Inspection Report

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

Valley Lodge Care Home

3 & 5 Valley Road, Chandlers Ford, Eastleigh, SO53 1GQ

Tel: 02380254034

Date of Inspection: 05 February 2014

Date of Publication: April 2014

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

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Camellia Care (Chandlers Ford) Limited
Registered Manager	Mrs Carolyn Moody
Overview of the service	Valley Lodge is a privately owned and managed care home offering care and support for up to 30 people, some of whom may have 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'.

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Summary of this inspection

Why we carried out this inspection

This inspection was part of a themed inspection programme specifically looking at the quality of care provided to support people living with dementia to maintain their physical and mental health and wellbeing. The programme looked at how providers worked together to provide care and at people's experiences of moving between care homes and hospital.

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 5 February 2014, 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 received feedback from people using comment cards.

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.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

There were 21 people using the service at the time of this inspection. The manager told us that all had been assessed as having some degree of dementia. We spoke with seven people who use the service, two visitors, four staff, the manager and deputy manager, a hairdresser and a chiropodist. We looked at the care and support records of five people who used the service and observed the care and support provided in communal areas.

We found that the service assessed, planned and delivered care for people with dementia in a considered and responsive way. They cooperated effectively with other providers to ensure that the safety and welfare of people was protected when their health care needs changed or when they moved between different services. The service was well led and continually assessed the quality of the care provided.

We observed that staff promoted an inclusive and supportive environment. A person living in the home told us "The care staff always make time to talk to me. There was something I was worried about; the staff told me they are here to help". Another person said "The main thing is I feel safe here; they have taken away the worry from me". A visitor remarked "This is a lovely home and the staff have so much patience and respect for the residents".

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

How are the needs of people with dementia assessed?
There was a pre-admission risk assessment tool that was used by the service when assessing a person's needs. The assessment included, for example, the person's medical history, mental state and communication, mobility, history of falls, weight, diet, diversity needs, interests and hobbies. There were also sections on pre-admission discussions with the person's next of kin, health professionals and social care staff.

Individually tailored care plans were generated from the assessments to help staff support people who developed symptoms that caused them distress, or who developed behaviour that challenged the service. For example, we saw that an external mental health professional had carried out an assessment for one person with complex needs and that this was subject to ongoing review. Another person could become distressed when staff attempted to support them with personal care. The service had also discussed this person's needs with external mental health services and this information was reflected in the care plan and assessment.

How is the care of people with dementia planned?
Each person whose records we looked at had a care and support plan, based on the assessment of the person's life history, social and family circumstance and preferences, physical and mental health needs, and current level of abilities. The plans provided guidance for staff on how people's needs should be met and were reviewed on a monthly basis or as circumstances changed. The care and support plans also contained person-centred information, such as people's preferred routines and what was important to them. For example, one person would sometimes choose not to wash. Their care plan explained how staff worked with the individual in ways that respected the person's independence and encouraged their health and wellbeing. People's end of life wishes and any advance decisions were also recorded as part of the care planning process. We saw how this information had been used to create a detailed end of life care plan for one person.

There were systems in place to ensure pain was managed effectively for people with dementia. We saw that care records, night care plans and medication support plans contained guidance for staff about how to make sure people were comfortable and free from pain, including how to identify signs of pain in people who may lack capacity to inform staff. One of the people we spoke with told us "After I went to the dentist I had pain. I asked for painkillers and one of the staff got me some".

Are people with dementia involved in making decisions about their care?
Staff we spoke with told us how people's views were taken into account. For instance, staff said that they involved people and their relatives by going through the care plans with them and explaining what they meant. We saw other evidence of this in the care records. Appropriate arrangements were in place where people lacked capacity to make decisions about their care. We saw that a best interest meeting had taken place in relation to a person's capacity to make decisions about taking medicines. The decisions had involved the person's relatives, GP and a pharmacist.

We observed that staff promoted an inclusive and supportive environment. A person who lived in the home told us "Overall the balance is caring and fun and including people in this home". Another person said "Staff ask my opinion, I get a choice".

Are people with dementia provided with information about their care?
The manager said that she discussed with staff about how to explain information to people in order to assist them to take part in reviews of their care. This was further confirmed through reading care plans and speaking with staff. Each person using the service had a named key worker, whose role was to help co-ordinate the person's care and support. This included involving them in their care reviews and keeping their relatives informed of changes, if appropriate. We saw that care plans had a section showing the frequency that people's relatives or representatives had chosen to review the care and support with the key worker, such as once a month or every three months. A member of staff explained how they would present information and choices to people with dementia. For example using short sentences, not giving too much information or asking too many questions, and giving people time to take in what was being said to them. We observed that staff communicated effectively with people using the service, taking into account people's usual communication skills.

We saw that the manager and deputy manager were approachable and responsive to people living in the home, visitors and staff. The manager told us about meetings she had facilitated to keep people using the service and their relatives informed about development plans for the extension and refurbishment of the home. Two people who used the service told us they could ask questions about anything if they wanted to.

How is care delivered to people with dementia?
We saw that staff involved people and treated them with kindness and respect. For example, we observed two staff serving tea and supporting people and another member of staff giving people their prescribed medicines. The atmosphere was relaxed and some people chatted to each other while they waited for their meals. A person using the service was singing and a member of staff joined in with them as they served the food. Another person did not want to sit down and went to the food trolley and stirred the soup. Staff carried on serving food and chatting to people. The member of staff giving medicines made sure they were positioned at the same level as the people they were speaking with as they gave them their medicines with a drink.

There were activities taking place in the morning and afternoon, which people using the service appeared to enjoy. For example, the activities co-ordinator was engaging people with a taste and smell activity. As staff walked through the lounge they chatted with people and asked if they were comfortable and happy. One of the care staff was giving manicures. A hairdresser and a chiropodist were visiting the home during the inspection and they also interacted with people living in the home. People appeared at ease with each other and with staff. A person living in the home told us "The care staff always make time to talk to me. There was something I was worried about; the staff told me they are here to help". Another person said "The main thing is I feel safe here; they have taken away the worry from me".

Is the privacy and dignity of people with dementia respected?
The manager confirmed there was zero tolerance to any disrespectful, discriminatory or abusive behaviour or attitudes towards people with dementia, their families and carers. This was supported by written policies and procedures, which staff were introduced to as part of their induction. We observed staff interacting with people in a respectful and caring manner. A person who used the service told us "They treat me very well here. They are always very respectful, friendly and helpful". A visitor told us "This is a lovely home and the staff have so much patience and respect for the residents".

The care environment promoted people's dignity and independence. Pictures were on bedroom doors that had relevance to the occupants. For example, one person had a picture of jewellery; another had a photo of the ocean. A new extension was being built and the manager told us that she and the owner were researching appropriate colours and furnishings. Another person using the service told us "I am able to do a lot for myself. It is a lovely place to live. I can choose when I get up and when I go to bed. I feel very safe and comfortable here. They help me stay independent".

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

How does the provider work with others when providing care to people with dementia?
The manager confirmed that for people whose placements were funded by social services, she had received an assessment of their needs. We saw examples of this in the records of people who used the service. For example, the pre-admission assessment carried out by the manager was backed up by information from the social services assessment. There were also hospital discharge summaries. This helped to ensure the accuracy of the information used to generate the care plan. Assessments and care plans contained evidence of discussions between the service and external health and social care professionals and also with people's relatives or representatives. This demonstrated that care and support plans were recorded and communicated with all relevant parties to ensure continuity and consistency.

Are people with dementia able to obtain appropriate health and social care support?
We saw how the home worked together with local community nursing and mental health services to ensure that the needs of people with dementia were identified and responded to appropriately. For example, one person's needs were the focus of a monthly assessment by a mental health senior practitioner and this was reflected in their care plan. We also saw that the service liaised with other health professionals in relation to providing appropriate end of life care when this was required. A person using the service told us "If I feel poorly they soon get a doctor for me. I see a dentist as well".

The care home worked with people with dementia and their families to request any support that was needed. The manager told us how, following a previous hospital admission for one person, a joint review had taken place with hospital staff and guidance had been implemented to support staff to attempt other interventions prior to hospital admission. We saw that a care plan and risk assessment was in place in relation to preventing admission to hospital whenever possible, in order to avoid unnecessary anxiety and distress to the person. When people were admitted to hospital, the service completed a hospital transfer form that provided a concise summary of the person's needs and preferences. This would help to ensure that the choices and preferences of people with dementia were respected as they moved between services.

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 receive.

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

Reasons for our judgement

How is the quality of dementia care monitored?
The manager had systems in place to monitor the quality of care being provided. These included talking with people using the service and relatives, staff supervisions and feedback, and observation. The manager worked 'on the floor' every third weekend, as she felt this was an important part of monitoring the quality of the service.

At the time of this inspection the manager was in the process of updating the training programme record. The manager told us that all staff, regardless of their job role, received basic dementia guidance during their induction by way of DVD training followed by a questionnaire. We were told that in June 2013 most of the staff completed a vocationally related qualification (VRQ) level 2 certificate in Principles of Dementia Care. We saw a sample of certificates of this. New staff and those who did not complete this training were waiting to be enrolled on the course at a local college. This was scheduled to take place on 25 February 2014. Ten members of staff would be undertaking the training in two separate enrolment sessions. This showed that the service supported staff learning in order to promote good quality care.

Staff we spoke with said the training they received helped them to understand and meet the needs of people with dementia. We observed that staff interacted with people using the service in a calm, caring and inclusive manner. Staff were not aware of National Institute for Health and Care Excellence (NICE) standards, however the manager had copies of these in the office. She told us that these had not yet been formally implemented and she would look into ways of incorporating the guidance into staff training and supervision.

Staff we spoke with confirmed they were supported and empowered to raise any problems and concerns and said they felt confident they could do so without fear of being penalised, bullied or harassed. The manager held regular meetings with staff and we saw that the supervision agenda included discussion about any concerns, complaints or safeguarding

matters. The manager said she felt confident that staff would raise any concerns immediately and not wait for supervision meetings. She gave an example of how staff had reported an issue that had been followed up and resulted in disciplinary action. The manager had spoken with the staff who had reported the matter and reassured them that they had acted appropriately.

How are the risks and benefits to people with dementia receiving care managed?
The manager told us the service rarely had incidents involving behaviour that challenged. She informed us that if a person became distressed or exhibited behaviour that challenged the service, staff would first check to rule out any possible physical causes, such as a urine infection. Staff we spoke with were aware of the guidance in people's care plans and told us how they would support the person at such times, which included giving the person time and diffusing the situation. A visitor told us "If one of the residents does get upset the staff are very good and go to them immediately and talk to them".

Staff told us they felt they had enough time to deliver good care to people with dementia. The manager told us that there were five care staff including the deputy manager on duty in the mornings; three care staff in the afternoons and two care staff on duty at night. The service also employed an activities co-ordinator, a cleaner and a cook, so that care staff were able to focus on providing care.

There were effective mechanisms in place to capture and report incidents and near misses. A single form was used to record falls, accidents and incidents and included a section for recording follow up actions, such as observations, reviews, updating risk assessments and notifying relevant external agencies. The manager carried out a monthly incident review in order to monitor for any patterns or trends. For example, a person using the service who had fallen three times had been referred to a GP and hip protectors had been ordered for the individual. The manager also demonstrated that lessons were learned from mistakes and were taken into account in relation to the training provided to staff. Following an in-house investigation into why an incident had not been recorded properly, the reporting system had been incorporated into the staff induction training.

The design, layout and maintenance of the premises and facilities enabled safe practices and the provider was making further improvements. The premises were in the process of being extended and refurbished and the manager told us about the research that she and the provider had carried out in order to make sure the design and layout would be suitable for people with dementia. The provider had also purchased a specialist 'profile' bed so that appropriate end of life care could be delivered.

Are the views of people with dementia taken into account?
The service had carried out a quality survey using questionnaires that were given to people using the service, relatives, staff and external professionals. The results were being collated at the time of this inspection. The responses we saw indicated that people's experiences of the service were positive. A visitor told us "I visit a lot of homes and this is the best one". A person using the service said "You can ask for anything in here". One person we spoke with was upset at changes to the garden as they liked to watch the birds. The manager was aware of their concern and told us they were going to make sure the person's new room faced the garden when the refurbishment was completed. Another person liked to walk and the manager was also aware of this and told us how people would be able to walk in the new garden independently and safely.

We saw there was a complaints procedure on display in the home and we looked at the

complaints log. A complaint had been received by the home from a relative and we saw that the manager had provided a full written response and the matter had been resolved. The manager informed us that the complaints procedure was available in a range of formats to suit people's needs, such as large print and audio versions. A person using the service said "Staff have a laugh with me. They treat me well. I have no complaints here". All of the people who we spoke with said they would complain to the manager. There was a note on the notice board asking people to speak to the manager if they had a problem.

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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