Portelet Manor Limited

Portelet Manor Rest Home

Inspection report

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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

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

Portelet Manor Rest Home was registered for 25 people. There were 18 older people living in the home at the time of our inspection. The home is an adapted building in a residential area of Bournemouth. People had a variety of care and support needs related to their physical and mental health.

This unannounced inspection took place on 10 November 2018. This was our first inspection of this service since it had been bought by the current provider in December 2017.

People and staff described that the home had been through a period of change. They were all confident that the new provider and the management team were ensuring improvements and stability.

People living in the home received care and support from staff who knew them well and understood their needs. People were happy with their care and they shared appreciation and confidence in the management and staff team. People were supported to make choices about their care. Staff understood how the MCA supported their work and that best interest decisions had been made when people could not consent to their care. Care plans reflected that care was being delivered within the framework of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards had been applied for when necessary.

There were enough staff and this meant people had support, care and time, when they needed it, from staff who had been safely recruited.

There was not a registered manager for the service. 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 registered manager had resigned and an application had been made to cancel their registration. The new manager had started their application to register with the CQC.

Staff understood people's care needs and spoke about the individualised support people needed to meet these needs. They told us they felt well supported in their roles and had received training that provided them with the necessary knowledge and skills. There was a plan in place to ensure staff received refresher and specialised as deemed necessary by the provider.

Care documentation had been transferred to a computerised system and staff were positive about the benefits of this for accessing and monitoring information. This documentation was being reviewed and improved.

People felt safe. Staff understood the risks people faced and how to reduce these risks. Measures to reduce risk reflected the person's preferences. Staff also knew how to identify and respond to abuse.

People told us they saw health care professionals when necessary and were supported to maintain their health by staff. People's needs related to on going healthcare and health emergencies were met and recorded. People received their medicines as they were prescribed.

Where people had received end of life care in the home, we saw feedback from relatives that was consistent in its acknowledgement of the kindness and compassion of the staff team.

People described the food as good and there were systems in place to ensure people had enough to eat and drink.

People were engaged with activities that reflected their preferences, including individual and group activities both in the home and the local area. Staff had received training to develop the availability of meaningful activities.

Staff were cheerful and treated people and visitors with respect and kindness throughout our inspection.

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 was safe.

People felt safe. There were enough, safely recruited staff to meet their needs.

People were supported by staff who understood the risks they faced and spoke competently about how they reduced these risks.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective. People who were able to consent to their care had done so and told us they directed the care they received. Staff provided care in people's best interests when they could not consent.

Deprivation of Liberty Safeguards (DoLS) had been applied for appropriately.

People's needs had been assessed and they were cared for by staff who understood these needs.

Staff had received the training they needed to support people.

People had the food and drink they needed and saw a range of health professionals when they needed.

Is the service caring?

Good

The service was caring.

People received compassionate and kind care.

Staff communicated with people in a friendly and warm manner. They treated people with dignity and respect.

People were listened to and felt involved in making decisions about their care.

Is the service responsive?

Good

The service was responsive. People told us they were supported to live their life the way they chose to.

People were confident they were listened to and knew how to complain if they felt it necessary.

The staff team were committed to providing high quality care to people at the end of their lives.

Is the service well-led?

Good

The service was well led.

People and staff had confidence in the management and spoke highly of the support they received.

There were systems in place to monitor and improve quality including seeking the views of people and relatives.

Staff were committed to the ethos of the home and understood their roles.

Portelet Manor Rest 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 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.

This inspection took place on 10 November 2018 and was unannounced. The inspection team was made up of one inspector.

Before the inspection we reviewed information we held about the service. This included notifications the home had sent us and information received from other parties. The provider had completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also gathered feedback from the local authority monitoring team.

The majority of people living in the home were able to describe their experience of the care they received. We spoke with nine people living in the home and one visitor during our inspection visit. We also observed care practices, spoke with three members of staff, the manager, the operations manager and a visiting health professional. We looked at records related to four people's care, and reviewed records relating to the running of the service. This included four staff records, quality monitoring audits and accident and incident records.

Good

Is the service safe?

Our findings

People were supported by staff who understood the risks they faced and valued their right to make decisions about the way they lived their life. This meant people's rights were protected and their views were respected. Staff described the risks people faced confidently and they understood the measures that were in place to mitigate them. Risk assessments were in place. These assessments reflected individual's needs such as protecting skin from damage or reducing the risk of falls. One person was at high risk of developing sore skin, staff understood how they supported them to avoid this and records reflected that the person received care as identified by their risk assessments and outlined in their care plan. Where people needed equipment to reduce the risks they faced staff made appropriate referrals and chased up actions.

Emerging risks were identified and responded to. Incidents and accidents were recorded and actions were taken to reduce risks of reoccurrence. One person had found it difficult to find their way home whilst out. They had been given a card with the home's address and were reassured by this.

Some information was not held clearly in people's care plans. For example, staff understood the importance of information such as air bed settings. However, it reduces the risk of this setting being wrong, putting people at risk of pressure sore development, to ensure it is recorded clearly. This information was added to care plans, alongside more recent emerging risk information related to people's health whilst we were visiting.

People told us they felt safe and visitors shared this feeling. One person told us: "I feel safe. The staff are all kind.", and a visitor reflected on how the staff provided support to keep their loved one safe.

Staff had all received training in how to follow the safeguarding process and were able to describe how they would report suspected abuse. They were confident any concerns would be taken seriously and acted on. One member of staff told us: "I would report any concerns to my manager." Staff understood that other agencies had a function in ensuring people were safeguarded. They knew who these agencies were or where to find this information quickly. The provider promoted a transparent approach to any safeguarding concerns and had followed up a concern raised by a person with the local safeguarding team and notified CQC of the potential allegation. This approach reduced the risks faced by people.

Equipment owned or used by the registered provider, such as hoists and stair lifts were maintained appropriately. Effective systems were in place to ensure equipment was regularly serviced, and repaired as necessary.

There were enough staff on duty to meet people's needs. People told us, and we observed, this was the case and that staff had time to sit and chat with them. We spoke with the operational manager who explained that staffing levels were determined with a dependency tool and they had been increased to reflect the needs of people in the home. They told us, and we saw, the rota allowed staff to meet people's care needs and social needs.

Staff had been safely recruited. Recruitment checks were in place and demonstrated that people employed had satisfactory skills and knowledge needed to care for people. All staff files contained appropriate checks, such as two references and a Disclosure and Barring Service (DBS) check.

Staff received effective training in safety systems, processes and practices such as moving and handling, fire safety and infection control. Staff were clear on their responsibilities to ensure infection control. A recent audit had identified the need for more hand gel stations in the building and these were being fitted when we visited. People's rooms and communal areas were clean throughout our inspection. One person told us: "They keep my room nice."

The service had safe arrangements for the ordering, storage and disposal of medicines. Staff responsible for the administration of medicines had undertaken training and had their competency assessed. Some medicines required cold storage and there was a medicines refrigerator at the service. The temperature of the medicines refrigerator and the room where medicines were stored were monitored and were within an acceptable range. Medicines that required stricter controls by law were stored correctly in a separate cupboard and records kept in line with relevant legislation. Medicine Administration Records (MAR) were completed and audited appropriately. People were supported to take their medicines in ways that worked for them. Pain relief was available at all times and offered regularly.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) 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 people lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and 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). DoLs applications had been made where appropriate and were awaiting authorisation by the local authority, who supervise this process.

MCA assessments and best interest decisions had been made and recorded and covered whether a person should receive their care the way they did. This included specific decisions such as whether staff should administer their medicines.

There were systems in place to check if people living at Portelet Manor Rest Home had a Lasting Power of Attorney arrangement for health and welfare. This means they would have appointed people to help them make decisions or make decisions on their behalf. One person told us the staff understood the powers their relative had to manage their money and the decisions they had asked them to take should they become unwell.

Staff had received training in MCA and DoLS and demonstrated an understanding of the principles of the legislation. Staff told people what they were doing throughout any care provision and asked permission from people. Staff gave examples of how they supported people to make as many decisions as possible by considering when and how they were asked to make them. For example, one person was not concerned about making the choice about their clothing but made clear decisions about the accessories they wore.

Before moving into the service people had their needs assessed. This assessment process identified initial support needs and enabled the service to determine whether or not they could meet those needs. People were protected from discrimination on the grounds of their gender, race, sexuality, disability or age and the paperwork associated with assessment had been updated to ensure that conversations related to equality started at the beginning of peoples' contact with the service. Admission assessments were used to develop a care plan for the person.

The use of technology and equipment to assist with the delivery of effective care, and promote people's independence, was being explored. There was a call bell system that people could use to alert staff if they needed support or in emergency and an electronic care planning system had been introduced that provided care plan information direct to staff and alerted senior staff if tasks were not carried out.

Staff had the appropriate skills, knowledge and experience to deliver effective care and support. New

employees completed a comprehensive induction programme. This consisted of training and shadowing including an introduction to organisational policies and procedures. One member of staff described this process saying: "It was helpful. It gave me the skills I need." The new manager had also completed shadowing to ensure they got to know people through staff that knew them well. One member of staff told us they had been enrolled on the Care Certificate. This is a programme of training designed to help ensure care staff that are new to working in care have initial training that gives them an understanding of good working practice within the care sector.

Staff received comprehensive training that enabled them to carry out their roles. For example, care staff received training in first aid, fire safety, infection control, moving and handling and safeguarding. They also received training to support their roles such as training to support the provision of appropriate activities and training related to specific health needs,

Staff told us they felt supported by their colleagues and the management team. They spoke positively about the new manager and provider representative who visited regularly. They all commented on how supportive and accessible the operational manager was. One member of staff said: "I feel very supported, I can talk about anything and ask any question." There was a system in place for staff to take part in regular supervision and appraisal sessions. They told us this gave them an opportunity to discuss any concerns and highlight any training or development needs.

People told us the food was good and that they were involved in decisions about what they ate and drank. One person said: "The food is lovely." The cook visited people daily to check what they wanted to eat. They told us this meant they knew what people liked because they were 'vociferous' in their feedback. People were also asked about what they liked to eat as part of their assessment process and this included any cultural or religious dietary needs. If people changed their mind about their choice of food they were offered alternatives.

People were supported to have a balanced diet that supported their health and well being. There were at least three choices available to people at each meal. Some people had been identified as being at risk because they had lost weight. Food and fluid charts were included in the computerised system and people's intakes were monitored and their weight was regularly checked. Care plans contained guidance for staff on how to support people to eat enough and information about people's preferences. Kitchen staff were aware of people's specific needs. They were knowledgeable about people's likes and dislikes and demonstrated a creative approach to encouraging people to enjoy food. One person was at risk of choking and needed a soft diet to minimise the risk. This person actual preferred a pureed diet and staff respected this. We observed people at lunch and saw it was a relaxed and social occasion. Some people required assistance and this was provided by staff who sat alongside them and communicated appropriately.

The Food Standard Agency had awarded a top rating of five following an inspection in July 2018. This meant the service met the highest standards of hygiene and safety.

People's day to day health needs were dealt with in conjunction with health care professionals. One person told us: "They will call a doctor if I need one." A visiting healthcare professional described how staff made contact appropriately and followed guidance. Records showed that people had regular contact from a range of health professionals.

People told us they liked the physical environment. One person told us: "It is a lovely place." There was clear signage to indicate shared lounges and bathrooms and people's individual bedrooms. This is important for people who can become disorientated in their environment. There was access to an outdoor space that

people used during our visit. There was decorative work going on during our visit and building work planned to improve the environment in response to the needs of people living there. For example, carpets were due to be changed once decorative work was finished. We checked the new carpets would reflect research regarding appropriate flooring for people with sensory perception difficulties. The operations manager confirmed this saying the complex patterned carpet would be replaced.

Good

Is the service caring?

Our findings

People told us they were happy with the care they received. They all told us how much they liked the staff. Comments from people included: "The staff are all very kind" and "I like the staff they are lovely." Staff told us they enjoyed their work and spoke warmly and affectionately about the people they supported and cared for. They told us their motivation for their work was the people living in the home. One member of staff described the things a person liked and said: "We want this to be people's home, we want them to feel cared for." Another member of staff told us: "I like to see people smile and know we have helped with that." They told us about people who had been through difficult times and how they were now able to relax more and receive and give kindness. Information about people's life histories was available to staff in people's care plans. Staff understood these histories and used the knowledge to develop warm and friendly relationships with people. The importance of developing relationships was promoted by the management team who always spent time with people before undertaking their office based work.

On the day of the inspection there was a calm and welcoming atmosphere in the home, which was at times punctuated with singing and laughter. We observed staff interacting with people in a caring and compassionate manner. For example, one person became upset and a member of staff chatted and used their knowledge of the person's interests to help them calm and get on with their day. People were supported to maintain their skills and staff knew which tasks people could do for themselves and those they needed help with.

Staff took time throughout the day to sit and talk with people in the communal areas and in their rooms. Some conversations were light hearted and familiar and this was appreciated. One person told us about how long they had known some of the staff. They appreciated the trust that came with this time and we heard them recounting shared memories with those staff members throughout the day. We saw that staff were also quiet and attentive when people needed reassurance or were focussed on a task. One person's communication had been impacted by their health and they no longer used words as their main means of communication. Staff described how they communicated their wishes and how they were able to spend time chatting about things the person cared about.

People told us staff respected them. Staff knocked on people's doors before entering and did not share personal information about people inappropriately. Bedrooms were individual; personalised with people's belongings, such as furniture, photographs and ornaments to help people to feel at home. One person told us: "I am happy here. It is really lovely."

People's cultural and spiritual needs were respected. One person told us they had been introduced to the local church when they moved in and now attended weekly.

People were encouraged to make decisions about their care, for example what they wished to wear, what they wanted to eat and how they wanted to spend their time. People appeared well cared for and staff supported them with their personal appearance; people's personal style was evident. A hairdresser visited regularly.

A visitor told us they could visit the service at any time and always felt welcome. People told us this was the case and that their visitors felt welcome and welcomed.

Good

Is the service responsive?

Our findings

People told us that staff spent time chatting with them and they enjoyed this. We also heard discussions about a forthcoming Christmas party which had captured the imagination of some of the people living in the home. People's care plans included information about how they enjoyed spending their time and this information was being developed. Staff had undertaken training in cognitive stimulation and used this in the development and monitoring of activities. Historically, people had not been keen on group activities but following training and as the activities changed the confidence of staff and people to take part was growing. We saw monitoring of activities that reflected how the person had communicated, how their mood had been impacted and how they enjoyed themselves. We heard about games and baking and physical activity from staff and people. Staff were also implementing activities based on a research based project from a local university.

At the start of activities people were encouraged to talk and share their views. This had led to some people raising concerns or minor complaints that had been easy to respond to. Alongside this informal encouragement of complaints the information people and visitors needed to complain was visible in the home. There was a clear procedure and process in place. No formal complaints had been raised. People told us that their grumbles were heard and we saw that this was the case with maintenance work addressing person's most recent concern when we visited. This work was being done in a way that suited the person and the person doing the work listened to the person's requests,

People were supported to live their lives the way they chose and staff respected their choices. Staff described people's needs without judgement and emphasised people's personalities and preferences in all their discussion with us. Care plans were current and covered a range of areas including mobility, communication and nutrition and hydration. They were individualised with information about people's likes and dislikes and what people wanted to achieve. Staff could access the information on a hand held device and this meant they had the information necessary to enable them to provide appropriate care according to people's personal preferences. Staff were aware of each individual's care plan, and told us care plans were useful and up to date. When care plans had been updated it was clear what had changed and why; this meant it was possible to monitor people's changing needs. We noted that some pieces of information had not been updated on people's care plans. This did not impact on care as staff were well informed about people's needs, however, the operations manager addressed these omissions immediately. People's rooms and communal areas were cleaned throughout our inspection. One person told us: "They keep my room nice." The new manager had started to review care plans and had identified that some information could be provided more clearly. They had started to address this.

People's communication needs were identified at assessment before people moved into the service. These were recorded in the care plan so staff had information about people's needs. The care plans were updated to reflect changes and new information. One person's verbal communication had been impacted by their health condition. Staff were able to describe the visual cues they could follow when this person wasn't using words. Communication needs were flagged in the emergency information that transferred with people should they need hospital treatment.

If people chose to they had a care plan which outlined their wishes and choices for the end of their life. When appropriate the service consulted with the person and their representatives about the development and review of this care plan. The operations manager was a champion of end of life care and staff had been trained to support people, and their families, at the end of their lives. A number of the staff team had also received this training and plans were in place for all staff to receive end of life training. The home had received compliments from relatives of people who had died. These compliments highlighted the kindness of staff and were available for staff to read.

Good

Is the service well-led?

Our findings

Portelet Manor Rest Home had gone through a period of change with a new provider and three managers in the last year. Whilst staff reflected on this, they were united in their positivity about the new provider and the support they were provided by the operations manager. People too commented on the changes. It was clear from the feedback that the new provider had respected the staff and people and that change was being managed sensitively and with staff support.

There was no registered manager in post. The registered manager had resigned and an application had been made to cancel their registration in October 2018. The current manager who had experience of being a registered manager has started their application to register with the Care Quality Commission. The operations manager had based themselves in the home since the summer. People reacted with warmth to them and this was reciprocated.

The management team spoke highly of the whole staff team and clearly respected their skills and experience. The staff team and management team reflected on the homely nature of the service and spoke of each other and the people they supported as being like an extended family. Staff spoke with pride about their own work and that of their colleagues in supporting people to live full and happy lives.

There was a culture of openness. Management described this and records indicated that information was shared with significant others after incidents or near misses. Staff told us they would be confident to raise concerns with the management if this was necessary. They were confident in the availability of management to hear any concerns.

The service had a clear management structure. A recently promoted senior member of the staff team told us they were confident about what was expected of them and felt supported in taking on these new roles.

The registered persons had ensured all relevant legal requirements, including registration, safety and public health related obligations, and the submission of notifications had been complied with.

There were systems in place to ensure data security breaches were minimised. Staff used passwords to log into the online recording system and understood the importance of respecting confidentiality. We did not hear staff talking about people within earshot of others and when they shared information this was considered and respectful and supported the development of relationships between people.

The registered provider had a quality assurance process that involved a monthly visit to the home. This visit included gathering the experience of people and staff and reviewing safety and quality measures. Audits were in place and these were effective in identifying where improvements were necessary to ensure quality in all areas of the service. This oversight had been effective in securing and improving quality. For example, menus had been extended and activities developed. There were plans to make alterations to the building to ensure people received a high quality service that would meet their changing needs. The approach to quality assurance also included completion of an annual survey. The results of the most recent survey had

been positive.

The management team valued their relationships with other agencies and described them as positive. Information shared by the local authority was embedded in practice in the home and where appropriate suitable information, for example, about potential safeguarding matters, was shared with relevant agencies.