling needs were safely met. During our inspection visit we did not observe any poor handling practices.

There were assessments to determine the risk of people developing pressure sores. Records showed appropriate action had been taken to reduce or eliminate the risks. However, the provider may find it useful to note the type of equipment being used was not always recorded in the care plan. This meant it would be difficult to determine whether the equipment used was appropriate for the level of risk.

Most of the care staff had achieved a recognised qualification in care, which would help them to look after people properly. Staff were observed interacting with people in a kind, patient, pleasant and friendly manner. We observed that any calls for assistance were answered promptly. One person said, "I press the buzzer and they arrive to help".

From looking at records, and from discussions with people who used the service, it was clear there were opportunities for involvement in some daily activities but generally this was when care staff were available. Staff told us, "We do what we can but it is hard to find the time". People living in the home told us, "We have a weekly bingo session although it's always the same people that turn up", "There isn't much going on and people generally stay in their rooms", "The library visits; I enjoy reading and TV", "We have an entertainer now and then" and "Sometimes there are things going on; I think people tend to occupy themselves". We observed people in various areas of the home and found there was positive interaction between staff and people living in the home. However, the provider may find it useful to note that the 'activity' records did not accurately reflect the one to one and group activities that had taken place. This meant it was difficult to determine whether people's social needs were being met. The manager advised she would discuss this with staff and review how 'activities' were recorded.

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

We looked at this outcome as we had been given information that some people were not being supported to eat or drink, which had resulted in them being admitted to hospital. During our visit we looked at four people's records, talked to people using the service and observed staff practice.

We found people's nutritional needs had been assessed which helped determine whether they were at risk of dehydration or malnutrition. People's weights and dietary and fluid intake were monitored and appropriate professional advice and support had been sought when needed. From a review of information that we hold about the service and from discussion with the manager we found no examples of people being admitted to hospital due to insufficient dietary or fluid intake.

Records showed there was a varied choice of food and drinks available. During our visit we observed people being offered alternatives to the menu and also people being offered their meals at a time that suited them. However, the provider may find it useful to note there were no records relating to the provision of meals on Grane View and no records relating to suppers, snacks and drinks on either unit. This meant it was difficult to determine whether everyone's nutritional needs were being met at all times.

People told us they enjoyed the food and were provided with a choice of suitable food and drink. We found that drinks were available in the lounges throughout the day. One person said, "We get regular drinks and snacks; I can either ring for a drink or go to the kitchen for one". Other comments included, "The food is lovely; it's like being in a hotel", "The food is generally alright; I get enough to eat and there are different things that I can have", "We get plenty to drink through the day and something at supper time" and "The food is very good; very tasty". Some people were able to discuss menus and their dietary preferences during 'resident' meetings.

One person told us there were certain foods he enjoyed but that he had not had them since moving to the home. We suggested he raised this with the manager which he was happy to do. We also discussed this with the manager who said she would look into it. Staff were aware of people's dietary preferences and needs and provided specialist diets as needed.

We observed staff being patient, attentive and supportive during the breakfast and lunchtime meals. People were supported and encouraged to eat and drink sufficient amounts to meet their needs. The dining rooms were bright and pleasant and people were provided with appropriate cutlery, crockery and condiments. The meal time was not rushed and people were able to eat at their own pace. People were able to choose where they dined.

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

We looked at this outcome as a whistle blower had told us there had been a recent high number of staff leavers and that other staff were concerned as some of the team were related to the manager.

During this inspection visit we looked at the staff rotas. We found the home had sufficient skilled and experienced nursing, care and ancillary staff to meet people's needs. Any shortfalls, due to sickness or leave, had been covered by existing staff or with bank staff. This ensured people were looked after by staff who knew them.

Staff confirmed there were sufficient staffing numbers to look after people properly. They told us there had been a number of recent changes to the staff team and were aware of some of the reasons. They were also aware that some staff were related to the manager and were confident that no one was treated any differently. One member of staff said, "There is no favouritism; we are all here to do our jobs and are all treated the same".

People told us there were enough staff to meet their needs. Comments included, "I press my buzzer when I need help and they always come", "Sometimes I have to wait if they are very busy but they let me know" and "I press the buzzer and they come". During our visit we observed people's calls for assistance were promptly responded to.

People made positive comments about the staff team. They said, "Staff are very efficient", "Staff are lovely; they work very hard" and "Staff are very good; they often bob in for a quick chat or just to check I am alright". Comments from staff included, "We have a good team" and "It's a good place; it can be hard some days but I love it".

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

We looked at this outcome as we received information from a whistle blower that new staff were not given induction training or moving and handling training. We were also told care staff were administering medicines without training.

We looked at two staff records and found evidence of an initial induction which included an introduction to the home, safe working practices, policies and procedures and practical moving and handling instruction. There was a training plan that showed all staff received a range of appropriate training, including moving and handling, medication and dementia training. This should help keep them up to date and give them the necessary skills and knowledge to look after people properly.

We spoke with five members of staff who confirmed there was an in depth induction programme for new staff which included a period of working with another more experienced member of staff. Staff told us, "We get the training we need", "Only the nurses and certain care staff are trained to give medicines" and "We have regular moving and handling training. We learn how to move people safely and how to use the equipment safely". Most of the care staff had a recognised qualification in care which showed the organisations commitment to improving standards.

Staff told us they were supported and were able to discuss their day to day concerns with the manager. Regular supervision helped to identify any shortfalls in staff practice and would identify the need for any additional training and support. The provider may find it useful to note there were no records to support the assessment of staff practice following training. This meant it was difficult to determine whether staff were competent in certain practical tasks such as medication administration or moving and handling. The manager agreed to review this.

Staff were provided with a contract of employment, job description, staff handbook and a range of policies and procedures to support them with their work. This should help staff to understand their role and responsibility within the organisation. Staff told us they were kept up to date and encouraged to share their views and opinions at regular meetings. They were confident they could raise any concerns and would be listened to.

The registered manager was responsible for the day to management of this home. She was supported by the owner. One member of staff said, "You can talk to the manager or the owner, they are both very approachable".

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

people's comments and complaints were appropriately responded to.

Reasons for our judgement

The complaints procedure was provided at the time of admission and was displayed around the home. People who used the service, and their visitors, were encouraged to discuss any concerns during meetings, day to day discussions with staff and management, reviews and also as part of the annual survey.

People told us they had no complaints about the service and felt confident they could raise any concerns with the staff or managers. Comments included, "I have nothing to complain about but I would speak to the manager if I was unhappy", "I'm very happy; it's not home but that is how it is" and "I'm always asked if I am okay; I am given lots of opportunities to discuss any concerns I might have".

Records showed there had been one complaint made in 2013. Records showed people's complaints were fully investigated and resolved, where possible, to their satisfaction. People were given the support they needed to make a comment or complaint. Complaints were monitored and the information was used to improve the service. However, the provider may find it useful to note that whilst we found some people's minor concerns had been recorded in the individual's care plan, there were no clear records to determine whether appropriate action had been taken, whether there were recurring problems or whether the information had been monitored and used to improve the service. We discussed this with the manager who assured us clearer records would be maintained of people's concerns.

We found there were a number of 'thank you' cards and compliments letters. Comments included, "Staff were sensitive and caring and much appreciated" and "We appreciate your kindness".

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's records did not accurately reflect their needs or the care and support being given which could result in inappropriate care.

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

During a recent visit to the service the local authority reported they had found damage to a person's record and had found some gaps in the way that information was recorded.

During our visit we looked at various records which the provider needed to maintain to protect people from the risks of unsafe or inappropriate care and treatment.

We looked at four people's records, spoke with staff and people living in the home and observed staff practice. We found the records did not always reflect the care and support being given as there were a number of gaps in the way that information was recorded.

For example, records showed that a number of people living in the home were unable to make decisions about their care for themselves but records relating to their care were unclear about the reasons behind 'best interest' decisions taken by staff.

We found records did not always reflect the equipment in use or the care and support being given to reduce any identified moving and handling risks or development of pressure sore risk.

There were no records of meals served or of people's choices on Grane View. There were no records to support suppers, snacks and drinks had been provided to people on either unit. This meant it was difficult to determine whether people's nutritional needs were being met.

We found the information in the daily reports was not detailed enough to reflect that people's needs or choices were being met.

We did not find any damaged records but we did find some pages that were 'loose' in the care plans. We discussed this with the manager as there was a risk they could be separated from the main files. The manager agreed to review this.

We discussed our findings with the registered manager following our inspection. We were told a full review of the information in people's care records had commenced.

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 activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: People were placed at risk of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained. Regulation 1(a)

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 02 October 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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