Inspection Report

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

Allendale House

11 Milehouse Lane, Wolstanton, Newcastle-Under-Lyme, ST5 9JR

Tel: 01782627388

Date of Inspection: 28 December 2012

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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
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Mrs Marcia Anderson
Overview of the service	Allendale house provides accommodation and support to up to 17 older people.
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'.

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 28 December 2012, 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 talked with stakeholders.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We spoke with three people who used the service, two relatives and six members of staff. We also spoke with a visiting health care professional. People who used the service told us they liked living at Allendale House. One person said, "It's a nice place, some of the staff are really nice". Relatives we spoke with told us they were happy with the care their relatives received. One relative said, "X is looked after very well".

We saw that assessments had been made to identify if people had the ability to make decisions for themselves or if they needed support to do this. We also saw that decisions were made in people's best interests in consultation with their relatives and health and social care professionals.

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

People who used the service felt safe and staff had the knowledge and skills to identify and report any safety concerns. We saw that there was an effective complaints system in place which people and their relatives were aware of.

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.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We reviewed how the provider followed the principles of the Mental Capacity Act 2005. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability, in these circumstances other people can be authorised to make decisions on their behalf as long as they are in the person's best interests.

We looked at the care records for five people who used the service, spoke with four people and two relatives. We also spoke with six members of staff. We did this to help us understand the outcomes and experiences of selected people who use the service.

The care records we reviewed showed that mental capacity assessments had been completed for four of the five people. We asked staff about the missing mental capacity assessment. Staff told us this person's mental capacity status and informed us they would record this in the person's care records.

We saw evidence in people's care records that best interest decision's had been made in consultation with people's relatives and health and social care professionals.

One person's relative told us they were consulted with to gain consent for their relative to receive the flu vaccination. This relative told us that they said no to the flu vaccine as their relative had always refused it in the past. When we looked at this person's care records we saw that the flu consent form which was completed by staff recorded that the relative had consented to the person receiving the flu vaccine. We also saw that the person received the flu vaccine. This meant that the process to gain consent for the flu vaccine was not recorded accurately and we could not be assured that this decision was made in the person's best interests. We spoke to the registered manager about this, who told us they would investigate this further.

The provider may wish to note that we asked five care staff if they understood what was meant by the term 'mental capacity'. Only one member of staff was able to answer this

correctly. We looked at the staff training records and found that four of these five staff had received training in the Mental Capacity Act 2005, and one was booked onto training.

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.

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

Reasons for our judgement

People who used the service told us they were happy with the care they received. One person said, "The staff are good. They listen to you and try to help". Another person said, "It's alright here, I like how they look after me". People's relatives also told us they were happy with the care. One relative said, "I'm very pleased with the care".

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. We saw that people had regular assessments of their risk of skin breakdown and that their weight was monitored to identify any nutritional needs. Care records contained information around people's individual needs and care plans were reviewed regularly.

Staff we spoke with told us how they cared for people who used the service. This was consistent with people's care records. This meant people received care from staff who were aware of their individual needs.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Risk assessments and risk management plans were in place and were reviewed regularly.

Care records we looked at showed that people had access to health and social care professionals, such as; general practitioners, district nurses, and opticians. One relative we spoke with told us they were happy with the way staff were working with healthcare professionals. They said, "They're liaising with the community psychiatric nurse to sort out X's medication". This meant that people's health and wellbeing needs were being addressed.

We spoke to a visiting health care professional who told us that the staff at Allendale House referred to and communicated well with their service.

Safeguarding people who use services from abuse ✓ Met this standard

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

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.

Reasons for our judgement

We spoke with six staff about their understanding of safeguarding. Safeguarding means protecting people's health, wellbeing and human rights, enabling them to live free from harm, abuse or neglect.

People we spoke with told us they felt safe. One person said, "I have always felt safe here".

Staff we spoke with were able to describe common signs of abuse. We looked at the staff training records which confirmed staff had received or were booked onto safeguarding training. This meant that staff would be able to identify and report suspected abuse.

Care staff told us they would report suspected abuse to the registered manager. They were also aware of the whistle blowing policy. This meant that staff knew the correct procedure to share information about poor practice.

We spoke with the registered manager who told us they would report suspected abuse to the local authority safeguarding team. This meant that the registered manager would follow the agreed local safeguarding procedure in the event of a safeguarding concern.

The provider may wish to note that when we asked a senior carer how they would report suspected safeguarding in the event of the manager's absence, they were unaware of the correct procedure to follow. The member of staff told us they would report any suspected safeguarding issues to the Care Quality Commission. This meant that although the correct reporting procedure would not be followed, the concern would have been reported to an appropriate organisation who would forward concerns to the local authority.

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

During our inspection there was 13 people living at Allendale House. We spoke with the senior carer and registered manager who told us there were two members of care staff on duty at all times. We looked at two months staff rota's which confirmed this. The staff rota's demonstrated that shifts were always covered in the event of staff sickness.

One person who used the service told us that on the day of our inspection they had to wait until 11am to be assisted to get out of bed. We spoke to the registered manager about this and were told that care was prioritised according to need. For example, if a person required assistance following incontinence, this would be seen as a priority to address before assisting others. This meant the service were responsive to people's needs.

The provider may wish to note that one member of staff told us that evening meal times were busy as care staff had to prepare the evening meal, meet personal care needs, administer medications and clean up after the meal. We asked why the cook was not able to provide domestic assistance at meal times. We were told the cook works until 2pm and will prepare sandwiches and get items ready for hot meals. This meant that there was extra demands placed on the care staff during evening meal times.

To help us see what people's experiences were we used our Short Observational Framework for Inspection (SOFI). The SOFI allows us to spend time watching what is happening within a service and helps us to record how people spend their time and whether they have positive experiences. This included looking at the support that was given by staff.

We undertook a SOFI observation for a 40 minute period during the evening meal. We observed four people who used the service. The provider may wish to note the findings of this observation as the registered manager must ensure that appropriate steps are taken so that at all times there are sufficient numbers of staff to safeguard the safety and welfare of people using the service.

People ate their evening meal in the lounge area. There was a 20 minute gap between the first and the fourth person receiving their meals, meaning that the four people we observed were eating at different times. We observed that at times there was no carer in the lounge because staff left the room to answer telephone calls and responded to the door bell. This meant that at times people were unsupervised whilst eating. On one of these occasions

one person upset another by trying to take their pudding from them. Staff were not readily available to observe and respond to this. On one occasion a person shouted help as they had spilled their drink over their food tray. The member of staff in the lounge area at the time was interacting with another person at the other side of the lounge and did not respond to the call. This meant that at times during the evening meal people did not get the support they required.

We asked three people if they received their care in a timely manner. One person said, "Staff always help me, there is always enough staff around". Two people told us that on occasions they have to wait to receive care. One person said, "It's always, just a minute". This meant that some people using the service on occasions felt that they have to wait to receive care.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

There was an effective complaints procedure in place. Copies of the procedure were located in public areas and in people's bedrooms. This meant that the complaints procedure was readily available to people using and visiting the service.

The people we spoke with were able to tell us how they would complain if they were unhappy about their care. One person said, "The manager is approachable".

We spoke with two people's relatives who also told us how they would complain if they needed to do so. One relative said, "I would speak to the senior carer or the manager if I needed to".

We saw that staff had resolved and responded appropriately to complaints.

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 dentists and other services at least once every two years. 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 but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

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. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. 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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