Portelet Care Limited

Portelet House Care Home

Inspection report

22 Grand Avenue
Southbourne
Bournemouth
Dorset
BH6 3SY

Tel: 01202422005

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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

This was an unannounced comprehensive inspection that took place on 29 June and 1 July 2016. At the last inspection, carried out in October 2013, we found the provider was compliant with the regulations and standards we reviewed.

Portelet House provides accommodation and personal care for up to 15 older people in a small, homely environment. At the time of the inspection there were 13 people living at the home.

There was no registered manager at the home at the time of the inspection. 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. The last registered manager ceased working at the home in September 2015. A new manager has been appointed to manage Portelet House and has applied to register as manager.

Overall, we found people were being well cared for and supported at Portelet House.

The home was well managed with established monitoring and auditing systems to make sure that the environment and way people were looked after were safe. Risk assessments had been completed to make sure that care was delivered safely with action taken to minimise identified hazards. The premises had also been risk assessed to make that the environment was safe for people.

Staff had been trained in safeguarding adults and were knowledgeable about the types of abuse and how take action if they had concerns.

Accidents and incidents were monitored to look for any trends where action could be taken to reduce chance of their recurrence.

Sufficient staff were employed at the home to meet the needs of people accommodated.

There were recruitment systems in place to make sure that suitable, qualified staff were employed at the home.

Medicines were managed safely.

The staff team were both knowledgeable and suitably trained.

There were good communication systems in place to make sure that staff were kept up to date with any changes in people's routines or care requirements.

Staff were well supported through supervision sessions with a line manager, and an annual performance review.

Staff and the manager were aware of the requirements of the Mental Capacity Act 2005 and acted in people's best interests where people lacked capacity to consent. The majority of people accommodated had capacity to make their own decisions for all aspects of their lives. They were all consulted about and had given consent to their care and support.

The home was compliant with the Deprivation of Liberty Safeguards, with appropriate referrals being made to the local authority.

People were provided with a good standard of food, appropriate to their needs.

People and staff were very positive about the standards of care provided. People were treated compassionately as individuals, with staff knowing people's needs.

People's care needs had been thoroughly assessed and care plans put in place to inform staff of how to care for people. The plans were person centred and covered all areas of people's needs. The plans we looked at in depth were up to date and accurate. It was agreed that for people with mental health needs, their care plans would be developed to further support these needs.

Staff and the manager took action when people's needs changed or responding to newly assessed needs.

Some activities were arranged by members of the staff team.

There were complaint systems in place and people were aware of how to make a complaint.

Should people need to transfer to another service, systems were in place to make sure that important information would be passed on so that people could experience continuity of care.

The home was well led. There was a very positive, open culture in the home.

There were systems in place to audit and monitor the quality of service provided to people.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service is safe.

Staff could recognise abuse and knew how to report concerns appropriately.

There were sufficient staff to ensure people's needs were met.

Medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff received regular training, supervision and appraisals and were well-supported to carry out their role.

The service was compliant with requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to have enough to eat and drink so that their dietary needs were met.

Is the service caring?

Good

The service was caring.

The staff team demonstrated compassion and a commitment to providing good care to people.

People's privacy and independence was respected

Is the service responsive?

Good

The service was responsive.

People's care and support needs had been assessed.

Individual care plans had been developed for people that were accurate and up to date.

There was a well-publicised complaints procedure.

Is the service well-led?

Good

The service was well led.

The manager provided clear leadership and direction.

The staff team were enthusiastic and were aware of their role and responsibilities.

There were auditing systems in place to seek improvement in the running of the home.

Portelet House Care Home

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 was 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.

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 improvements they plan to make.

We reviewed the notifications we had been sent from the service since we carried out our last inspection. The notifications we were sent had not included any substantiated safeguarding allegations. A notification is information about important events which the service is required to send us by law.

This inspection took place on 20 June and 1July 2016 and was unannounced. One inspector carried out the inspection over both days. We met with the majority of people living at the home and spoke with some people; however, because most people were living with dementia 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.

The manager of the home assisted us throughout the inspection. We spoke with three visiting relatives and a friend of someone living at the home. We also spoke with four members of staff.

We looked in depth at two people's care and support records, people's medication administration records as well as records relating to the management of the service. These including staffing rotas, staff recruitment and training records, premises maintenance records, a selection of the provider's audits and policies and quality assurance surveys.

Good

Is the service safe?

Our findings

Relatives we spoke with had no concerns about their family member's safety. One relative, when asked about safety, said, "They are safe and well cared for; I have confidence in the home." Another relative told us, "We now have peace of mind as they (their relative) was no longer safe at home because of declining mental health and falls."

Overall, we found the provider had taken steps to make sure people were protected from avoidable harm and abuse so that people's human rights were protected.
Staff were knowledgeable about identifying the signs of abuse and knew how to report possible abuse to the local social services.

Staff had completed training in adult safeguarding that included knowledge about the types of abuse and how to refer allegations. The staff were also aware of the provider's policy for safeguarding people who lived in the home. Training records confirmed staff had completed their adult safeguarding training courses and received refresher training when required.

The registered manager ensured risks were minimised in delivering people's care by carrying out risk assessments for areas that could affect older people, such as: malnutrition, falls, mobility and skin care. Risk assessments were in place for the people on whose care we focused. They had been reviewed each month, or when people's circumstances changed, to make sure that information for staff was up to date. The risk assessments then underpinned care plans that had also been developed to make sure that care was delivered as safely as possible.

The premises had also been risk assessed to minimise the potential of any hazard to cause harm to people. Radiators were covered, window restrictors were fitted to windows above the ground floor to prevent accidents and thermostatic mixer valves were installed on hot water outlets to protect people from scalding water. Portable electrical equipment had been tested to make sure it was safe to use.

Accidents and incidents that had occurred were monitored by the registered manager and reviewed to look for any trends where action could be taken to reduce the likelihood of recurrence. For example, for one person, whose health had deteriorated and who had experienced a number of falls, a pressure sensitive mat had been introduced and the person referred to both their GP and the falls clinic.

Where bed rails were being used to prevent a person from falling from bed, a detailed risk assessment had been completed to make sure they were used safely.
Personal evacuation plans, to be followed in the event of fire, had been completed for each person and were recorded in people's files.

The registered manager had completed a dependency profile concerning each person help determine the levels of staffing required to keep people safe and to meet their needs. Relatives and staff had no concerns about staffing levels and thought they were sufficient to meet people's needs.

At the time of inspection the following staffing levels were in place: between 8am and 11am, four care assistants and three between11am and 8pm. During the night time period there were two awake members of staff on duty. The manager told us these levels could vary on some days depending on people's needs.

The home had a core of staff who had worked for a long time. Robust recruitment procedures had been followed and all the required checks had been carried out. Records had been collated; these included a photograph of the staff member concerned, proof of their identity, references, a health declaration and a full employment history with gaps explained and reasons given for ceasing work when working in care. A check had also been made with the Disclosure and Barring Service to make sure people were suitable to work with people in a care setting.

The manager had systems in place to make sure that medicines were managed safely.

There was a system for ordering medicines required and to check medicines received from the pharmacist. Records showed that people had received medicines as required by staff who had been trained in safe medication administration. These staff had also had their competency assessed.

The home had adequate storage facilities for all medicines and medicines were stored in an orderly way and not overstocked. The home had a small fridge for storing medicines that required refrigeration. It was agreed that a record would be maintained of the maximum and minimum range of temperatures and not the record of the temperature of the fridge at one point in the day. We carried out a sample audit of medicines held and found that the amounts held tallied with the records.

Good

Is the service effective?

Our findings

A person told us, "I can see when I am in the lounge with my father that the staff know how to interact with everyone". Relatives had confidence in the staff team and told us that people's needs were met.

Staff had the skills and knowledge to make sure people received effective care. One member of staff told us, "The home is nice as it is small and therefore it is very personal."

Overall the staff were satisfied with the levels of training provided. The manager had a system in place to make sure staff received training that was appropriate to their role. Records provided showed the courses staff had attended and when they were due for update training. Training courses included: food hygiene, the Mental Capacity Act 2005, dementia awareness, moving and handling, infection control, adult safeguarding and health and safety training. Because some of the people accommodated had mental health conditions, training in this field had recently been sourced.

Staff told us they felt supported by the manager and the providers of the service, who regularly visited the home. Staff received regular one to one supervision sessions in line with the home's policy as well as an annual appraisal to look at their career development and review their year's performance.

Staff were knowledgeable about the needs of individuals we discussed with them. They told us there was good communication through staff handovers at the beginning of each change of shift.

Staff sought people's consent about how they were supported, for example, asking them where they would like to sit and what they wanted to eat. A relative told us, "My mother used to eat in her room but with gentle encouragement she now eats in the dining room; she is never forced to do anything".

Because the majority of people were living with dementia they were not always able to give their consent or to make some specific decisions. Under these circumstances people are subject to the requirements of the Mental Capacity Act 2005 (MCA). This provides a legal framework for making particular 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 be as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. Staff had good knowledge and understanding of the MCA as they had received training in this area. Mental capacity assessments were in place on people's files concerning specific decisions about their care and treatment, where staff had grounds to think that people might not be able to give consent. Where best interests decisions had been reached there was clear evidence recorded of the people involved and how the decisions were the least restrictive. The manager was aware of the need to establish whether relatives had been granted any lasting

powers of attorney so that staff knew about legal authority for decision making where people lacked capacity.

We also found that where people had been deprived of their liberty, applications had been made to the local authority. There was also a system to monitor whether applications had been granted and whether any conditions on authorisations to deprive a person of their liberty were being met.

People were supported to have sufficient to eat, drink and maintain a balanced diet. A relative told us, "The food is good; all home cooked". The mealtime was a positive experience for people with staff assisting people appropriately where this was required.

People's weight was regularly monitored and action taken when people lost weight. Nutritional assessments identified people's needs and personal preferences.
There were systems in place to monitor people's on-going health needs. Records showed referrals were made to health professionals including opticians, chiropodists, GPs and specialist health professionals.

Good

Is the service caring?

Our findings

A relative told us, "The staff are very caring"; they went on to say, "The home is what I would want and what I want for my father". From our observations it was evident that people felt comfortable and at ease with the staff. People would go to staff for reassurance and the staff responded warmly to people.

Throughout the inspection music appropriate to the age of people accommodated was played unobtrusively in the background. One person particularly enjoyed this and on more than one occasion wanted to dance with a member of staff. Overall, there was a positive ambience in the home.

The manager told us about a recent project to acquire some chickens, which was led by the staff who helped to raise money for the chicken coop and run installed in the back garden. The project had been very successful and given people a focus and interest.

We saw that staff respected people's privacy and dignity by knocking on their bedroom door before entering and ensuring that any personal care was carried out in privacy.

The staff were very knowledgeable about people and knew of their histories as there was information from relatives about life histories and personal preferences within people's care files. Staff addressed people by using their preferred form of address.

Relatives told us that they could visit at any time and were always made welcome.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Relatives told us they had been consulted in planning their family member's care.

Assessment procedures made sure that the home could meet people's needs. A preadmission assessment of a person's needs had been carried out before a person moved into the home.

When a person was admitted to the home, more in depth assessments were carried out using a range of assessment tools and risk assessments. These were used as part of the system to develop an individual care plan for each person. Care plans we looked at were up to date and reflected people's needs. The care plans were person centred, having taken into account people's life history, giving a good overall picture of each person's ability and how to support their needs. It was agreed that for people who had mental health needs, more in depth care plans relating to their condition would be developed, for example, providing staff with information that would indicate a person's mental health was deteriorating and the link people to contact in this event.

People had been provided with specialist equipment where this was needed, such as an air mattress. Where air mattresses had been provided, staff ensured people's mattress settings corresponded to their weight. People who required the use of a hoist for their moving and handling needs had their own slings to minimise the risk of cross infection.

Some people had been referred to speech and language therapists because of swallowing difficulties, with a resulting 'safe swallow' plan in place. The staff were aware of these people's needs and followed their care plans followed in response.

The home did not employ a dedicated activities coordinator; however, a member of staff was delegated for two hours each afternoon to provide activities. Staff told us this arrangement worked well with communal activities provided such as quizzes, arm chair exercises and discussions. Some people liked to go for short walks or spend time in the lounge or garden, which had been made more inviting and safer for people to use.

People knew how to make a complaint if they needed as this procedure was well-publicised, being detailed within Terms and Conditions of Residence and posted on each floor of the home. No complaints had been raised about the service this year.

There was a system in place should people need to transfer between services, for example, if they had to go into hospital or be moved to a nursing home. This ensured information accompanied the person so that consistent, planned care could be provided to that person.

Good

Is the service well-led?

Our findings

A new manager had been appointed to run the home and was in the process of registering with the Care Quality Commission (CQC). There was a positive, caring and open culture in the home and everyone spoke highly of the manager and how the home was run.

The staff we spoke with all told us that there was good morale with everyone working together in supporting people at the home. Relatives also confirmed that the registered manager was open and always available to speak with.

The records we reviewed were accurate and up to date and were readily accessible when asked for.

There were regular meetings for staff, which provided updates on changes happening at the home, shared learning from accidents, incidents and complaints, and covered items raised by staff themselves.

There were well-developed quality assurance systems in place to monitor the quality of service being delivered and the running of the home. These included audits such as medication, infection control, accidents, incidents and care planning.

The manager had notified CQC of significant events, such as deaths, serious injuries and applications to deprive people of their liberty under the Deprivation of Liberty Safeguards. We use such information to monitor the service and ensure they respond appropriately to keep people safe.