Isle of Wight Care Limited

Portland Lodge

Inspection report

21 Landguard Manor Road
Shanklin
Isle of Wight
PO37 7HZ

Tel: 01983862148

Date of inspection visit:
07 January 2019
10 January 2019

Date of publication:
13 February 2019

Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 07 and 10 January 2019 and was unannounced.

Portland Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Portland Lodge provides accommodation for up to 19 people and supports older people, some of whom are living with dementia or a mental health need. At the time of our inspection, there were 18 people living in the service.

There was a registered manager at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection, in July 2016, the service was rated as Good. At this inspection, we found the service remained Good overall, however we found evidence that some areas of the service were in need of improvement. You can see more about these findings in the Safe section of the report.

The risk of infection was not always managed safely. Appropriate hand washing facilities were not in place in the laundry room and the condition of the flooring in two communal bathrooms meant they could not be cleaned effectively.

Environmental risks had not always been considered and risk assessments were not always completed to reduce the risk of harm to people.

People felt safe living at Portland Lodge. Staff knew how to keep people safe and how to identify, prevent and report abuse. They engaged appropriately with the local safeguarding authority.

Systems were in place to ensure the safe management of medicines. People were supported to receive their medicines by staff who had been trained appropriately and medicine administration records were completed accurately.

Thorough staff recruitment checks were carried out when a new staff member started working for the service. There were enough staff available to keep people safe and staffing levels were monitored by the registered manager.

Staff received a variety of training and demonstrated knowledge, skill and competence to support people effectively. Staff were supported appropriately by the registered manager and deputy manager.

People had access to health and social care professionals where required and staff worked together co-operatively and efficiently.

Procedures were in place to help ensure that people received consistent support when they moved between services.

People were supported by staff with their nutritional and hydration needs. People were offered choice at mealtimes and menus contained a variety of nutritious and healthy foods. Where people had specific dietary requirements, this was well documented and staff were aware of how to meet these needs.

People were cared for with kindness and compassion. Staff had developed positive relationships with people and knew what mattered most to them.

Staff took action to protect people's dignity and privacy and encouraged people to be independent with all aspects of their daily routines where possible.

People had a clear, detailed and person-centred care plan in place, which guided staff on the most appropriate way to support them.

People could take part in activities which reflected their interests and provided mental and physical stimulation, as well as opportunities to be part of the local community.

People, their relatives, visitors and staff members commented positively on the leadership of the service and felt that the service was well-led. The provider was engaged with the running of the service and was approachable to people and staff.

Staff were organised, motivated and worked well as a team. They felt supported and valued by the registered manager.

There was an open culture in which people, visitors and staff were encouraged to given feedback about the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The risk of infection was not always managed effectively.

Some environmental risks had not been considered and risk assessments were not always in place to reduce the risk of harm.

People felt safe and staff knew how to identify, report and prevent abuse.

People received their medicines safety and as prescribed. Medicines were ordered, stored and disposed of correctly.

Appropriate recruitment procedures were in place. There were enough staff to meet people's needs.

Is the service effective?

Good

The service remained Good.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Good

The service remained Good.

Is the service well-led?

Good

The service remained Good.

Portland Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place on 7 and 10 January 2019 and was unannounced. On the first day of the inspection there were two inspectors and on the second day of the inspection, there was one inspector.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed the information in the PIR, along with other records we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

We spoke with eight people living at the home and four family members. We spoke with the registered manager, the deputy manager, three care staff, a domestic staff member and the cook. We also received feedback from three visiting healthcare professionals. We looked at care plans and associated records for six people, records relating to staff recruitment, training and support, records of accidents and incidents, policies and procedures and quality assurance.

The home was last inspected in July 2016 when it was rated as 'Good' overall.

Requires Improvement

Is the service safe?

Our findings

The risk of infection was not managed effectively in some areas of the service. For example, the flooring in two communal toilets was ill-fitting and badly stained. The gaps around the edges of the room created traps where bacteria could breed and pose a risk of infection. We raised these concerns with the registered manager and by the second day of the inspection, maintenance work was underway to replace the affected areas. The laundry room was organised and measures had been taken to ensure the risk of infection was minimised. For example, there was a dirty to clean flow for laundry, which helped to prevent cross contamination. However, there were limited hand washing facilities available to staff within this area. Some staff informed us that they would often use the sink in the nearby kitchen to wash their hands following their completed activities in the laundry room, or would go to the 'staff toilet' in another area of the home. This practice could cause contamination in food products and kitchen equipment and increase people's risk of illness. We discussed these concerns with the registered manager and by the second day of the inspection, a new hand wash basin had been ordered and plans were in place for this to be fitted. Personal protective equipment (PPE) was available throughout all areas of the home. Staff were seen to be wearing gloves and aprons when appropriate and had received training in infection control.

Some environmental risks to people living at the service were not managed safely. We identified a medicine that was prescribed for a staff member was left unsecured on a kitchen work surface, where people had access to it. We raised this with the registered manager, who confirmed the medicine should be securely stored and out of view. By the second day of the inspection, the registered manager had developed a clear risk assessment to ensure the medicine was stored securely and the risk of harm to people was minimised.

Most rooms on the first floor of the building had a secure window restrictor fitted to ensure people's safety. However, we identified one person's bedroom which did not have a fitted window restrictor. This was due to the person's preference and a risk assessment had not been completed around this risk. We discussed this with the registered manager and by the second day of the inspection, a risk assessment had been developed to ensure appropriate precautions were in place to protect people's safety.

All other individual risks to people had been considered and were managed effectively. Risk assessments had been completed and identified possible risks to people, along with actions staff needed to take to reduce the risks. For example, where people may behave in a way that might present a risk to the person or others, the behaviours and triggers had been identified and these were clearly understood by staff. People who were at risk of choking had clear and up to date information within their risk assessment of how this should be monitored and managed by staff. This included information about the need for fluids to be thickened with a thickening agent and highlighted the required consistency of the fluids and the amount of thickening agent to be used. Where people were at risk of falling, this was clearly documented in their care plan and risk assessment. Other risks were monitored and managed and risk assessments in place included moving and positioning, skin integrity, medicines management and smoking.

People told us they felt safe living at Portland Lodge. One person said, "I feel safe and secure" and another person told us, "It's the first time in years I have felt happy and safe." Staff had received training in

safeguarding and knew how to identify, prevent and report abuse. Staff had access to phone numbers for the local authority safeguarding team and were aware of how to contact them should the need arise. A staff member said, "I would go to [the registered manager and the deputy manager] first and if neither of them sorted it out, I would go to the safeguarding team or you [CQC]." The registered manager had contacted the CQC and the local authority safeguarding team where appropriate to raise issues of safeguarding concern.

People received their medicines safely. Medicines were administered by staff who had received appropriate training and had their competency to safely administer medicines assessed. We observed medicines to be administered in a safe, dignified and respectful way to people. A medicines profile had been completed for each person. This showed any allergies to medicines and the person's preference in taking their medicines. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved.

Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. On viewing the MAR chart no gaps were identified, this indicated that people received their medicines appropriately. There were suitable systems in place to ensure that medicines were securely stored, ordered and disposed of correctly and safely. Full stock checks of medicines were completed monthly to help ensure they were always available to people. Controlled drugs were stored in accordance with legal requirements and there were auditing systems in place to ensure that all medicines were given as prescribed and managed safely. Safe systems were in place for people who had been prescribed topical creams.

There were safe recruitment procedures in place. These included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. We found these checks had been completed appropriately before new staff started working with people. Potential new staff were shown around the home and introduced to some of the people using the service as part of the interview process. The registered manager told us that where possible, feedback was sought from people to give their initial views of the potential new staff member.

People and their relatives told us that there were sufficient staff to meet their needs. Comments included, "There's just about enough staff", "If I ring the call bell, the staff will come" and "Maybe [the service] could do with a few more staff, but generally it's ok." The registered manager told us staffing levels were assessed regularly according to people's level of needs. They further commented that if required, existing staff were able to pick up additional shifts to ensure adequate staffing cover. We observed that staffing levels in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner.

Where an incident or accident had occurred, clear records were made, which enabled the registered manager to identify any actions necessary to help reduce the risk of further incidents. Where people had fallen, the registered manager used a monthly falls monitoring system to track any trends or patterns.

There were clear emergency procedures in place. An on-call management system was used, so that staff knew who to contact in the event of an emergency, when a manager was not on the premises. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. People had personal evacuation plans in place detailing the support

they would need in an emergency. Staff had also undertaken first aid training.

Good

Is the service effective?

Our findings

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. One person said, "The staff are good, I get help when I need it" and another said, "I am well looked after." A relative told us, "[My relative] is a changed man, they have sorted out his washing, shaving and his personal care brilliantly."

New staff completed a structured induction programme before being allowed to work on their own. This included a period of shadowing a more experienced member of staff and the completion of essential training, such as fire safety and moving and handling. Experienced staff received regular refresher training in all key subjects and were supported to undertake other training relevant to their role, such as trauma first aid. A staff member said, "I completed all of the mandatory ones when I started, but we get refreshers for them, it still continues. There is so much training." People and their relatives commented positively on staff knowledge and competence to carry out their roles. A relative told us, "The staff are well trained, they look after [my relative] well and they are nice people." Staff told us they felt supported in their roles. Staff received regular one to one sessions of supervision and an annual appraisal, which were recorded in a clear format. Supervisions and appraisals provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns and discuss training needs. Staff were also regularly observed by the management team and provided with feedback in relation to these observations.

Information in relation to people's health needs and how these should be managed was clearly documented within people's care plans. People's general health was monitored and they were referred to doctors and other healthcare specialists when required. Staff described how they supported people, which reflected the information in people's care plans and risk assessments. Records showed that people were seen regularly by doctors, opticians and chiropodists as required. A person told us, "They [staff] make sure I'm well, they will take me to health appointments if I need them to." A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used the Malnutrition Universal Screening Tool (MUST) to help calculate people's body mass index and identify the need for nutritional support. Other nationally recognised tools were used to assess people's risk of developing pressure injuries.

There were clear procedures in place to help ensure that people received consistent support when they moved between services. For example, within people's care records there was a transfer to hospital form which included; information about the person's general health, current concerns, abilities and level of assistance required, communication abilities as well as information about their cognitive abilities and behaviours. This allowed person centred care to be provided consistently.

People were complimentary about the food provided. One person described the food as, "Lovely." Another person told us, "The food is very good; dinner on Friday was smashing." Throughout the inspection, we saw that people were offered snacks and hot and cold drinks, and staff prompted people to drink regularly. People confirmed that they were able to have drinks and snacks in the evening or at night if they wished. People were also able to get their own drinks and snacks independently from the kitchen if they were able.

One person said, "I can get my own breakfast in the morning or make myself a snack or a drink."

People were given a choice between two set options at meal times and alternative snacks such as soups and sandwiches were also available on request. One person said, "If didn't want what was offered, I could always ask for something else." Where people required assistance to cut up their food, this was provided promptly in a patient and supportive way. People were also supported to eat independently and were provided with alternative cutlery and crockery to aid their independence. When new people moved into the service, important information such as people's allergies was passed to the cook, in addition to people's likes or dislikes. The cook also told us that they spoke with people regularly about the menu to allow them to make suggestions about meal choices. Where people had been identified as having particular dietary requirements, including diabetic diets, this was clearly documented in people's care plans and understood by staff.

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Records showed that where people lacked capacity, decisions made on their behalf were done so in their best interest and with the support of people who had the legal authority to make those decisions. Staff had received training about the MCA and understood how to support people in line with the principles of the Act.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. Applications had been appropriately made to the local authority. Where DoLS had been approved by the local authority, there was a system in place to ensure any individual conditions were known, recorded in people's care plans and complied with. There was also a process to ensure DoLS were reapplied for when necessary.

People told us that staff asked for their consent when they were supporting them. During the inspection, we saw staff were considerate of gaining people's consent, such as asking permission before entering their bedroom. Staff described how they sought verbal consent from people before providing care and support. For example, one staff member describing how they supported people with personal care commented, "I always speak to [people] about what I'm doing and make sure they are ok with it."

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. One person told us, "Staff talk to me nicely" and another person described staff as "friendly." A visiting health professional commented, "I have always found staff to be pleasant and welcoming."

We observed interactions between people and staff which were positive, attentive and supportive. Staff addressed people using their preferred name, knelt to their eye level and used touch appropriately to provide reassurance. Staff spoke with people in a polite manner and took time to engage with people on a personal level, without rushing them. For example, when a person told a staff member they were cold, they immediately fetched a warm blanket and ensured the person was comfortable. They then checked the temperature of the person's bedroom and made sure there was not a window open, as they knew the person liked to spend time in their room. Another staff member, who was already occupied with a task, stopped to welcome a person into the communal lounge and sang with them, whilst assisting them to a chair. We saw the person smiling and enjoying the interaction whilst they sang together, which clearly put them in a cheerful mood.

Staff supported people to maintain relationships with the people that were important to them. Visitors were welcomed at any time and were offered refreshments, or to stay for a meal with their relative if they wished. Some people who were able to access the community independently, were encouraged to stay in contact with their friends and family by visiting them regularly. Staff had developed positive relationships with people and spoke about them with genuine affection. One staff member said, "It's very friendly and relaxed here. It's a small home so we get to know people really well." People were assigned a specific member of staff as their key worker. A key worker is a staff member who takes a particular interest in a named person, ensures the person's care plan is up to date and makes sure they have enough personal items, such as toiletries.

Several people living at the service had a diagnosis of dementia, which had an impact upon their physical and emotional needs. We observed interactions which clearly demonstrated that staff had a good knowledge of how to communicate with people living with dementia, in a caring and empathetic manner. For example, we observed one person walking around the home looking for their relative, who was visiting them later in the day. A staff member approached them and said, "I don't think they are here just yet, let's have a sit down and a drink." The staff member stayed with the person, speaking with them gently and patiently until the person had settled.

Staff understood the importance of protecting people's privacy and dignity and ensuring people were happy to receive care before providing this. Staff were considerate of people's privacy when attending to their personal care needs. For example, we observed a member of staff approach a person who was sat in a communal area with other people, and discreetly ask if the person would like to have a shower.

Staff respected and promoted independence by encouraging people to do as much as possible for themselves. People's care plans included clear information as to what support they needed and what parts

of personal care they could do independently.

People's cultural and diversity needs were explored during pre-admission assessments. Where people expressed a preference, they were supported by staff to maintain their faith, culture and life choices. For example, the cook told us about a person who had religious beliefs which meant they could not eat a particular meat and they were offered alternatives instead. The registered manager told us about another person who was visited by a local priest at the service, in order to maintain their faith.
The service had considered people's individual communication needs to ensure they received information in a way that they understood. People had a 'communication care plan' in place to guide staff on the best way to speak with people or present them with information. For example, one person's care plan stated, 'Give me time to express my wishes and concerns and offer me reassurance when it is needed.'

The registered manager was aware of how to request the services of independent advocates if needed. For example, they described how one person was visited each week by their advocate. Advocates can be used when people have been assessed to lack capacity under The Mental Capacity Act 2005 for a specific decision and have no-one else to act on their behalf. They spend time getting to know the people they are supporting to help make decisions that they believe the person would want.

Good

Is the service responsive?

Our findings

People received person-centred care and support that met their needs. One person said, "I'm happy, I'm fairly well looked after." A relative commented, "[My relative] is well looked after. I'm very happy with the service and [my relative] is happy, which is the main thing. I am really glad he's there, we were worried before, but I'm relieved he is there now."

Assessments were completed before people moved into the service, and the information was used to develop a care plan in consultation with people and their relatives where appropriate. As part of the assessment process, consideration was given to exploring people's personal history, interests and their individual preferences. Information of this type helps to ensure people receive consistent support and maintain their abilities and independence levels.

Care plans were clear, detailed, organised and provided comprehensive information to enable staff to deliver care and support in a personalised way. The care plans were centred on the needs of each person and how they wished to receive care and support. They each contained a description of the individual care people required, covering needs such as washing, dressing, continence, nutrition, health needs and information about activities and interests. For example, one person's care plan describing their night time routine said, 'I like my door to be open during the night, so the light from the hallway shines in.'

Staff used the information contained in people's care plans to ensure that care provided met the individual needs of each person. Staff had a good awareness of people's needs and daily records of care were up to date and showed care was being provided in accordance with people's needs. Care staff could describe the care and support required by individual people. For example, one care staff member described the support a person required when displaying behaviours which may cause harm to themselves or others. Another was able to tell us about activities a person enjoyed and what was important to them. This corresponded to information within care plans and was appropriate to ensure their needs were met.

Staff promoted choice and respected people's autonomy by empowering them to make as many of their own decisions as possible. A staff member said, "People can change their minds and we respect this." We heard people being offered choices throughout the inspection in relation to what they ate, where they wanted to sit, and how they spent their time. People confirmed staff offered them choices and respected their wishes. For example, one person said, "They give me a choice, I choose what to do."

Staff were responsive to people's changing needs. Records showed that when people's health deteriorated, the service referred people to appropriate health care professionals. People's care plans also contained detailed information for staff about what actions were required if people's needs changed. A low turnover of staff meant that people's needs were met consistently by staff that knew them well. Staff were kept up to date on people's changing needs through verbal handover meetings which were held in between shifts. These meetings provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting.

People had access to activities that they were interested in; however due to their needs and previous life choices, most people in the home preferred to follow their own interests with limited personal interaction. Despite this, staff encouraged people to participate in group activities if they wished, such as a weekly music and singing activity. Furthermore, the registered manager told us about arrangements they had made with a local arts charity, which they hoped would appeal to people with a creative interest. During the inspection, we saw people were free to spend their time where their wished and follow their own interests such as crafts, reading and watching television. The registered manager held regular coffee mornings and gatherings within the service, where people's families and friends were invited to join. Some people also went out independently in the local town to shops, cafes and on walks. A visiting health professional commented, "I have worked with a number of residents who have been [at Portland Lodge] for many months and are supported in leading independent interests outside of the home."

At the time of the inspection nobody was receiving end of life care, however the registered manager was able to describe how they supported family members and people, as they approached the end of their lives. Care plans contained information about people's next of kin and basic end of life wishes, such as the funeral provider people would want and whether they had a will in place. This would help to ensure that people's end of life preferences were respected and acted upon.

Since the previous inspection, no formal complaints had been received, however a process was in place to record and investigate complaints if required. People and their relatives told us that they felt able to raise a complaint and the provider and registered manager were approachable to discuss concerns. A relative said, "I have no concerns, but if I did, I know [the registered manager] would sort it."

Good

Is the service well-led?

Our findings

People told us they enjoyed living at Portland Lodge and felt the service was well-led. People's comments included, "This is my home now; it's tip top", "I am very happy", "I love it here, I don't want to go back home" and "I feel safe and wanted here."

There was a clear management structure in place consisting of the registered manager, the head of care and senior care staff. Each had clear roles and responsibilities and the management team worked well together. People and their relatives spoke positively of the leadership of the service and confirmed they were visible and approachable at all times. Comments included, "The [registered] manager is very nice, I've always got on with her", "She's very nice, she is a good boss" and "[The registered manager] is great, if I need to talk to her, she is there ready to talk." The registered manager was supported by the provider, who visited the service often and was fully engaged with the running of the service.

The registered manager had developed good working relationships with professionals and had a detailed knowledge of people's needs and medical conditions. Health professionals repeatedly told us how the registered manager worked hard to prioritise people's best interests and ensure their health needs were met. One visiting health professional said, "[The registered manager] has recently gone way above and beyond what should be expected of her to support a person who has very complex challenging needs and was at an extreme risk to life. She was the only person on the Island who was able to provide support and was going out all through the night to ensure this person was safe. It is not often that I come across this level of dedication towards others wellbeing by managers." Another described their close working partnership with the registered manager; they commented, "She is committed to the care of her patients and also bent over backwards to support [a person] as well."

The registered manager stayed up to date with safety alerts relevant to the care sector, such as drug safety and staying safe in extreme hot and cold weather. They also informed us of regular care forums and meetings which they attended alongside other care service providers and registered managers, as an opportunity to share and learn from best practice.

The service sought feedback from people, their relatives, staff and visiting professionals through annual surveys. The results of the surveys were collated by the registered manager and where issues were identified, follow up action had been taken. Furthermore, feedback was also obtained from people living at the home in an informal manner, where the registered manager or staff members sat with people individually to discuss any issues or suggestions.

Staff told us they enjoyed their roles and had confidence in the management of the service. One staff member commented, "I think [the registered manager] is lovely, she and the deputy manager work well together. They always communicate well with each other." Staff had an opportunity to give feedback about the service during regular staff meetings. These gave staff a chance to discuss particular areas of the service collaboratively with their colleagues.

Quality assurance processes had been developed to assess, monitor and improve the service, which included audits completed by the registered manager. These included auditing aspects of the service, such as medicines, care planning and fire equipment. The audits demonstrated that where concerns had been noted, actions were taken in a timely manner. Policies and procedures viewed were appropriate for the type of service and were accessible to people and staff members if required.

The service had a positive culture that was open and honest. Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager had informed the CQC of reportable events. The rating of the previous inspection was on display in the reception area of the service. A duty of candour policy had been developed and was being followed, to help ensure staff acted in an open and honest way when accidents occurred.