Review of compliance

Portelet Care Limited Portelet House Care Home	
Region:	South West
Location address:	22 Grand Avenue Southbourne Bournemouth Dorset BH6 3SY
Type of service:	Care home service without nursing
Date of Publication:	July 2012
Overview of the service:	Portelet House is a care home service without nursing and it is registered to accommodate up to 14 people. The home provides a service for older people with enduring mental health problems including dementia.

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

Our current overall judgement

Portelet House Care Home was meeting all the essential standards of quality and safety inspected.

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 because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 12 June 2012, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

We carried out an inspection visit to Portelet House on Tuesday 12 June 2012 because we had received information from an anonymous source. It alleged that people living in the home were being neglected, receiving a poor standard of care and their dignity was being compromised.

We used a number of different methods to help us understand the experiences of people using the service. This was because they had complex needs which meant they were unable to tell us what it was like to live at Portelet House. For example we spent almost an hour watching and observing the help and support people received. We also spoke to the relatives of three people and telephoned a health care professional who regularly visited the home.

We looked at the records the home kept about five people including two of the people we observed and whose relatives we spoke with. We also spoke with three staff who were on duty at the time of our inspection visit. This was in order to see what they knew and understood about the care needs of the people whose records we looked at.

We noted that staff generally encouraged and supported people appropriately.

All the visiting relatives we spoke with told us they visited the home regularly. The relatives of two of the people living at the home expressed very positive views about the home and the care their relatives received. The third relative expressed several concerns.

A health care professional who visited the home frequently told us that they had no concerns about the home. They said that in their view people were well looked after. They told us the staff were observant and skilled at identifying problems that required their help.

What we found about the standards we reviewed and how well Portelet House Care Home 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

Appropriate arrangements were in place where because of their frailty people's own views could not be taken into account in the way their care was provided.

People's privacy, dignity and independence were generally respected.

The provider was meeting this standard.

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

People experienced care, treatment and support that met their needs.

The provider was meeting this 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.

Where we judge that a provider is non-compliant with a standard, we make a judgement about whether the impact on people who use the service (or others) is minor, moderate or major:

A minor impact means that 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.

A moderate impact means that 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.

A major impact means that 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.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary changes are made.

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
We were unable to speak to people using the service about this outcome because of their physical and mental frailty. We gathered evidence of people's experiences by talking to visiting relatives, observing the help and support people received and also by looking at relevant records and documents.

Other evidence
We looked at the records the home kept about five of the people who lived there. We saw that care plans included details about individual's lifestyle preferences and likes and dislikes. This showed that the home promoted individualised or person centred care.

We also saw documentary evidence that relatives had been involved in decisions about the care of individuals. These included the use of bed rails to protect them from harm and resuscitation in the event of a serious and life threatening illness. We noted that relatives had also signed care plans. This showed where people had been unable to be involved in making decisions about their care and treatment appropriate arrangements had been made to ensure their rights were upheld.

Two of the three visiting relatives we spoke with told us that they had been fully

involved in decisions about the care and treatment their relatives received. One relative said, "I sit down and talk about his care with the manager and I have also been asked about flu jabs".

We observed how people were helped and supported for almost an hour in the home's lounge/diner before and during the main meal of the day. We saw staff generally treated people with dignity and promoted people's independence. We noted one person was sensitively reassured when they were distressed and upset.

The provider may find it useful to know that saw one member of staff undermine people's dignity. The individual concerned used the inappropriate and demeaning expression "good girl" when helping a person to eat. We observed them accidentally stand on another person's foot and fail to acknowledge what they had done. We saw them put a bowl with a food down in front of another person abruptly and without any explanation or description. They also failed to take action when a person they had helped to eat inappropriately put a spoon they had been using into a glass of juice they were drinking. We later observed another member of staff remove the spoon and replace it and the person's drink.

Two of the three visiting relatives we spoke with told us that they thought the staff treated their relatives with respect and their independence was promoted. One relative who told us they spent a lot of time in the home said, "I came in for a whole day and watched how staff looked after my mother. I could not believe it they treated her as if she understood everything. They explained everything to her before they helped her. It was not just, alright love and then get on with it".

Another relative said, "They don't automatically feed him but they encourage him to retain his independence".

One visitor told us that on one occasion they observed their relative's dignity and privacy being undermined when staff had not used a screen in the home's lounge. They also said that in their opinion, "A lot of eastern Europeans seem harsh in their manner. I do not think people need to be spoken to harshly".

We spoke to staff about the procedures they used when they had to check if a person needed help with specific care needs. They told us they either took people to their bedrooms or used a screen to provide privacy.

The evidence above showed that people's dignity and privacy were usually promoted.

The actions of one member of staff that had comprised the dignity of people were brought to the notice of the registered manager. She told us that she would address them with the person. She said that the individual's role did not normally include providing help directly to people living in the home. She told us that consequently the person's training had not included the fundamental principles that underpin social and health care such as dignity and independence.

Our judgement
Appropriate arrangements were in place where because of their frailty people's own views could not be taken into account in the way their care was provided.

People's privacy, dignity and independence were generally respected.

The provider was meeting this 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
We were unable to speak to people using the service about this outcome because of their physical and mental frailty. We gathered evidence of people's experiences by talking to visiting relatives, observing the help and support people received and also by looking at relevant records and documents.

Other evidence
The evidence set out below shows that people's needs were assessed and help, support and treatment was planned and delivered in line with their care plans in a way that ensured people's safety and welfare.

We looked at records and documents the home kept about five people living at the home including those of two people whose relatives we spoke with.

The documents we looked at included assessments of the needs of individuals and risks to their welfare such as developing pressure sores and malnourishment. We saw there were plans in place to meet those needs and manage the risks. We also saw that care plans and the assessments upon which they were based were reviewed every month. This ensured that the information in the plans was up to date and accurate and enabled a person's condition to be monitored. For example the home used the malnutrition universal screening tool (MUST) a nationally recognised method for assessing a person's nutritional risks and it required that an individual be weighed wherever possible as part of the assessment. This ensured that weight gain or loss could be quickly identified.

Other documents we saw showed that care plans were being followed and included daily notes, turning or repositioning charts, food and fluid charts and medication administration records (MAR). The documents we looked at were all completed and up to date. They showed that actions staff were required to take, such as repositioning a person to prevent them getting a pressure sore were being carried out in accordance with their care plan. Records showed that that people at risk of developing pressure sores were being turned or repositioned with the frequencies set out in their care plans. We also noted that pressure relieving equipment including air mattresses or pressure relieving cushions were in place and used for these people in accordance with their care plans.

The registered manager told us that at the time of our visit one person was being treated by the district nursing service for sores that had been a "long standing" problem.

We telephoned and spoke to a district nurse who visited the home regularly. This was in order to manage some of the health care needs of people living there. The nurse told us that the community nursing team had no concerns about the home and that in their view people were well looked after. The nurse said that one person they called to see "Would not have lasted as long as they have without the care given by the staff". They also said that the home's staff were observant and quickly identified potential health problems.

A visiting relative told us that they knew that any indication or hint of a problem and the home's staff arranged for treatment to be provided as quickly as possible.

We observed the help and support people received in the home's lounge and dining room for about one hour before and during the main meal of the day. We specifically noted that one person whose care plan we looked at was provided with a special diet and encouraged to drink fluids in accordance with their plan.

We spoke with two care staff about the needs the five people whose care plans we looked at. It was apparent that they knew what support and help each person required and would be able to ensure their needs were met.

One visiting relative expressed concern about the length of time their relative was left before they were assisted with toileting. We telephoned and spoke with a district nurse who visited the home regularly about the continence products prescribed for people in the home and the frequency with which people received help with toileting. They told us that the home's staff appropriately followed the advice given about the use of continence products. This showed that the home's staff managed the specific needs of people based on advice they received from healthcare professionals.

Our judgement
People experienced care, treatment and support that met their needs.

The provider was meeting this 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.

Where we judge that providers are not meeting essential standards, we may set compliance actions or take enforcement action:

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. 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

Document purpose	Review of compliance report
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