Review of compliance

Alton House Partnership Alton House Care Home - Hayling Island	
Region:	South East
Location address:	37 St Leonards Avenue Hayling Island Hampshire PO11 9BN
Type of service:	Care home service without nursing
Date of Publication:	March 2012
Overview of the service:	Alton House is a care home without nursing. The home is registered to accommodate 18 people. It provides personal care for older people who require long term care and older people with mild to moderate dementia.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Alton House Care Home - Hayling Island was meeting all the essential standards of quality and safety.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review as part of our routine schedule of planned reviews.

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 20 January 2012, checked the provider's records, observed how people were being cared for, talked to staff, reviewed information from stakeholders and talked to people who use services.

What people told us

We spoke with three people who use the service and they told us that they liked living there. One person told us the home was "like one big family." Another person told us: "I like being here." One relative told us: "My dad loves it here. He seems to be more settled and the staff go out of their way to take care of him."

What we found about the standards we reviewed and how well Alton House Care Home - Hayling Island was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

People who use the service were treated with care and respect. There were systems in place to ensure that their privacy, dignity and independence was maintained. Overall, we found that Alton House had met this essential standard.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

The home had carried out an assessment of the needs of people who use the service. Care plans were in place and risk assessments had been completed and reviewed. People received care that met their needs. Overall, we found Alton House had met this essential standard.

Outcome 07: People should be protected from abuse and staff should respect their human rights

Staff had received training in safeguarding vulnerable people and were of the aciton to take if they suspected that abuse had occurred. This meant people who use the service were protected from the risk of possible abuse. Overall, we found Alton House had met this essential standard.

Outcome 14: Staff should be properly trained and supervised, and have the chance to develop and improve their skills

The home had systems in place to ensure members of staff received the appropriate training, supervision and appraisal to enable them to deliver care and treatment to people who use the service. Overall, we found Alton House had met this essential standard.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

The home had systems in place to monitor the quality of care provided to people who use the service. It involved people and their relatives in the service. Overall, we found Alton House had met this essential standard.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

The provider is compliant with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
People living at Alton House told us that they were supported and enabled to do things for themselves. They felt that members of staff always respected their wishes and provided help when they needed it. We spoke with three people who told us that they were able to express their views and felt involved in their care.

Other evidence
During the visit we spent time completing a Short Observational Framework for Inspection (SOFI). This was designed to record the experiences of people who would not be able to report them to us in a conversation or written survey. We used the SOFI because this service provided support to people with dementia. During the observation we saw examples of good staff interactions with people who use the service. For example, they asked people whether they wanted to join in with activities, responded to questions and supported people to make choices about drinks and snacks. We also saw a member of staff ask one of the residents if he wanted to go to rest after dinner and he declined.

During our visit all interactions we saw between members of staff and the people living at the home were respectful. We saw help was offered and provided in a way that

ensured people's privacy and dignity were respected. For example, we saw that members of staff knocked before entering people's bedrooms. We saw people were spoken with in a sensitive, respectful and professional manner

We saw people being helped with courtesy and obtaining their permission. For example, a member of staff explained to a person using a wheelchair that she was going to remove the footplates and reposition the person's feet. The person nodded his head in agreement and the task was carried out. Another person needed special equipment to eat his meals and this was recorded in his care plan. We saw that during dinner, he was provided with the specialist equipment that helped him be independent.

Care plans had been developed for each individual and provided detailed information to members of staff on how people preferred things to be done. We spoke with three members of staff who told us that it was people's own choice what time they woke up and request the assistance they wanted for their personal care. All such requests were noted in the care plans. Care plans we reviewed also had details about people's capacity to make decisions about the care provided. The care plans gave guidance about whether people were able to make their own decisions about the care and support they required or whether best interest decisions needed to be made on their behalf.

During our inspection we saw some people were able to spend their day how they wished to. For example, the home had a quieter lounge area off the main lounge where we saw four people resting. We spoke with one person who told us he liked to go there when the rest of the people were undertaking various activities. The home also organised regular residents and relatives meetings. We spoke to one relative who told us that whilst she was unable to attend these meetings, she was able to share any of her concerns with the registered manager and was confident that these would get resolved.

Our judgement
People who use the service were treated with care and respect. There were systems in place to ensure that their privacy, dignity and independence was maintained. Overall, we found that Alton House had met this essential standard.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
People we spoke with said they received the care they needed. One person said he had been consulted about his needs when his care plan was being developed. He told us: "They (members of staff) always come and ask how I want things done."

Other evidence
The registered manager told us that people's needs and preferences were assessed before they arrived at the home. We saw that this information was documented in people's care plans. The care plan recorded people's preferences regarding, for instance, how they wanted to be addressed, what they liked to eat and foods they did not like. It included a detailed history of the person using the service including their work and life experiences, places they had visited, countries they had lived and pictures of their family.

During the visit, we looked at six people's care plans. Each person had a set of plans that provided guidance about how their needs should be met. People and, where appropriate, their representatives had been involved in the care plans and had signed them to confirm their agreement. Members of staff told us that they found the plans useful and said they were always updated when people's needs changed. For example, one person recently requested he wanted to have a bath rather than a shower. We saw this request was recorded in his care plan and a record of when this was given was also noted.

The care plans contained information about risks assessment that had been

undertaken. For example, one person's mobility care plan identified that she was more likely to start walking without using her walking frame. We saw her care plan contained guidance about how members of staff should support the person to prevent the risk of them falling..

We spoke with members of staff who demonstrated a good understanding of people's needs and how these should be met.

The care plans we inspected had been reviewed monthly and updated by the deputy manager. Each person also had an appointed key worker. The role of the key worker was to be the first point of contact between the family and the person using the service.

The registered manager undertook monthly audits of all care plans. In a recent audit, she identified that care plans needed to be restructured. The home has now identified a new system for recording of information in care plans and we were told that a new format of care plans will be implemented as of 1 March 2012.

The home arranged for regular visits from other healthcare professionals such as GPs, chiropodists, district nursing, community psychiatry nurses, opticians and others. Each care plan we looked at recorded such visits. We spoke with a local district nursing team who told us that they had no concerns about the care provided in the home.

During the inspection, we saw members of staff interacting with people in a friendly and respectful manner. We saw people enjoyed the exercise activity provided in the main lounge. We saw a member of staff working with each resident undertaking various activities including exercises such as kicking a ball, exercise stretches, and others. There was a weekly activity chart that highlighted the activities provided by the home. These included entertainers who visited the home regularly, chaplains who offered communion to people, hairdressers and others.

Our judgement
The home had carried out an assessment of the needs of people who use the service. Care plans were in place and risk assessments had been completed and reviewed. People received care that met their needs. Overall, we found Alton House had met this essential standard.

Outcome 07:
Safeguarding people who use services from abuse

What the outcome says

This is what people who use services should expect.

People who use services:
* Are protected from abuse, or the risk of abuse, and their human rights are respected and upheld.

What we found

Our judgement

The provider is compliant with Outcome 07: Safeguarding people who use services from abuse

Our findings

What people who use the service experienced and told us
People told us that they felt safe living in the home. People we spoke with told us that the manager was always "there" and if they had any concerns, they could go to her and it would be "sorted."

Other evidence
The registered manager told us that safeguarding vulnerable adults was taken seriously and people were treated with dignity and respect. The home had a safeguarding of vulnerable adults policy. The manager told us that all members of staff received regular training and updates on how to detect signs of abuse.

During the visit, we spoke with three care assistants. One care assistant had started recently (September 2011) and had received safeguarding of vulnerable adults training as part of her induction. She told us that she was aware of how to detect signs of abuse. We checked the records of all members of staff and found that they had received training in safeguarding vulnerable adults in 2011.

Members of staff we spoke with showed a good knowledge about how to safeguard people from abuse. For example, they were all aware of the Care Quality Commission (CQC) Whistleblowing guidance that they had seen on CQC's website. They were aware of their own whistleblowing policy and had been given information about how to report concerns to other agencies, such as the local authority safeguarding unit. We found that the home reported any concerns appropriately and attended local authority safeguarding meetings when required. Members of staff we spoke with told us that

they would would report any safeguarding concerns to the manager or the deputy manager and were confident that action would be taken as a result.

Our judgement
Staff had received training in safeguarding vulnerable people and were of the aciton to take if they suspected that abuse had occurred. This meant people who use the service were protected from the risk of possible abuse. Overall, we found Alton House had met this essential standard.

Outcome 14:
Supporting staff

What the outcome says

This is what people who use services should expect.

People who use services:
* Are safe and their health and welfare needs are met by competent staff.

What we found

Our judgement

The provider is compliant with Outcome 14: Supporting staff

Our findings

What people who use the service experienced and told us
People told us that members of staff were kind and helpful. One person told us that members of staff "treat you with kindness."

Other evidence
The home employed 12 carers. Six carers had National Vocational Qualification (NVQ) in care at level 2 and four carers had NVQ at level 3.

An external training organisation managed the induction standards for new members of staff. Members of staff told us that they received support from the training organisation and once they were considered competent, they received their certificates that confirmed that they had completed the induction programme.

During the visit we inspected the home's training records for all members of staff. These records demonstrated that members of staff took part in a range of training courses such as dementia care, nutrition, prevention and early detection of pressure sores, palliative care, continence care, infection control, prevention of falls and others. The registered manager told us that the external training organisation met with her regularly to identify training needs. They had jointly designed a training programme to meet the needs of staff. The registered manager had a matrix of all training that members of staff had completed and there was a system to identify when refresher courses were needed.

Members of staff we spoke with received regular ongoing supervision every two months from the registered manager. Each member of staff had an individual supervision file

that recorded when the supervision had taken place. Members of staff told us that these sessions were valuable and they felt well supported. All twelve members of staff had also received an appraisal in 2011.

The home was in the process of developing individual learning and development plans for each member of staff. These will be linked to their supervision and appraisals. They were recently provided with a template that will be rolled out for all members of staff beginning February 2012.

Our judgement
The home had systems in place to ensure members of staff received the appropriate training, supervision and appraisal to enable them to deliver care and treatment to people who use the service. Overall, we found Alton House had met this essential standard.

Outcome 16:
Assessing and monitoring the quality of service provision

What the outcome says

This is what people who use services should expect.

People who use services:
* Benefit from safe quality care, treatment and support, due to effective decision making and the management of risks to their health, welfare and safety.

What we found

Our judgement

The provider is compliant with Outcome 16: Assessing and monitoring the quality of service provision

Our findings

What people who use the service experienced and told us
People told us that they were asked for their views about the service. Two people remembered completing a survey about the service.

Other evidence
The registered manager told us that there were two ways the home assessed and monitored the quality of the service provided: The registered manager undertook three monthly formal audits of various areas such as the environment, care plans and others. Through these audits, the registered manager identified areas for improvement. For example, an audit of falls had recently beeen carried out (December 2011) and there were plan to share the findings with members of staff to identify what actions could be taken to prevent them from occurring. We saw these were going to be discussed at the monthly staff meeting at the end of January 2012.

The home also had an external consultant who visited the home four times a year to assess the quality of the service. These were unannounced visits and the registered manager was provided with a set of actions, which were followed up a few weeks later by a visit from the nominated individual. We saw the most recent report and the registered manager told us the actions that had been completed. For example, as previously mentioned, the home was in the process of developing individual learning and development plans for each member of staff. These were identified as an action from the external quality assurance visits.

The home recorded any adverse events and action had been taken to prevent such

incidents occurring again. For example, there was a recent incident where a pressure sore was not detected early enough. As a result, the home instituted a training programme for all members of staff on the prevention and early detection of pressure sores.

The home also received regular feedback from relatives. As a result of feedback from families (January 2011), the home was now planning to undertake a major refurbishment programme beginning in Summer 2012 that would increase the size of the kitchen, the living room, the dining areas and provide people with en-suite shower facilities. Annual surveys were undertaken annually with the next one planned for February 2012. We spoke with the registered manager who told us that people using the service and their relatives had been involved in the planning of the refurbishment programme,for example, in the selection of paint and carpets in the room. As mentioned earlier, the home also organised regular residents and relatives meetings.

Our judgement
The home had systems in place to monitor the quality of care provided to people who use the service. It involved people and their relatives in the service. Overall, we found Alton House had met this essential standard.

What is a review of compliance?

By law, providers of certain adult social care and health 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 Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

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