Review of compliance

Hamilton Care Limited The Lodge	
Region:	Yorkshire & Humberside
Location address:	Westbourne Road Scarborough North Yorkshire YO11 2SP
Type of service:	Care home service without nursing
Date of Publication:	October 2012
Overview of the service:	The Lodge is registered to provide care and accommodation for a maximum of 38 people.

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

Our current overall judgement

##Report Error## Improvement actions should no longer be set

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 21 September 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 spoke with five people who lived at the home. They told us that the staff consulted them about their care. They added that they were enabled to live their lives as they wished, have outings and that visitors were made welcome. People told us they had good care and that they enjoyed the meals. They told us that they felt safe at the home.

What we found about the standards we reviewed and how well The Lodge 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

The provider was meeting this standard. People's views and experiences were taken into account in the way the service was provided and delivered.

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

The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

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

The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the

possibility of abuse and prevent abuse from happening.

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

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.

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 provider was meeting this standard. The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

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 spoke with three people and all told us that they had been involved in planning their care. One person told us that she had recently moved to The Lodge from another care home. She told us that the staff had spent time talking with her about her care needs which included her likes and dislikes, the people who were important to her and what she enjoyed doing. Another person told us that staff asked about her daily living decisions, for example, menu and activity choices.

Other evidence
People who use the service understood the care and treatment choices available to them.

The manager told us that people were consulted before admission during the assessment process, to ensure that they had sufficient information to make an informed decision about admission.

We saw evidence in written assessments and care plans that people's consent to their care and treatment had been sought. For example, people's likes and dislikes had been recorded. This gave details of choices in daily care. The provider may wish to note that of the four care plans we looked at, two were not signed to show that the person agreed

with the contents. However, we spoke with two members of staff who told us that people were consulted about their care. We observed staff speaking with people in an inclusive and respectful way. They asked people about their preferences for food and how they were assisted to move about the home.

Staff told us that they always treated people with respect and regard for their dignity and we saw that the home had a policy which included privacy and dignity. Consulting people about their care was included in each staff member's induction training.

Our judgement
The provider was meeting this standard. People's views and experiences were taken into account in the way the service was provided and delivered.

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 told us that they enjoyed their life at The Lodge and that they were enabled to have freedom in their daily routines according to their wishes. This included regular trips out of the home to take part in individual interests and to keep in contact with friends and relatives. People said they knew about their care plans and had been involved in developing them. One person told us that the staff would accompany them into the garden or into town for shopping. One person told us that the manager listened to suggestions and requests.

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

We carried out observations during the inspection visit which gave us some information about the way staff interacted with people living at the home. We observed two members of staff. Both asked people what they wanted to do, how they were feeling, whether they wanted assistance and where they wanted to be. Staff chatted with people in a kind and friendly way. They spent time with those who needed assistance to ensure they were comfortable. Staff were skilled at showing they were listening, often getting down to speak with people at eye level which ensured that people were given the attention they required.

Both staff we spoke with told us that their training had covered how to approach people with respect and that people's views were of central importance to their care. Staff also

told us that they were given time to spend with people, asking them about their choices.

People were also consulted in regular residents meetings. These meetings were documented and suggestions by people were recorded with examples of when these had been acted on.

We looked at four assessments and care plans with associated documentation. Care plans often included people's views on the way they wished to receive their care. For example, they included what people preferred to eat, wear, how they preferred to be dressed and their routines of daily living.

Care plans included both physical and mental health needs. They contained a personal history of each person which had been completed either with the person, a representative, or both. Plans included details on people's wishes for future care. This gave staff valuable information about the person, their likes and dislikes, their personality and what was important to them including interests and significant relationships. Staff said these histories were useful as a point of conversation and helped them to give focused and personalised care.

It was clear from examining daily notes and plans that people were enabled to take part in various activities according to their particular interests.

Daily notes contained professionally written information to help staff monitor people's well being.

Where appropriate, care files showed evidence that specialists had been consulted to ensure people had the benefit of expert advice and knowledge. The provider may wish to note that advice was not always incorporated into care plans, but was stored separately on file. Potentially, this information could be missed and people may not receive the correct care. Health care professional visits were recorded so that staff could note any interventions and advice. However, these visits were recorded in general notes, not separately. This meant that potentially, information could again go unnoticed by staff and have an adverse impact on people's care.

Risk assessments were in place to ensure people were protected from harm. Any risk assessments were included as part of the main care plan rather than being recorded separately. We spoke with the manager about the dependency levels of the people the home cared for. People were being admitted to the home with more complex care needs than in the past. This meant that care planning tools used by the home were in need of reappraisal to ensure people received appropriate care. The lack of separate risk assessments could lead to risks not being adequately assessed or minimised.

We saw reviews of care plans on file. These sometimes took the form of written notes and were not always incorporated into care plans. Overall care plans were not being used as a definitive document which staff could consult for up to date information about current care needs. The provider may wish to note that this meant staff had to read through the whole file to ensure they had the correct information to offer correct care. We noted there was a risk that staff may miss information. This could have a negative impact on people receiving the service.

Our judgement

The provider was meeting this standard. People experienced care, treatment and support that met their needs and protected their rights.

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 they felt safe at the home.

Other evidence
The provider responded appropriately to any allegation of abuse.

Staff said they had received safeguarding training and records confirmed this. They could also correctly explain what they should do if they suspected abuse. This ensured people who lived at the home were protected from harm and the risk of harm.

Staff did not have up to date training on mental capacity or deprivation of liberty safeguards. However, they could explain their responsibilities in relation to mental capacity and deprivation of liberty to ensure people's rights were upheld. The manager told us that she and the deputy had both completed this training and had cascaded the principles to staff. Also, mental capacity and deprivation of liberty training was planned for all staff. The provider may wish to note that a mental capacity assessment had not always been recorded on people's files where appropriate. Because of this it was possible that decisions could be made on behalf of a person who had capacity to decide for themselves.

We had written evidence that the home had notified us of safeguarding and other incidents which may affect the welfare of those living at the home so that suitable steps could be taken to protect them.

We saw evidence that the home had obtained Criminal Records Bureau (CRB) checks for staff working at the home. The manager explained what she would do if there were any issue on a CRB check. This ensured that people were protected from staff who were known to be unsuitable to work with vulnerable people.

Our judgement
The provider was meeting this standard. People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Outcome 14:
Supporting workers

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 workers

Our findings

What people who use the service experienced and told us
We spoke with five people who lived at the home but their comments did not relate to this outcome area.

Other evidence
Staff received appropriate professional development.

We saw the training and supervision records for three members of staff. Staff had received induction training and subsequent training in all core subjects including equality and diversity update training. This ensured that staff had the skills to offer correct care.

Staff told us they received good support from the manager and the senior members of staff. They also told us they were regularly supervised to ensure they continued to offer suitable care to people. Records showed that staff had received supervision and that this covered areas which promoted skill development and confidence.

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.

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
We spoke with five people who lived at the home. Three people told us they had confidence their concerns would be listened to, treated seriously and that something would be done to put things right straight away. The feedback from the remaining two people did not relate to this standard.

Other evidence
People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

The manager told us she carried out quality checks including health and safety. This included ensuring equipment was safe, that water temperatures were recorded and that risks for example in relation to the use of bed rails were audited. The pharmacy used by the home also carried out a regular audit of medication and recommendations from the latest audit had been implemented.

Surveys had been carried out in the past but these had been stopped because of poor response rates. However, the manager told us that residents were consulted about their care at reviews and in residents meetings. Staff confirmed that the results of quality checks were fed back to staff and people living at the home in staff and resident meetings. This ensured that the manager had systems in place to keep people informed about her plans. We saw written evidence of resident meetings notes and action points from these were recorded to ensure people had their suggestions acted upon.

The quality assurance system did not include regular internal audits of medication, to ensure inaccuracies were quickly rectified. There were also no written audits of care plans, pressure care, accidents or infection control. The manager told us that these areas were looked at periodically but that the results were not recorded. Although there was an improvement plan in place this was not written down. The provider may wish to note that this could make monitoring improvements problematic and could have an adverse effect on people living in the home.

The manager told us that she investigated complaints and recorded actions and outcomes. We saw a complaint policy and procedure and noted that this gave clear timescales and actions which would be taken to ensure people's complaints were resolved quickly.

We spoke with two members of staff who told us that the home treated complaints seriously and acted quickly to put things right.

Our judgement
The provider was meeting this standard. The provider had a system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

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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