Inspection Report

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

Dauntsey House

9 Church Street, West Lavington, Devizes, SN10 4LB

Tel: 01380812340

Date of Inspection: 25 January 2014

Date of Publication: February 2014

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
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Dauntsey House Care Limited
Registered Manager	Miss Lucy Caroline Anne Corbin
Overview of the service	Dauntsey House provides accommodation and care for 20 older people, some of whom may have 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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	4
Our judgements for each standard inspected:	
Consent to care and treatment	5
Care and welfare of people who use services	7
Cleanliness and infection control	9
Staffing	11
Records	12
About CQC Inspections	13
How we define our judgements	14
Glossary of terms we use in this report	16
Contact us	18

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 25 January 2014, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. One person living at the home said "you don't have to go out, it's up to you".

One person living at the home said "staff are so nice, there is never any difficulty, they are always willing to help". One person's relative said "it's first class, they are good at encouraging people to interact with activities in the home and locally".

There were effective systems in place to reduce the risk and spread of infection.

There were enough qualified, skilled and experienced staff to meet people's needs.

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

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.

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. We spoke with four people living at the home. All said that staff asked for their opinions and carried out their wishes where possible. One person said "they are always very good, I always get a say". Another person said "If I say 'I don't want food', they say 'what do you want instead?' You can order different meals".

We spoke with two relatives of people living at the home. They both confirmed that people were offered choice and that consent was sought for care and treatment. One person said "they are involved with decisions, I've seen that when I'm at the home".

We observed staff members asking people for consent before providing care and support. We saw staff asking people if they would like to participate in a quiz and respecting their wishes. We also observed staff knocking and waiting to be invited in before entering people's bedrooms. We spoke with one staff member who explained how they would seek consent from people living at the home and, where appropriate relatives, for photographs to be taken of activities taking place at the home.

We reviewed four people's care plans. We saw that consent forms had been completed and signed by people living at the home for areas including personal care, support to take medication, and sharing information with external professionals involved with the person's care. We saw that in one file it was documented that the person had declined to sign a form as they did not wish to provide consent to participate in a particular activity. The deputy manager explained how this person's choice was respected.

We saw that that "do not attempt cardiopulmonary resuscitation" forms were present in two people's files. In one case it was stated that the decision had been fully discussed with the person living at the home, involved staff, and the GP. In the other form it was reported that the person was not deemed to have capacity and that a decision was made in the person's

best interests with relatives, staff, and the GP. We saw that in a third person's file it was documented that the person living at the home had not wished to discuss the issue of resuscitation. It was indicated on the form that staff had respected their wishes about this.

The manager and deputy manager explained that if there were concerns that a person did not have mental capacity then a capacity assessment would be conducted by staff within the home or by an external professional as appropriate. They said that if a person did not have capacity to make a decision then this was made in their best interests. They said that this would occur through discussion with relatives, staff, external professionals, Lasting Power of Attorneys, and independent Mental Capacity Act advocates as appropriate.

The manager and deputy manager showed us the Mental Capacity Act assessment forms used by the home. We reviewed completed forms in two files. We saw that these forms did not indicate the specific decision that was being considered in the assessment. The manager and deputy manager both confirmed that capacity assessments were conducted in relation to specific decisions for people living at the home. The manager stated that she had already began review different documentation formats and sought advice from external healthcare agencies to ensure that specific decisions about mental capacity were clearly documented in the paperwork.

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

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. We spoke with four people living at the home and all were positive about the care and support offered. One person said "everyone is so kind, activities are exceptionally good". Another person said "I can go to staff if I have any worries". A third person said "they all know what help I need, they look after me, night staff couldn't treat me better".

We spoke with two relatives of people living at the home and they were also positive about the care provided. One relative said "I can't fault the care". Another relative said of the staff "I have never met such nice people". They then said that their relative was "always beautifully dressed, nice and clean, and well fed".

We observed interactions between staff and people living at the home. We saw that these were friendly, supportive, and respectful. We observed staff supporting someone who was distressed and helping them to feel reassured and become calmer. We saw that rooms were personalised and homely and that people living at the home appeared well presented.

We saw that a timetable of activities for the week was present on the board in the hallway. This detailed a range of events such as attending church, coffee mornings, chats, and visits from the hairdresser. We spoke with the activities coordinator, four people living at the home, and two relatives. All confirmed that a variety of activities were available within the home and in the community. The activity organiser described events such as flower arranging, walks, and poetry. We observed that activities took place during the day such as a quiz and a Burns night meal.

We reviewed three people's care files. We saw that these contained risk and needs assessments and care plans. These covered a variety of areas such as communication, cognition, emotional needs, washing and dressing, mobility, eating, continence, and breathing. We also saw that files contained personal information sheets which included details of people's families, life history, preferences, and likes and dislikes.

We saw that monitoring sheets were completed in line with individual care plans, such as food intake monitoring, pressure area monitoring, and monthly weight charts. We saw also observed evidence of visits from involved health and social care professionals, including nurses, GPs, and chiropodists.

We saw that information relevant to people's care needs had been included in the handover book and in the daily notes completed by staff. We saw that staff on each shift had signed the handover book to confirm that they were present at the handover. We spoke with the manager, deputy manager, and one staff member. All stated that they felt that care plans and handover provided sufficient information to enable staff to adequately support people at the home.

There were arrangements in place to deal with foreseeable emergencies. We saw that a signing book was present in reception. We observed procedures in the event of a fire were displayed around the home and that personal evacuation plans were present in two of the three files we reviewed. The deputy manager explained that they had completed the personal evacuation plan in the third case and that they would ensure that a copy was replaced in the file as soon as possible. The manager and deputy manager showed us a hospital transfer form that was completed by staff if someone needed to be admitted to hospital. The manager explained that she or the deputy manager were on call to provide advice at any time.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection. We conducted a tour of the home and inspected bedrooms, communal areas, staff areas, bathrooms and toilets, the kitchen, and the laundry area. We saw that these all appeared clean and equipment used in the home for supporting people also looked clean. We also observed that cleaning was in progress on the day of the inspection. We saw that adequate supplies of soap, hand towels, antibacterial hand gel, and personal protective equipment was located around the home in appropriate places.

We spoke with the cleaner. They showed us a list of areas and items that were cleaned on a daily basis and described the process of cleaning the home. We saw that cleaning staff had signed to state the areas of the home that had been cleaned each day. The cleaner also showed us of a list of cleaning duties for the night staff which had been signed to show that they had recently been completed.

We reviewed the infection control policy at the home and this contained relevant information. The infection control lead explained that if someone did have an infection then a risk assessment would be conducted and if appropriate the person would be would be cared for in their bedroom until the infection had passed. They stated that staff would wear personal protective equipment to support the person and the GP would be contacted.

The infection control lead also explained that staff were asked not to come in for a set time period if they had an infection. We observed a sign on the front door asking people not to visit if they had symptoms of norovirus. The sign also requested that all visitors use hand gel on entering the home which we saw was available in reception.

We spoke with two staff members and the manager and they explained that black bags were used for disposing of rubbish, and that soiled waste was put in a bag and then disposed of in the black bags. The manager and staff members stated that district nurses took dressings away with them and disposed of them elsewhere. They explained that laundry was put in white bags and soiled laundry in red bags. We observed that this system for distinguishing between items was apparent in the laundry room.

The manager stated that people at the home had not had infections for a long period of time. She said that if anyone developed an infection, then a system would be arranged for washing the person's laundry separately, disposing of infectious waste separately, and having it immediately removed by an external company. The infection control lead confirmed that no infections had taken place at the home in the past year and showed us the annual infection report which also stated this.

The infection control lead showed us evidence of a variety of audits for cleanliness and infection control which had been completed on a weekly, monthly, and quarterly basis. They also described how they would participate in training and liaise with other professionals to ensure that their knowledge remained up to date.

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

The deputy manager explained staffing requirements for early, late, and night shifts. They explained how one senior staff member would need to be present on each shift to administer medication. They also described the requirements during each shift for care staff, kitchen staff, domestic staff, and staff to organise activities. We reviewed rotas for the past two weeks and saw that this allocation had been met.

The manager explained that staff did not often call in sick, but that if they did then cover would be provided by existing staff. The manager and deputy manager stated that they did not ever employ agency staff.

We spoke with four people living at the home and all said that they felt that there were enough staff to ensure that their needs were met. One person said "staff come quickly if needed, you only have to pull the bell and they're there". We also spoke with two relatives of people living at the home and both said that they thought that there were enough staff to meet people's needs.

The deputy manager and manager described the process for ensuring that staff received adequate support supervision. The deputy manager showed us a supervision folder where a log of supervision was recorded and signed by the supervisor and supervisee. We spoke with one staff member who said "I can't fault the manager or other staff, I can contact the manager at any time of day".

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. We reviewed three files of people living at the home. We observed that information within the files was legible and entries by staff members had been written in pen, dated, and signed. The manager explained that the format of files was currently being reviewed so that care plans were typed rather than handwritten so that they were easier to read. We reviewed one of the files in this new format and saw that information was clear.

We observed records relating to the management of the premises had been maintained. We also saw that records relating to staff employment, rotas, and supervision were present.

Records were stored securely. We observed that care plans and files for people living at the home were stored in a locked office. Staff confirmed that the office was usually kept locked, but that they were able to access files as needed.

The manager and deputy manager explained that some information relating to people living at the home was stored on the computer. They said that this was password protected and only people who needed to access it were given the password such as senior care staff, the manager, and deputy manager.

The manager and deputy manager told us that confidential information was disposed of in the incinerator. The manager told us that information that was no longer current was securely archived in a locked office. She said that she had not destroyed any information since she had been in post. She stated that decisions for how long records should be kept would be made through discussion with the provider and with reference to relevant guidelines and policies.

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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