Inspection Report

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

Saltmarsh House Residential Care Home

12 Saltmarsh Lane, Hayling Island, PO11 0JT

Tel: 02392462183

Date of Inspection: 21 February 2014

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We inspected the following standards to check that action had been taken to meet them. This is what we found:

Care and welfare of people who use services	✓ Met this standard

Details about this location

Registered Provider	Mrs K Dixon
Overview of the service	Saltmarsh House Residential Care provides accommodation for up to 12 older people with mild to moderate dementia.
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

We carried out this inspection to check whether Saltmarsh House Residential Care Home had taken action to meet the following essential standards:

- Care and welfare of people who use services

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 21 February 2014, talked with people who use the service and talked with staff. We reviewed information given to us by the provider.

What people told us and what we found

Following an inspection of Saltmarsh Residential Care Home, in November 2013, the service was identified as not being compliant with one of the essential standards. This standard related to care and welfare of people who used services . This concern was judged to have had a minor impact on people who used the service.

The provider wrote to us telling us that they were compliant with this standard on 23 January 2014.

At this inspection we spoke with a person who used the service, the registered manager, deputy manager and two members of staff.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Accidents/incidents were recorded, risk assessments carried out and care plans updated to reflect the care needs of people who used the service.

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

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.

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

Reasons for our judgement

At an inspection in November 2013 it was judged that the provider was not meeting this essential standard.

At that time the registered person had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of an up to date risk assessment, plan and delivery of care to ensure their welfare and safety. This concern was judged to have had a minor impact on people who used the service.

The provider was required to submit a plan detailing the action they were taking to ensure compliance with this standard and the date at which they would be compliant. The provider told us in their plan that they would be compliant with this standard by 23 January 2014.

At this inspection we spoke with two members of staff, the deputy manager and registered manager who each told us they had a system of reporting and monitoring accidents, falls, slips and trips. The deputy manager showed us the forms they used which included an accident/incident report and a falls register form.

A member of staff we spoke with demonstrated their understanding of the reporting procedure and told us they were not at the staff meeting, held earlier in the month of our inspection, but the manager had spoken with them separately. They also told us that there was a poster for staff which described the actions to take following an accident/incident. We saw this in place on the staff notice board.

Another member of staff told us they were told about the new reporting procedure at a staff meeting and went on to described the procedure to follow after an accident/incident. This matched the actions listed on the poster the previous member of staff spoke about. This member of staff said, "You've got it covered. This way there is less chance of it (accident/incident) not being communicated as there a number of copies made".

The manager told us, "Following any accident risk assessments are completed and care plans are updated".

During our inspection the registered manager told us, "A resident had a fall last night and the paperwork is still on my desk ready to be completed". They went on to tell us that this was the only accident that had happened since the date of their action plan and the new process had been put into place. Records we looked at confirmed this.

We looked at the falls register, which we were told was completed for all falls, and found that a record had been completed for the person who had fallen the night before our visit. The registered manager told us that they were in the process of completing an accident/incident form for this person at the time of our inspection.

We asked the registered manager to tell us what their next steps would be and they said, "I would speak to the resident and double check for injuries". We observed them checking the person who had fallen for injuries. We also observed them checking the person's wellbeing with a member of staff who had given them personal care earlier that day.

The registered manager also said they would, "Observe and record anything in the daily care diary". We looked at the daily care diary for this person and saw that the fall had been documented; which included, how the fall happened, action taken and that, "No injuries had been sustained".

We looked at this person's manual handling risk assessment which was completed in August 2013 and found that the assessment had documented the person was at risk of falling and had been assessed by a physiotherapist.

We spoke to the registered manager and asked if falls were audited and they told us, "A member of staff looks at falls incidents regularly and if they notice anything concerning they will liaise with appropriate professionals". We asked for documented evidence of this and was told, "No central audits are kept. The information is written in the care plan files".

We looked at the care plan file of one person who had fallen and found that there was evidence of liaison with other professionals regarding this person falling; however the information was not easily found.

During the inspection the deputy manager informed us that they lived on site with their partner and baby. We saw that there was a door in the lounge that the deputy manager came out of when we arrived. The deputy manager told us, "I live the other side of the door and have always lived on site since my parents started this business". On three occasions we observed the deputy manager's partner enter the home with their baby via the door in the lounge.

We spoke to the deputy manager and asked if their partner had a Criminal Record's Bureau (CRB) check. The deputy manager told us, "I'm not sure, I will have a look". They later confirmed that their partner had not had a CRB check. We spoke to the registered manager about this and the checks required for anyone who has access to people who used the service. The registered manager advised that they would complete the necessary checks immediately.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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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