

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

Hylton House

34 The Ridgway, Sutton, SM2 5JU

Tel: 02086612663

Date of Inspection: 15 February 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Ms Sarah Storey
Registered Manager	Mrs. Jenny Knight
Overview of the service	Hylton House provides personal care, support and accommodation for a maximum of six younger adults who have learning disabilities, physical disabilities and/or sensory impairment. The service provides 24-hour care and support and accommodation is provided over three floors. There is a lift and the home is suitably designed for people who use wheelchairs.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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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 15 February 2013, 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 carers and / or family members and talked with staff.

What people told us and what we found

Due to their complex needs, the people living at Hylton House were unable to share direct views about their care experiences. In order to make judgements about the care that individuals received, we observed care practices; staff interactions and checked three people's records of care. We met with the deputy manager and four members of staff. We also spoke to the relatives of three people. Comments from relatives included, "it's a lovely home, and the residents seem to be loved and well cared for" and "X gets the best possible care."

People living in the home have learning and physical disabilities, sensory needs and no verbal communication. During our visit we saw positive interactions between staff and people who use the service. People were offered choices, supported to feel involved and staff knew how they should respond to their communication styles or body language. We saw that people were relaxed and comfortable in their surroundings.

People benefitted from a stable staff team who have worked at Hylton House for several years. Relatives described the staff as "really, really nice", "very compassionate" and "warm, caring people." Staff told us that they were happy working at the home and felt well supported by the manager.

Plans of care were person centred, well created and closely reflected the specific needs of the person. People's needs were regularly reviewed to make sure they got the right care and support.

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

Respecting and involving people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People's privacy, dignity and independence were respected. People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People were able to express their views were involved in making choices about their care and treatment as far as possible. Although people using the service were unable to communicate verbally; we observed that staff were attentive and that people were given time to try and express their needs. Staff explained how they promoted choices and prepared different foods for people to taste, for example.

There were visual aids and objects of reference to help people identify with their surroundings and to help them recognise their daily routines. We saw that people had large photograph albums of activities, special events and outings.

We saw that people's choices and preferences were recorded and updated at regular intervals. Examples included support plans, health action plans and monthly keyworker reports. People's care needs, choices and preferences were recorded and written in a person centred way such as "things I like to do "and "how I communicate". This information helped staff make sure people were involved in daily decisions about their care.

As people could not make decisions for themselves, family members or representatives had been consulted. The provider had robust arrangements in place to support people and ensure that any decisions were made in their best interests. We saw an example where the service held discussions about how they could make sure people's best interests were represented. Decisions had only been made on their behalf within a multiagency framework, involving family members.

The provider may find it useful to note however that there were no records to confirm that people did not have the capacity to make decisions. This would be important when providing care to people who may not be able to consent for themselves. The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards provides legislation to protect people who are unable to make decisions for themselves.

People were supported in promoting their independence and community involvement. Each person had an illustrated activity planner based upon their needs and interests. Examples included swimming at a hydrotherapy pool, college, restaurants, cinema and visits to parks and places of interest. An aromatherapist visited the home on a regular basis and staff had been trained to use 'creative interaction therapy' to meet people's sensory needs. Activities included drama therapy and music sessions. A relative told us, "I was also amazed at the number of outings and activities that the residents participate in." Another relative told us their family member had been ice skating and that the home did "lots of things." During our visit one person was supported by their keyworker to attend a sport ability session at a local centre.

People's diversity, values and human rights were respected. People had the right specialist equipment to promote their independence and meet both their physical and sensory needs. This included objects of reference, hoists and slings, special beds and adapted wheelchairs. Care records included information about any specific ethnic or cultural preferences.

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 and protected their rights.

Reasons for our judgement

The people we met were not able to tell us directly about their care experiences; however we saw that their care and welfare needs were clearly recorded and staff knew how to support them. Most of the staff group had worked at the home since it opened and as a result, they knew people well. The low turnover of staff meant that people benefited from stability and consistent care.

Staff were attentive to individuals and were able to identify with the gestures and reactions that people gave, what these were likely to indicate and respond appropriately. People living in the home also had a range of complex healthcare needs that included epilepsy. The deputy manager and staff were knowledgeable about each person's personal and healthcare support routines.

Although people living at Hylton House had limited verbal communication, staff supported and encouraged people to be as fully involved as possible. Despite their physical limitations to actively take part, staff made sure people were included in what was going on by involving them in conversation and describing what was going on around them. We saw one member of staff prepare the evening meal and consistently chat with the person using the service. Other people listened to music in the lounge and staff encouraged each person to respond in their own way.

People's needs were assessed and care was planned and delivered in line with their individual care plan. We looked at care records for three people using the service. These looked at all areas of the individual's life in a person centred way. Each person had an accurate assessment of their needs that they and people close to them, had been involved in. Illustrated with photos and clear language, care plans reflected what was important to someone, their capabilities, and what support they needed. There were also guidelines and specific plans in respect of individual needs such as mobility, eating and drinking and epilepsy. Each person also had photographs and a communication passport. This guidance gave lots of detail about how a person expressed themselves and helped staff to interpret each person's body language and sounds and what it might mean.

Records told us that people's care plans were regularly checked and updated where necessary. Review meetings were held at least annually to make sure the service was still meeting people's needs properly. These involved care managers, family and other

representatives such as advocates to represent people's interests. Care records showed that each person had a named keyworker who produced a monthly report to evaluate whether goals and activities have been achieved and highlight any other significant events or issues. This meant that care plans were current and relevant to the person's support requirements. Relatives we spoke to confirmed that they were invited to meetings and were always kept informed of anything significant.

We looked at daily reports which gave a good overview of a person's daily experiences, activities, health and well being and any other significant issues. We saw that there were ongoing reviews of people's care needs and staff had updated them accordingly to meet individual changing needs and circumstances.

Care and treatment was planned and delivered in a way that ensured people's safety and welfare. There was correspondence which showed that the staff team worked closely with other professionals so that people received the healthcare services they needed. Records we reviewed included routine checks and appointments with other professionals such as the optician, dentist, dietician, GP, physiotherapist and consultant. This showed that staff made sure people's general health needs were regularly reviewed and met. Each person had a hospital passport which contained important information about how staff should communicate with the individual concerned along with medical and personal details. This document could then be taken to the hospital or the GP to make sure that all professionals were aware of people's individual's needs.

We saw that each person had a specific support plan for eating and drinking written by the 'Dysphagia' team from the local authority. The plan gave detailed guidance on how the person should be supported and the type of eating aids or equipment that must be used. It included pictures and photos and was also available as a place mat on the dining table for staff to refer to. This helped staff know how to support each person's physical needs and preferences and manage any risks.

There was evidence that any risks people may experience had been assessed and recorded. Individual assessments covered the full range of assessed risks and matched the needs of each person. Examples seen included personal care, eating and drinking, mobility, accessing the home / wider community and using the home's vehicle. There were specific risk plans associated with people's healthcare needs such as epilepsy, skin care and diet. This meant risks relating to people's health or welfare had been identified, assessed and managed.

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

Our judgement

The provider was meeting this standard.

People who used 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

People who used 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. Staff we spoke to demonstrated an awareness of the different types of abuse and what they must do should they witness anything untoward or poor practice. They were aware of what to look for and also what to do if they saw anything of concern. Staff told us that if they suspected abuse or were told about an allegation of abuse they would inform the manager immediately. This showed us that staff understood their responsibilities to protect the people who used the service and to report any concerns.

There were systems in place and relevant policies to safeguard people's welfare. The provider had clear procedures on safeguarding vulnerable adults including how to recognise abuse and what steps to take. There was also a whistle blowing procedure for staff and a copy of the London multi-agency guidelines was available in the office. In line with the guidance, the manager was appointed as the safeguarding lead and records showed that all other staff had completed relevant training. This included online training or 'e-learning' courses run by the local authority.

Records evidenced that the correct recruitment checks including a Criminal Record Bureau disclosure were made on staff suitability before they started work.

Our records reflect that no safeguarding incidents or allegations of abuse had been received by us at the time of this inspection. The deputy manager was aware of their duty to notify us about reportable events.

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

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.

Reasons for our judgement

Staff received appropriate professional development. We spoke with two staff about their experience of working at Hylton House. They gave positive feedback and told us that they received a lot of relevant training. The staff had a good understanding of the care and support needed by the people who use the service. We observed that staff were alert to changes in people's mood and body language and knew how they should respond to individual needs. Staff gave examples of training they had undertaken to help them meet people's specialist needs. This included training on epilepsy, using hoists, colostomy care and nutrition and hydration.

Records showed that staff had completed a range of training and learning to support them in their work and keep up to date with current practice and legislation. This included mandatory courses on key areas such as safeguarding, the Mental Capacity Act (2005), Deprivation of Liberty Safeguards, moving and handling, health and safety, handling medication and emergency first aid.

Staff had attended other specialist courses that were specific to people's assessed needs. For example, staff learnt about dysphagia to help them understand the difficulties people have with swallowing. Staff also completed a course on intensive interaction therapy so they could meet the needs of people who have sensory impairments. Records showed that the manager had also introduced competency checks on staff capability when using moving and handling techniques. The deputy manager discussed forthcoming training plans which included end of life care.

Feedback from relatives was complimentary about the staff and manager. Comments included, "the staff are lovely and have a very happy disposition" and "I never find the staff stressed, they are very compassionate." One relative said that the manager "makes a special effort to e-mail me photos of X from time to time which I greatly appreciate."

Records showed that staff were supported in their jobs through regular supervision and the manager had completed yearly appraisals with all staff in the past two months. These showed that that job performance was monitored and career development needs were discussed in relation to the home's objectives and people's needs. Staff confirmed that they had regular supervision and felt well supported by the manager. One told us, "If I have a concern, I am immediately supported by management."

Staff meetings were being held regularly and staff said they were able to contribute their ideas. We sampled some of the minutes which were clear and focused on people's needs as well as the day-to-day running of the home. Staff felt there was good teamwork which meant that there was ongoing dialogue and information exchange about the needs of people using the service. There was also a communication book, daily shift plans and handover records to support the sharing of information.

Assessing and monitoring the quality of service provision

✓ Met this standard

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

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people received.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service and others.

Reasons for our judgement

Due to their needs, the people using this service did not have the capacity to share their views regarding their care. We gathered evidence of people's experiences of the service by reviewing care records, surveys, audit reports for the home and speaking to relatives.

We were told that families were very involved in all aspects of a person's care and asked for their views about Hylton House. This was confirmed by the relatives we spoke to.

There were various systems in place to monitor the quality of the service provided. We saw that people using the service and their relatives were given satisfaction surveys once a year. The most recent surveys were sent out to people's relatives and other professionals involved with the service in April 2012. We sampled some of their responses which reflected positive feedback. The provider may wish to note that staff were not given surveys to feed back their experiences about how the home was run. This meant that not all those involved with the service had formal opportunities to contribute their views and ideas for improvement.

Regular health and safety checks were carried out on all aspects of the premises and equipment. This included appropriate maintenance contracts concerning fire, gas and electrical safety and for servicing equipment such as the lift, hoists and adapted baths. The provider may wish to note that although wheelchair repairs had been undertaken when needed there were no routine servicing records or regular maintenance checks on wheelchair safety. Other recorded audits were undertaken weekly or monthly and looked at areas such as the environment, food safety, care plans, medication and fire safety.

The provider took account of complaints and comments to improve the service. Relatives we spoke to told us they had never had cause to complain but were confident that management would address any concerns.

We saw that monthly unannounced visits were being undertaken by the registered manager. These reports always considered the experiences and outcomes for people

using the service as well as any actions taken to improve where needed.

The provider had developed a maintenance plan which identified planned improvements for the home including the completion of a garden shed conversion into a sensory room.

There was a record of all accidents, incidents and complaints and details of how these had been investigated. As required by law, our records show that the service has kept us promptly informed of any reportable events.

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.

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